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 _____	11/08/2022

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

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F 000	INITIAL COMMENTS An extended recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 10/31/22 through 11/3/22 and on 11/7/22 through 11/8/22. Good Samaritan Society Sioux Falls Village was found not in compliance with the following requirements: F550, F565, F585, F600, F604, F610, F656, F657, F677, F679, F803, F804, F812, F835, F865, and F880.	F 000		
F 550 SS=F	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550	On 11/28/22 signage for resident #19 was removed from room; By 12/8/22 all resident rooms will be inspected for signage related to personal and private information. By 12/8/22, Administrator or designee, will educate all staff on treating residents in a dignified and respectful manner, including signage related to personal information, acknowledgement of resident needs, ensuring residents are covered to uphold dignity while being transported through halls, speaking and treatment with respect, dignity and in a professional manner.	12/8/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Baeten | TITLE: Administrator | (X6) DATE: 12/19/2022

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

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F 550	Continued From page 1 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the provider failed to ensure residents were treated in a dignified and respectful manner as demonstrated by: *Signage on one of one resident's (19) walls revealing personal and private information. *Lack of appropriate acknowledgement of one of one resident (63) when she requested assistance from one of one nurse aide (NA) S. *Disregard for appropriate body coverage when an unidentified staff member was transporting resident (6) through the hallway in a shower chair. *Ensuring all staff who provided care for residents were acting in a professional manner related to one of one resident's (83) documented grievance. *Ensuring three of three residents (51, 57, and 83) had received assistance related to toileting and dining. *Ensuring four of four residents (83, 204, 363, and 365) had been spoken to with respect and compassion. Findings include:	F 550	All other residents have the potential to be affected by the deficient practice. To ensure deficient practice will not recur, by 12/8/2022, we will initiate Angel Rounding; an intentional tool to observe staff, assess the resident environment, and interview residents, to assess residents are being treated in a dignified and respectful manner. Department supervisor or a designee from each department will participate in Angel Rounding weekly. All staff and new hires will complete education upon hire and annually, topics include Protecting resident rights in a Nursing Facility; Abuse and Neglect of Vulnerable Adults; HIPPA; Communicating Effectively.	

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F 550	Continued From page 2 1. Observation and interview on 10/31/22 at 5:00 p.m. of resident 19 in her room revealed: *She had five multi-colored paper signs taped in various places above her bed. *She said the signs made her feel embarrassed. *She felt she was being treated like a "little girl." *The signs revealed: -Diet restrictions. -Told her how to drink. -Told her where her money was being held. -Foods to avoid due to her diagnosis. -Told her the facility's address. 2. Observations and interviews on 10/31/22 at 5:00 p.m. through 6:15 p.m. of resident 51 revealed she had sat in the dining room for over an hour and no staff assisted her with dining. She left the dining room without eating any of her meal due to not receiving assistance. Refer to F677, finding B. 3. Observation on 10/31/22 at 5:54 p.m. in the facility's 400-wing dining room revealed: *Resident 63 was sitting at a table and raised her hand for assistance. *NA S said in a sharp tone, "What do you want?" -NA S turned and noticed the surveyor standing there after she said that to resident 63. -An unidentified resident sitting next to resident 63 stated, "she can't hear you," informing NA S that resident 63 was hard of hearing. -Resident 63 wheeled herself up to NA S to ask for assistance. 4. Observation and interview on 11/1/22 at 8:52 a.m. with resident 57 revealed: *Her call light was on. *She: -Stated she put her call light on about 10 minutes	F 550	To monitor performance and ensure on going compliance the Administrator or designee, will audit leadership rounding including completion of random resident interviews weekly x 4, biweekly x2, monthly x 1 and quarterly x1. The results of those audit findings will be brought to the monthly QAPI Committee meeting by the Administrator or designee and continued until the facility demonstrates sustained compliance as determined by the committee.	

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F 550	Continued From page 3 ago. -Really had to use the restroom. -Was going to have another accident if someone did not come help her soon. -Had voiced many concerns to them regarding her call light wait times. 5. Observation on 11/1/22 at 11:47 a.m. of resident 6 being pushed through a busy hallway in a shower chair by an unidentified staff member revealed the resident was naked and was covered in only a bathing blanket, which had not fully covered the resident. 6. Observation and interview on 11/1/22 at 7:21 a.m. of licensed practical nurse (LPN) II with resident 204 revealed: *LPN II had been getting medications ready to administer to residents. *A water pitcher with cups was on top of the cart. *Resident 204 had been restless and seated in a high back wheelchair next to the medication cart. -The wheelchair had been reclined so the resident had been unable to get out of the chair. *He was sitting forward and attempting to get up and out of his chair. *He requested water. *LPN II asked the resident to "sit back" in a stern voice. *When he asked for water a second time, she looked at him and asked him to "wait" in a frustrated tone. *He asked for water a third time. *LPN II poured water into a cup and handed it to him. *He drank the water quickly. Observation on 11/1/22 at 11:15 a.m. of resident 204 at the nurse's station:	F 550		

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F 550	Continued From page 4 *He was seated in the middle of the room in his wheelchair. *There were several unidentified nursing staff, including LPN II, in the room. *The staff were discussing confidential resident information. *He was staring off across the room and the staff were not including him in conversation. Interview on 11/2/22 at 9:53 a.m. and again at 10:27 a.m. with LPN II about resident 204 revealed: *He had been challenging to work with because he was often restless and agitated. *Redirection had not been effective. *He had fallen repeatedly. *His days and nights were mixed up and he only slept a few hours a night. *She felt one to one staffing was needed to keep him safe but there was no physician order for that staffing. *It had been impossible to remain with him all the time. *It had been very difficult to get all their duties completed and care for his needs at the same time. *The unit that resident 204 had been residing on was very busy due to all the resident's many medical needs. *Most of the residents in his hallway had required a mechanical lift for transfers with the assistance of two staff to operate, including resident 204. Observation and interview on 11/3/22 at 7:10 a.m. with LPN MM revealed: *She was a traveling nurse. *She was doing the morning medication pass for the residents. *Resident 204 was seated in a reclined position in	F 550		

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F 550	Continued From page 5 his wheelchair in the 300 hallway near her and the medication cart. *The resident had been fidgeting, sitting forward, and repeatedly attempting to stand up. *She used a sharp tone with the resident and asked him to sit back. *She had flushed cheeks and appeared to be frustrated with the resident. *It had been difficult for her to get her tasks completed and watch resident 204 at the same time. Observation on 11/8/22 at 7:05 a.m. with resident 204 in the 300 hallway revealed: *He was seated in his wheelchair. *There was a noticeably large hole about the size on a large egg in the resident's groin area of his sweatpants. *His underwear was exposed. *Several staff walked by, ignoring him, and had not assisted him to change his clothing or cover the hole. 7. Interview on 11/1/22 at 10:40 a.m. with anonymous resident 363 and their family member revealed: *Some of the staff spoke harshly and were not friendly or compassionate to the residents. *Those same staff argued with the residents at times. *Evenings were worse with staff who had poor attitudes and negative interactions with residents. *This resident's family member visited often and had heard staff speaking harshly with residents on several occasions. *The resident had repeatedly expressed concerns regarding staff poor treatment of residents. *They wished to remain anonymous because they did not want the situation to become worse or to	F 550		

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F 550	Continued From page 6 face retaliation by the staff. 8. Interview on 11/3/22 at 9:40 a.m. with resident 83 regarding her rights and grievances revealed: *A while back the call light system had stopped working. *A certified nursing assistant (CNA), that is no longer employed at the facility, had been in and out of her and her roommate's room. *The CNA had been helping her roommate and left before asking if she needed help. *Due to the call lights not working, she had no way to call for help and she was incontinent of urine. *On-coming CNA's requested report on how to care for resident 83's roommate. *The off-going CNA stated to ask resident 83 as she knew how to take care of her roommate. *Another incidence, CNA Q had been helping her to the toilet. *After helping her to the toilet, CNA Q was in the entry way using her personal cellphone. *While using her phone, she asked resident 83 if she was "done yet?" *When CNA Q helped her to lower her pants, she would grab the crotch of the resident's pants and pull down. *She does not feel that she should have to advocate for her rights. *She had asked administrator A if CNA Q was going to keep working at the facility. *He had told her that CNA Q's contract would not be renewed. *She had asked DON C if CNA Q was still working at the facility. She was informed that they were short staffed, and CNA Q would be staying. Interview on 11/3/22 at 11:00 a.m. with administrators A and B, and DON C regarding	F 550		

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F 550	Continued From page 7 CNA Q revealed: *Administrator B said she had renewed CNA Q's contract. Refer to F585, finding 3. 9. Observation on 11/8/22 at 9:23 a.m. of staff interacting with resident 365 in the 200-hallway revealed: -Resident was sitting in her wheelchair in her doorway. -She reached her hand out to get the attention of staffing coordinator BB. -Staffing coordinator BB said impatiently to the resident, "What do you want?" -Without giving the resident time to speak, staffing coordinator BB continued loudly, "You are right where you need to be, you're going to have a good day today!" -The resident looked disappointed as staffing coordinator BB walked away without giving the resident time to respond. Review of the provider's October 2022 Resident Dignity policy revealed: *"The location will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality." *"Treating residents with respect (e.g., [for example] addressing the resident with a name of the resident's choice; avoiding use of labels for residents, such as 'feeders;' not excluding residents from conversations or discussions in community settings in which others can overhear private information." *"Addressing residents as individuals when providing care and services." *"Maintaining an environment in which there are no signs posted in resident's rooms or in	F 550		

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F 550	Continued From page 8 employee work areas are able to be seen by other residents and/or visitors that include confidential clinical or personal information (such as information about incontinence, cognitive status). It is allowable to post signs with this type of information in more private locations such as inside of a closet or in employee locations that are not viewable by the public. An exception can be made in an individual case if a resident or responsible family remember insists on the posting of care information at the bedside..."	F 550		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every	F 565	By 11/29/22 facility completed Suggestion and Concern forms for each concern that was voiced during resident group meetings looking back 3 months. Grievance process was initiate per policy for each concern. Any resident raising a grievance during resident group has potential to be affected be the deficient practice. To ensure deficient practice will not recur, by 12/8/22, Administrator or designee will Social Services and Activity departments on policy for resident group and expectation for addressing grievance/	12/8/2022

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F 565	Continued From page 9 request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interviews, review of one of one resident council meeting minutes, and policy review, the provider failed to follow their policy for documenting and responding to resident's and/or family grievances, suggestions, or opportunities for improvement in care and services for all residents residing in the facility. Findings include: 1. Interview on 11/1/22 at 2:00 p.m. in the provider's "Wilcox Lounge" with residents 9, 10, 48, 55, 60, 61, 83, 97, 104, 112, 117, and 135 revealed: *The resident council met monthly with activities supervisor KK as the designated staff person who helped their resident group. *They voiced continued concern regarding the meal service. -Long wait times for meals to be served to the residents. -Not being served what was listed on the menu. --The kitchen running out of the main entrée before the end of meal service. -No choice of entrée. -Room trays with cold food and no condiments. *Concerns with restorative nurse aides (RNAs) getting pulled to the floor as certified nursing	F 565	concerns raised in resident group meetings. We will complete Suggestion and Concerns forms initiating location's Grievance process per policy for any grievances, suggestions or concerns discussed during resident council. Suggestion and concern forms be reviewed for resolution by administrator or designee once completed. To monitor performance and ensure on going compliance the Administrator or designee will audit Resident/Family Group meeting minutes to ensure policy and procedure is followed for documenting and responding to resident's and/or family, grievances, suggestions, or opportunities for improvement in care and services for all residents. Audits will occur monthly x3. Administrator or designee will report findings to the QAPI Committee monthly and will continue until the facility demonstrates sustained compliance as determined by the committee.	

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F 565	Continued From page 10 assistants (CNAs). *Concerns with the recently installed call light system. *Concerns with long response times to call lights. *Concerns with not enough staff during the evening. *When asked if the provider acted promptly to grievances or suggestions from the resident council, the response was "not really" as they heard "we're working on it" repeatedly. *When asked if the resident council received responses from the provider's grievance official, the resident group revealed: -Supervisor of social services H had not attended the resident council meetings and did not provide responses to the group's concerns. -Administrator A and/or administrator B attended the resident council meetings on occasion, and they do "some fancy side stepping" when addressing the concerns of the resident council. *When asked if staff treat residents with respect and dignity so that residents do not feel afraid, humiliated, or degraded, the group response revealed: -It was rare to see residents being treated with respect and dignity. -The group was concerned with those residents that were "not able to speak up for themselves." -They voiced many concerns regarding certified nursing assistant (CNA) Q and how she spoke to the residents. -It was a common occurrence to see residents pushed down the hallway on a shower chair with just a bath blanket covering the resident. --One unidentified resident said she had seen a resident transported in such a way with one side of the naked resident exposed. --She was not able to give the date, the name of the resident, or the staff member.	F 565		

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F 565	Continued From page 11 Interview on 11/3/22 at 9:46 a.m. with activities supervisor KK revealed: *She had been the activities supervisor for nine years. *The supervisor of social services H was the provider's designated grievance official. *The resident council meetings averaged between 10-25 residents in attendance. *The meetings included: -A reading of the minutes from the previous meeting. -Updates by one of the two administrators. -Discussion of department issues with department managers present. -They currently do not review any resident rights. *Following the resident council meeting, the concerns raised were sent out in an email from activities supervisor KK to the appropriate department manager(s), supervisor of social services H and both administrators (A and B). *She had not used the provider's "Suggestion or Concern" form to document the resident group's concerns. *The provider's "Suggestion or Concern" form was used for the concerns of individual residents. Review of resident council minutes from August 2022 through October 2022 revealed the following resident concerns: *Long wait time for meals. *When the food on trays was cold, staff were not helping with reheating the food because they were too busy. *Concern with salt and pepper shakers not always being available on the dining room tables. *Residents would like to have a choice of entrées at meals. *RNAs were being pulled to the floor as CNAs too	F 565		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 12 often. *Room trays at times arrive warm, but not consistently. *Vegetables were not drained and soaking everything on the plate. *Staff that were serving put cold and hot items together on the plate. *Residents were not getting condiments on their room trays. *No supervisor was present at evening meal service. -Residents felt younger staff did not know what they were doing and needed more supervision. *Residents were not receiving what was on the menu and when they asked why, staff stated the kitchen had run out of the main entrée. *Residents feel there were not enough staff in the evening. *Concern that trays and meals served in two dining rooms, "Sells" and "Friendship" were so late in being served. *Responses to the concerns were noted in the minutes following the concern in parentheses. Further review of resident council minutes from April 2022 through July 2022 revealed: *There were no minutes for May 2022 resident council meeting. *Residents were concerned with cold food and long wait time for food to be served. -"...takes 1/2 to 1 hour." Noted from June 2022 resident council meeting. -"Taking up to 1 1/2 hours to be served in dining rooms at times" noted from April 2022 resident council meeting. *There had been no documented resolutions or follow-up comments related to the resident's voiced concerns.	F 565		

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	435045	A. BUILDING _____ B. WING _____	11/08/2022

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F 565	Continued From page 13 Review of the provider's 10/6/22 "Resident Groups" policy revealed: *The purpose included "To ensure that residents are provided a means of voicing grievances and participating in decision making[.]" *The policy included "The location must provide a designated employee who is approved by the group to be responsible for providing assistance and responding to written requests that result from group meetings. The location must consider the views of the residents and act promptly upon the grievances and recommendations of the group concerning issues of resident care and life in the location." *The procedure included: -"All grievances discussed at the group meeting will be written in the minutes and filed on the Suggestion or Concern form..." -"Each department will respond to the resident group recommendations, concerns and grievances as requested and as appropriate, with plan of correction submitted to the administrator."	F 565		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the	F 585	On 11/29/22 Suggestion and Concern forms were completed for residents (9, 83, and 138) regarding voiced concerns. Grievance process completed for all 3 residents including documenting update to family and/or resident regarding progress of resolution and/or progress of investigation.	12/8/2022

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F 585	Continued From page 14 facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for	F 585	All residents who submit a grievance have the potential to be affected by this deficient practice. To ensure the deficient practice will not recur, on 12/7/2022 corporate Director of Risk Management or designee will educate location leadership on 12/7/22 Grievances, Suggestion or Concerns Policy and process per policy and procedure including documentation and updates to family and/or resident regarding progress of investigations. By 12/8/22, administrator or designee will education all staff on the policy and procedure for documenting and responding to a resident's and/or family grievances, suggestions or opportunities for improvement in care and services for residents residing in facility Suggestion and concern forms be reviewed by IDT for follow up communication to family and/or	

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F 585	Continued From page 15 example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.	F 585	residents regarding progress of resolution and/or progress of investigation after completion. To monitor performance and ensure on going compliance the Administrator or designee will audit all Suggestion and Concern Forms for completeness of documentation and updates to family and/or resident regarding progress of resolution or progress of investigation weekly x 4 weeks, every other week x2, monthly x1 and quarterly x1. The results of those audit findings will be brought to the monthly QAPI Committee meeting by the administrator or designee and will continue until the facility demonstrates sustained compliance as determined by the committee.	

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F 585	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure resident and family complaints had been documented on a grievance form and they were kept updated on the progress of the investigation for three of three sampled residents (9, 83, and 138) who had spoken to staff regarding their concerns. Findings include: 1. Review of resident 138's electronic medical record revealed: *Her diagnoses were dementia, Alzheimer's disease, anxiety disorder, and major depressive disorder. *She was unable to be interviewed. *She had a medical incident on 8/22/22 that required she be taken via emergency medical services to the emergency room. *During the hospitalization it was discovered she had fractures in both of her upper arms. *She returned to the facility on 9/1/22. Interview on 11/8/22 at 8:11 a.m. with resident 138's sister revealed: *While hospitalized it was discovered the resident had bilateral fractures of her upper arms. *She had not been concerned about her sister's care at the nursing home but wanted answers as to what had happened to her. *She voiced her concerns to the nursing home staff. *Administrator B had been in charge of the investigation. *She was informed they had reviewed camera footage and the footage had been inconclusive as to finding a cause for the fractures. *She felt she had not received ongoing	F 585		

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F 585	Continued From page 17 communication from administrator B regarding investigation findings and felt frustrated. *Administrator B had not been easy to get in contact with. Interview on 11/8/22 at 9:26 a.m. with supervisor of social services H revealed: *She had contacted resident 138's sister for an update on her progress at the hospital and discussed her bed hold. *The sister had voiced concerns about the fractures and inquired how the fractures could have happened. -She informed the sister that an investigation had already been started by administrator B for the incident regarding her sister. -She had not filled out a grievance form regarding her conversation with resident 138's sister but did forward the sister's concerns to administrator B. Interview on 11/8/22 at 10:42 a.m. with administrator B regarding resident 138's grievances revealed: *She agreed that she could have been in better communication with the family to let them know the investigation status. *She confirmed a grievance form had not been completed when the sister voiced her concerns and should have been. 2. Interview on 11/1/22 at 9:52 a.m. with resident 9 revealed: *Her room was located in the 200 hallway, not far from the nurses' station. *She had a brief interview for mental status (BIMS) score of 15 which indicated her cognition was intact. *A few days previously on a weekend she had been helped onto the toilet by a certified nursing	F 585		

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F 585	Continued From page 18	F 585		

assistant (CNA) with a sit-to-stand mechanical lift.
*The same CNA left for the day and had not returned to help the resident off the toilet.
-The time she had been assisted to the toilet was about 2:15 p.m. and she was not helped off the toilet until about two hours later.
*She pressed the bathroom call light, and nobody came.
*She yelled and hollered attempting to get the attention of the staff.
*The time had been about 4:15 p.m. when a CNA came and helped her off the toilet.
*She was scared, crying, and very upset by the time staff had come to help her.
*Staff came back and told her the call lights had not been working that day and they were working on getting a new call light system installed.
*She could not remember the names of those who had talked with her.
*She phoned her son and informed him about the incident.

Interview on 11/8/22 at 8:25 a.m. with resident 9's son and daughter-in-law revealed:
*That had not been the first time his mother was left on the toilet for an extended time.
*He called and spoke with the supervisor for social services the Monday after the incident happened.
*She informed them that the call light system had not been working.
*The facility had been working on the call light system for several weeks prior to this incident.
*The facility had not given them any further information about the investigation and what had happened that day other than to say the call light system was down.

Interview on 11/8/22 at 9:10 a.m. with supervisor

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F 585	Continued From page 19 of social services H revealed: *She spoke to resident 9's son the Monday following the incident. *His mother had been very upset about what happened and he voiced his concern about her care. *She explained to him the call light system had not been working that day. *The weekends tended to be busier for staff. *She had not filled out a grievance form after the call which was their policy when a family called with a concern. *She agreed a grievance form should have been completed and the family notified of investigation results. Interview on 11/2/22 at 3:31 p.m. with director of nursing (DON) C regarding the above incident with resident 9 revealed: *She had been aware of the incident. *She had spoken with the son about what happened and explained they had an issue with the call lights that day. *The resident had a history of reporting long call time waits when she had only waited a few minutes. -There had been no documentation in charting to confirm this information. *The phone conversation staff had with the son had not been documented in charting. *Agreed that when the son called to voice his concern about what happened to his mother a grievance form should have been filled out, investigated, and the results communicated with him. *She agreed she should have followed through. *They had not followed their policy. Interview on 11/2/22 at 3:58 p.m. with medication	F 585		

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F 585	Continued From page 20 assistant (MA) I revealed: *She had been working the day resident 9 had been left on the toilet. *The call lights were not working that day and it took some time for them to discover the problem with the call lights. *CNA JJ had found resident 9 sitting in the bathroom and assisted her off the toilet with the sit-to-stand and reported the incident to her. *The call light had been depressed but not working. *The resident had been crying and was distraught when she was discovered about 4:00 p.m. or 4:15 p.m. by CNA JJ. *Confirmed the staff that helped the resident onto the toilet had completed her shift and gone home for the day. *Was not sure why she had not been heard yelling for help. *Agreed the time the resident reported was correct for the length of time she waited for assistance. Interview on 11/2/22 at 6:32 p.m. with CNA JJ regarding the above incident revealed: *Administrator A had requested staff to go room to room and check on residents. *That was when the resident had been discovered. *When she found the resident, she was crying and upset. *She helped the resident off the toilet using the sit-to-stand lift. *She thought the time she had been there was about 4:00 p.m. *The resident had been on the toilet for about 2 hours. 3. Resident 83 had filed grievances regarding a	F 585		

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F 585	Continued From page 21 staff member and had not had her grievance resolved. Refer to F550, finding 8. Interview on 11/8/22 at 10:42 a.m. with administrator B about grievances revealed: *Anytime a resident or family member voiced a concern to staff, it should have been recorded on a grievance form, followed up on, and results reported back to whoever had the concern. *She agreed they had not followed their policy. Review of the provider's revised 9/16/21 grievance policy revealed: "Procedure: 1. When a resident patient, family member, visitor or employee expresses a concern or grievance, it will be received in an open, friendly, non-judgmental manner and without discrimination or reprisal. If the concern is an allegation of abuse, neglect, injury of unknown origin, misappropriation of resident property or exploitation, follow the abuse and neglect procedure. 2. If the problem can be resolved immediately, the employer will thank the individual for the information and proceed to take action regarding that problem. If this is not possible, the individual will be told who will address the problem and provide a response that will include the time frame by which the issue will be addressed. 3. On weekends and holidays, all concerns that pose an immediate danger will be handled by the weekend supervisor. The weekend supervisor then will take the necessary action to start an investigation and notify the necessary personnel. 4. The grievance will be documented on the Suggestion or Concern form and submitted to the grievance official. 5. The grievance official will route the form to the	F 585		

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F 585	Continued From page 22	F 585		

appropriate department manager as soon as is reasonably possible.
6. An investigation must be completed for all grievances. The investigation may be informal, but must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. NOTE: Investigations will be conducted in compliance with state specific rules and regulations.
7. The grievance official will issue a written grievance decision to the individuals filing the concern and to the administrator. The written grievance decision must include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued.
8. The grievance official will provide the contact information of independent entities with whom grievances may be filed (the pertinent State Long-Term Care Ombudsman program or protection and advocacy system.)
9. If the individual is not satisfied with the response and/or resolution to the grievance or concern, the grievance official will notify the administrator.
10. The grievance official will maintain a confidential file of documented concerns and report trends and actions to the QAPI committee.
11. The grievance official will be responsible for posting this procedure in an area accessible to residents/families and visitors. This responsibility also includes educating employees, residents, patients, family and visitors on the use of this

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F 585	Continued From page 23 form, as well as where visitors, employees, patients and residents can obtain forms for filing or how to verbalize their suggestion/concerns. 12. The Suggestion and Concern form will be maintained for three years from the issuance of the grievance decision."	F 585		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure three of three residents (9, 24, and 135) had a way of contacting staff when the call light system was malfunctioning. Findings include: 1. Observation and interview on 11/1/22 at 9:52 a.m. with resident 9 revealed: *Her room was located in the 200 hallway, not far from the nurse's station. *She had a brief interview for mental status (BIMS) score of 15 which indicated her cognition	F 600	For resident 9, by 12/8/2022 DNS or designee will education all nursing staff on importance of communicating during shift hand-off. Care plan review shows resident has documented preference to toilet for extend period of time. Investigation into allegation will be completed by 12/8/2022. For resident 24 and 135 the call light system has been functioning properly since 11/8/2022. On 11/28/22 Stanley Call light system engineers were on site to complete call system replacement. On 11/29/22 location verified enough metal call bells were available for all residents in location, in the event of call light system malfunction.	12/8/2022

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F 600	Continued From page 24 was intact. *A few days previously on a weekend she had been assisted onto the toilet by a certified nursing assistant (CNA) with a sit-to-stand mechanical lift. *The same CNA left for the day and had failed to return to assist the resident off of the toilet when she was done. Refer to F585 finding 2. 2. Interview on 11/1/22 at 9:58 a.m. with CNA CC about a situation with resident 24 when their call light system was malfunctioning revealed: *The facility was in the process of replacing their call light system. *About two to three weeks previously, the call light system had not been working altogether. *They gave residents metal bells to use while the call light system was down. *Staff soon realized they could not adequately hear the bells. *During one of the days the call light system was not working: -CNA CC took resident 24 to the restroom. -Resident 24 required the use of a stand-aide to transfer from her wheelchair to the toilet. -CNA CC did not bring the metal bell into the bathroom for resident 24 to use when she was done. -Resident 24 had no way of notifying staff that she was done using the bathroom. -CNA CC said she forgot about resident 24 for about 45 minutes to one hour. -She felt awful about leaving resident 24 on the toilet for that long and had profusely apologized to her. -CNA CC informed administrator A and clinical care leader F about the situation. Interview on 11/1/22 at 10:14 a.m. with resident	F 600	All residents who are dependent on staff for mobility have the potential to be affected by this deficient practice. By 12/8/2022 Emergency management plan and facility assessment will be updated to reflect actions taken in event of call light system failure. By 12/8/22 Administrator or designee will educate all staff to the procedure in the event of a call light system failure. By 12/8/2022, we will initiate Angel Rounding; an intentional tool to observe staff, assesses the resident environment, and interview residents, to assess residents are being treated in a dignified and respectful manner. Department supervisor or a designee from each department will participate in Angel Rounding weekly. All staff and new hires will complete education upon hire and annually, topics include Protecting resident rights in a Nursing Facility; Abuse and Neglect of Vulnerable Adults; HIPPA; Communicating Effectively.	

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	435045	A. BUILDING _____ B. WING _____	11/08/2022

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F 600	Continued From page 25 24 about the above situation revealed: *She remembered being left on the toilet for a long period of time. *She had a good relationship with CNA CC and did not blame her for what happened. A follow-up interview with CNA CC on 11/7/22 at 9:35 a.m. confirmed she reported the above situation to administrator A and clinical care leader F, and she did not know what they did with the verbal report. Interview on 11/7/22 at 10:02 a.m. with administrators A and B revealed: *They were not aware of the situation where resident 24 was left on the toilet for about 45 minutes to an hour when the call lights were malfunctioning. *They expected staff to: -Provide residents with the metal bells and ensure the residents always had the bells with them. -Perform additional rounding and monitoring for those who were physically unable to make the metal bells ring, and for those who were cognitively unable to understand the purpose of the bells. Interview on 11/7/22 at 11:09 a.m. with clinical care leader F revealed she was unaware of the situation where resident 24 was left on the toilet. Review of resident 24's electronic medical record revealed: *She was 100 years old. *She had a brief interview for mental status (BIMS) score of 15, indicating she was cognitively intact. *Her 10/10/22 minimum data set (MDS)	F 600	To monitor performance and ensure on going compliance regarding residents being free from potential neglect and delayed care and services, Administrator or designee, will audit leadership Angel rounding including completion of random resident interviews weekly x 4, biweekly x2, monthly x 1 and quarterly x1. The results of those audit findings will be brought to the monthly QAPI Committee meeting by the Administrator or designee and continued until the facility demonstrates sustained compliance as determined by the committee. The results of those audit findings will be brought to the monthly QAPI Committee meeting by the DNS or designee and will continue until the facility demonstrates sustained compliance as determined by the committee.	

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F 600	Continued From page 26 assessment indicated she: -Required extensive assistance with one person for transfers. -Required extensive assistance with one person to use the toilet. *Her care plan included a focus area of "The resident has an [activities of daily living] self-care performance deficit [related to] impaired mobility [related to] heart failure," with an intervention of "TOILET USE: use sit-to-stand [with one staff] using the leg straps." 3. Interview on 11/1/22 at 10:38 a.m. with resident 135 about the call lights revealed: *He explained about one month ago: -He was experiencing some pain with how he had been positioned in bed, and he pressed his call light with no one answering for about 90 minutes. -A CNA from another unit happened to be walking by and had heard him yelling; he finally got the help he needed. -During that time, he felt stranded, alone, and unsafe. *He was unaware that other residents were provided with metal bells and was upset that staff did not provide him with a metal bell when the call light system was malfunctioning. *Since he had a diagnosis of cerebral palsy, he relied on staff to help him with activities like dressing, personal hygiene, toileting, and transferring. Interview on 11/7/22 at 10:02 a.m. and 11:09 a.m. with administrators A and B, and clinical care leader F, respectively, revealed that no one had informed them that resident 135 had not been provided with a metal bell when the call light system was malfunctioning. Administrator A reviewed camera footage and confirmed resident	F 600		

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F 600	Continued From page 27 135 had had to wait over an hour for someone to answer his call light on the night described above. Review of resident 135's call light audits generated from 8/1/22 to 10/31/22 confirmed he had pressed his call light on 10/5/22 at 2:01 a.m. The call light was cleared by a staff member on 10/5/22 at 3:38 a.m., 97-minutes later. Review of resident 135's electronic medical record revealed: *He had a BIMS score of 15, indicating he was cognitively intact. *His 8/15/22 MDS assessment revealed he: -Required extensive assistance of two or more staff for bed mobility and toileting. -Was totally dependent on two or more staff for transfers. *His care plan included a focus area of "The resident has an [activities of daily living] self-care performance deficit [related to] cerebral palsy [as evidenced by] need for [activities of daily living] assistance." He required extensive to total assistance from one to two staff for all bed mobility, total assistance with toileting, and total lift with two staff for transfers.	F 600		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	F 604		

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F 604	Continued From page 28 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and admission packet review, the provider failed to ensure: *One of one sampled resident's (204) wheelchair had not been reclined and positioned to restrict his movement to prevent him from getting out of his wheelchair. *One of one sampled resident (6) had been assessed for the use of an assist bar installed on her bed on a quarterly basis. Findings include: 1. Observation on 10/31/22 at 4:05 p.m. with resident 204 in the 300 hallway revealed: *He had been seated in a high-back wheelchair. *The seat had been in a reclined position.	F 604	On 11/28/22 resident #6 assist bar was assessed for use and risk of potential restraint. This grab bar was assessed and documented within medical record appropriately, along with a quarterly assessment scheduled for ongoing assessment of grab bar use. On 11/28/22 resident #204's highback reclining wheelchair was assessed for potential restraint, a physician order was obtained, and residents daughter voiced preference for resident to continue to use reclining wheelchair. Care plan for resident #204 updated to reflect appropriate wheelchair use. All other residents using assist bars have the potential to be affected by this deficient practice. By 11/28/22 those residents identified were assessed for use of grab bars, with assessments scheduled on a quarterly basis for ongoing assessment. Other residents utilizing high back reclining wheelchairs have the potential to be affected by this deficient practice. Audit was conducted	12/8/2022

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F 604	Continued From page 29 *The resident had been moving his upper body forward and attempted to get out of the chair. *The position of the wheelchair had made it difficult for him to move freely. Observation on 11/1/22 at 7:21 a.m. of resident 204 revealed: *He had been seated in a high-back wheelchair in the 300 hallway. *His wheelchair had been reclined back. *The pedals of his wheelchair had been raised up. *He had been sitting forward and scooting his bottom toward the front edge of the seat of the wheelchair attempting to stand up. *LPN II had been at the medication cart administering medications. *She got the assistance of a couple of unidentified CNAs to help her with the resident. *They repositioned him back into his wheelchair, placed the pedals down and moved the back of his wheelchair into an uprights position. Interview on 11/1/22 at 9:58 a.m. with CNA PP regarding resident 204 revealed: *The resident had a lot of falls since his admission a few weeks ago. *The resident had required a lot of staff time because he had been restless and tended to try to get up out of his wheelchair all the time. *They could use someone to stay with him on a one-to-one basis. *It had been difficult for them to get their work done in the 300 hallway and attend to his needs at the same time. Interview on 11/1/22 at 1:59 p.m. with clinical care leader F revealed: *He admitted on 10/21/22.	F 604	11/30/22 to identify residents and appropriately assess and care plan to reflect appropriate wheelchair use. By 12/8/2022 Director of Nursing or designee will educate Nursing staff regarding physical restraints, including initial assessment and ongoing quarterly requirements of physical devices, and alternatives to restraints. To ensure the deficient practice will not recur, new admission checklist and MDS quarterly assessment checklist have been created, including assessment of grab bars and reclining wheelchairs upon admission and scheduling quarterly review for ongoing assist bar and reclining wheelchair use. To monitor performance and ensure on going compliance, DNS or designee will monitor compliance by randomly auditing 10% of resident population and completion of assist bar and reclining wheelchair use assessments including initiating and	

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F 604	Continued From page 30 *He had a fall at another facility, broke his femur and admitted for rehabilitation and long-term care services. *He has dementia and has had a history of falls. *His daughter is a physical therapist and comes to visit him often. *The daughter reported he is not as alert and cognitive since he broke his femur. *Physical therapy had not released him to walk on his own yet. *He had been okayed to walk with two staff, one beside him with a gait belt, and another staff with a wheelchair who followed behind. *Staff had not done that much due to worry about him falling. *He sat in his chair most of the time. *His sleeping schedule is backwards with him sleeping more in the day and not at night. *The memory care unit had not been appropriate for him because most all those residents were ambulatory or had the ability to stand up on their own. *He had been restless and fidgety most of the time when he is awake. *Agreed that if he were reclined back in his wheelchair, it would be more difficult for him to move. *She agreed staff should not lay him back in his wheelchair to restrict his movement. Observation on 11/1/22 at 4:15 p.m. of resident 204 in the 300 hallway by the nurse station revealed: *He is seated in his high-back wheelchair in a reclined position. *That position had made it more difficult for him to lean forward. *He had been trying to get up and out of the chair. *He is restless and fidgety in his wheelchair and	F 604	ongoing use on a quarterly basis weekly x 4 weeks, every other week x2, monthly x1 and quarterly x1. The results of those audit findings will be brought to the monthly QAPI Committee meeting by the DNS or designee and will continue until the facility demonstrates sustained compliance as determined by the committee.	

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F 604	Continued From page 31 his eyes are open. Interview on 11/2/22 at 9:53 a.m. with LPN II regarding resident 204 revealed: *He is restless and has been agitated at times. *Redirection does not work well with him. *He moves backwards in his chair by moving his feet and would not keep his feet on the foot-pedals. *He attempted to stand up all the time. *He has been found on the floor repeatedly. *Most times he had slid off his bed onto the floor or had been attempting to stand up. *He had only slept a couple of hours last night. *There had not been an order for the resident to have one-to-one care. *The staff who worked with him tried to keep him on one-to-one care due to fall risk and to keep him safe. *The CNA on overnights had to go from room to room with him while she assisted other residents. *He would sit in his wheelchair just outside of the room in the hallway when she assisted others. *It had been impossible to be with him all the time. *He holds staff hands hard at times because he would try to pull himself out of the wheelchair by holding onto staff. *It had been hard to keep him safe and get their work done at the same time. -She agreed they reclined his wheelchair to prevent his movement and/or falling. Interview on 11/2/22 at 10:13 a.m. with CNA PP revealed: *She had worked at the facility since June 2022. *He had only been at the facility for a few weeks. *Most of the time he needed supervision. *They could use more help to assist him and the	F 604		

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F 604	Continued From page 32 needs of all the residents in the 300 hallway. *It is a high acuity hallway. *The nurse had not been available or with him all the time because then she could not get her work done. *Sometimes he is more alert than other times. *Communication with him is minimal. *His daughter comes to see him often and he does better when she is here. *He has his days and nights mixed up. *His family brought him in a new mattress, but the bed frame is as low as it goes. *She thought he would benefit from having his bed lowered and a fall mat next to the bed to protect his knees. Further interview on 11/2/22 at 10:27 a.m. with LPN II regarding resident 204 revealed: *She had been scheduled to cover on the memory care unit as well as the 300 hallway. *The restorative aid had assisted with him if she had the time. *The resident had kept them busy, and the 300 hallway was very busy. *She had two CNAs to help her with those residents. *Almost every resident had needed a lift for transfers which required two staff. *She thought they could use more help from 6:00 to 10:00 a.m. to assist with the morning rush. *When he first admitted he had someone scheduled to work with him one-to-one. *The one-to-one staffing had only lasted the first few nights and had not continued. *The nursing staff were running trying to get all the residents cared for. Observation on 11/3/22 at 7:10 a.m. with LPN MM and resident 204 in the 300 hallway revealed:	F 604		

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F 604	Continued From page 33 *She had been a traveler and was just started the morning medication administration for the residents. *He had been seated in his wheelchair next to her. *The wheelchair had been reclined back. *He had been alert with eyes open, restless, and attempting to stand up. *She asked him to sit back in a stern voice. *He attempted to stand up again and she gestures him to sit back. *The position of the wheelchair had made it difficult to get up. *He does sit forward to try to get out of the chair. *She appeared frustrated with him and the situation. Interview on 11/8/22 at 4:30 p.m. with administrator A revealed: *They had been getting to know the resident as he had recently admitted. *He had not been aware staff had at times reclined the resident back in his wheelchair. *He agreed it could restrict the resident's movement if his wheelchair had been in a reclined position or the foot pedals on his wheelchair had been lifted upright. *He would expect staff to keep the resident safe but not restrict his movement. *He would not expect staff to leave the resident alone in the nurses' station unsupervised. Interview 11/8/22 at 2:30 p.m. medical director D regarding resident 204 revealed she agreed with surveyors concerns regarding resident 204 and stated reclining his wheelchair could be considered a restraint. Interview on 11/8/22 at 5:12 p.m. with resident	F 604		

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F 604	Continued From page 34 204's daughter revealed: *A care conference had taken place earlier that day for the resident. *She had requested a low bed and fall mat to be placed next to his bed but was told that would be considered a restraint. *She had witnessed her father in the wheelchair with foot pedals up and the wheelchair reclined back at times when she visited him. *She was unhappy with him being positioned that way because it restricted his movement. *She wanted him to be put in bed so he could get better rest. *She thought he needed more stimulation to keep him occupied. *Her occupation was physical therapist. *She had been able to stop in often to see him and check on him. *She agreed he had been a fall risk but would rather have him in a high-back chair without foot pedals attached so he had free movement. She wanted the staff to put a mat beside his bed and use a low bed with him so that he could just scoot onto the floor if he wanted to move around. Review of the provider's admission packet information revealed: *"The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms." 2. Observation of resident 6 on 10/31/22 at 5:48 p.m. in her room revealed she was in her bed which was positioned with one side along the outside wall with the window and the other side	F 604		

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F 604	Continued From page 35 towards the room with an assist bar. Review of resident 6's medical record revealed: *She was admitted on 8/11/15. *Her diagnoses included unspecified dementia. *Her annual minimum data set (MDS) assessed her cognitive skills for daily decision making as "Severely Impaired" with her brief interview for mental status (BIMS) not completed. *Her most recent "Physical Device and Restraint Review" was completed on 5/18/20. -The restraint being reviewed was "grab bars on bed[.]" -The purpose of this review was "To conduct a periodic review of physical restraints in order to encourage reduction and to ensure the restraint is the least restrictive." -The review was "Required quarterly." Interview on 11/2/22 at 4:01 p.m. with director of nursing C revealed: *The 5/18/20 "Physical Device and Restraint Review" was the most recent assessment for resident 6's assist bar. *She agreed the assist bar had been assessed quarterly prior to 5/18/20. *She did not have a reasonable explanation on why the quarterly assessments had stopped after 5/18/20.	F 604		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.	F 610	By 12/8/2022 fall histories of resident 92, 138, and 204 will be reviewed to ensure complete and accurate investigation and communication of prevention interventions.	12/8/2022

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F 610	Continued From page 36 §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to investigate and accurately document as well as report potential for abuse and neglect to the South Dakota Department of Health (SD DOH) for three of three residents (92, 138, 204) who had repeated falls. Findings include: 1. Review of resident 138's electronic medical record revealed: *Her diagnoses of dementia, Alzheimer's disease, anxiety disorder, major depressive disorder. *She was unable to be interviewed. *She had a medical incident on 8/22/22. *She had been gone unresponsive while seated in the memory care dining area. *She was taken to the emergency room by emergency medical services (EMS) personnel for treatment. *The resident was hospitalized and was found to have fractures in both of her upper arms. *She returned to the facility on 9/1/22. Review of resident 138's fall investigation forms had revealed: *Falls on:	F 610	Any resident experiencing and event requiring an investigation has the potential to be affected by this deficient practice. By 11/28/22, facility will audit all incident reports for last 30 days to determine other residents who have the potential to be affected to ensure thorough investigation was completed and fall huddle forms filled out correctly. By 12/8/2022, DNS or designee will educate all nurses in expectations for completing incident reports and fall scene huddle worksheets. Fall scene huddle worksheets will be reviewed by Safety committee monthly to identify opportunities for improvement and education. To monitor performance and ensure on going compliance, the administrator or designee, will audit all abuse and neglect allegations for complete investigations, and 10% of fall scene huddle worksheets for completeness. Audits will occur weekly x 4 weeks, every other week x2, monthly x1 and quarterly x1.	

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	435045	A. BUILDING _____ B. WING _____	11/08/2022

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F 610	Continued From page 37 -9/22/22 at 1:14 p.m. -10/10/22 at 11:00 a.m. -11/4/22 at 8:00 p.m. Review of resident 138's fall investigation reports revealed: *On 9/22/22 at 1:14 p.m. the resident had an unwitnessed fall. -The form had not indicated if there was injury from the fall. -Corrective actions taken to prevent recurrence of this incident: Had been left blank. -Narrative comments: Resident hassling and immobilizer to bilateral arms. Does mess with immobilizer/sling. Discussed with hospice workers about discontinuing it. -Attached Fall Scene Huddle Worksheet had blank areas. *On 10/10/22 at 11:00 a.m. the resident had a witnessed fall. -She had no injury from the fall. -Summarize factors contributing to this incident: Had not been filled out. -Corrective actions taken to prevent recurrence of this incident: Had not been filled out. -Narrative comments: Encourage restorative when able. Staff to ambulate if anxious. Care plan updated. -Attached Fall Scene Huddle Worksheet had blank areas. *On 11/4/22 at 8:00 p.m. the resident had a witnessed fall. -The date of the investigation had not been filled out. -Corrective actions taken to prevent recurrence of this incident: Had been left blank. -Narrative comments: Take foot pedal off after transporting.	F 610	The results of those audit findings will be brought to the monthly QAPI Committee meeting by the Administrator or designee and will continue until the facility demonstrates sustained compliance as determined by the committee.	

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F 610	Continued From page 38 *There had been a fall on 8/29/22 but a fall report and the investigation form had not been filled out. Interview on 11/8/22 at 8:11 a.m. with resident 138's sister revealed: *Her sister had been hospitalized on 8/29/22 due to being unresponsive. *EMS was called and transferred her to the emergency room for care. *While hospitalized it was discovered through testing the resident had bilateral fractures of her upper arms. *She had not been concerned about her sister's quality of care at the nursing home but wanted answers as to what had happened to her. *She voiced her concerns to the nursing home staff. *Administrator B had been in charge of the investigation. *She was informed they had reviewed camera footage and the footage had been inconclusive as to finding a cause for the fractures. *She felt she had not received ongoing communication from administrator B regarding investigation findings and felt frustrated. *Administrator B had not been easy to get in contact with. Interview on 11/8/22 at 9:26 a.m. with supervisor of social services H revealed: *She had contacted resident 138's sister for an update of her progress at the hospital and to talk about her bed hold. *The sister had voiced concerns about the fractures and inquired how the fractures could have happened. *She was informed that an investigation had already been started by administrator B for the incident regarding her sister.	F 610		

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F 610	Continued From page 39 *She had not filled out a grievance form regarding her conversation with resident 138's sister but did forward the sister's concerns on to administration. Interview on 11/8/22 at 10:42 a.m. with administrator B revealed: *The incident with resident 138 had been reported to the state agency and the final report had been accepted. *An internal investigation had been ongoing. *She agreed she could have been in better communication with the family to let them know the investigation status. *She confirmed a grievance form had not been completed when the sister voiced her concerns and should have been. *Anytime a resident or family member voices a concern to staff, it should be recorded on a grievance form, followed up on, and results reported back to whoever had the concern. *She agreed they had not followed their policy. 2. Review of resident 204's EMR revealed: *His admission on 10/21/22. *He had diagnoses of: -Fracture of left femur. -History of falls. -Atrial Fibrillation. -Hypertension. -History of traumatic brain injury. -Dementia. -Psychotic disturbance. -Mood disturbance. -Anxiety. *The resident had several falls since his admission on 10/21/22 including: -10/23/22 at 8:40 a.m. -10/23/22 at 7:15 p.m. -10/25/22 at 4:00 a.m.	F 610		

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F 610	Continued From page 40 -10/25/22 at 2:00 p.m. -10/26/22 at 9:50 a.m. -10/31/22 at 7:00 a.m. -11/2/22 at 10:00 a.m. Review of resident 204's fall investigation reports revealed: *The reports had not been investigated or thoroughly completed. *On 10/23/22 at 8:40 a.m. the resident had an unwitnessed fall in his room. -He had been discovered beside his recliner on the floor. -He had no injury from the fall. -The date of investigation had not been completed. -Corrective actions taken to prevent recurrence of this incident: --Employee education/training or re-instruction had been checked. --Resident education/training or re-instruction had been checked. --Other: Ensure proper footwear. --Narrative comments: Ensure footwear. Care plan reviewed. -Attached Fall Scene Huddle Worksheet had blank areas. *On 10/23/22 at 7:15 p.m. the resident had an unwitnessed fall in his room. -List of caregivers/employees for past 72 hours had not been completed. -Corrective actions taken to prevent recurrence of this incident: Left blank. -Narrative comments: Will ensure that proper footwear is on at all times. -Attached Fall Scene Huddle Worksheet had blank areas and was not signed. *10/25/22 at 4:00 a.m. the resident had an	F 610		

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F 610	Continued From page 41 unwitnessed fall. -He had no injury from the fall. -Corrective actions taken to prevent recurrence of this incident: --Modify environment: need low bed and floor mat. Who will complete the corrective action: nursing. -Attached Fall Scene Huddle Worksheet had blank areas. *On 10/25/22 at 2:00 p.m. the resident had been found slipping out of bed and assisted to the floor by CNA. -Date of investigation was left blank. -Corrective actions taken to prevent recurrence of this incident: --Employee education/training or re-instruction had been checked. --Resident education/training or re-instruction had been checked. -Narrative comments: New mattress, medical doctor looking at medications, medication changes, new wheelchair. -Attached Fall Scene Huddle Worksheet had blank areas. *On 10/26/22 at 9:50 a.m. the resident had an unwitnessed fall. -List of caregivers/employees for past 72 hours had not been completed. -Corrective actions taken to prevent recurrence of this incident: Left blank. Narrative comments: New mattress brought in by family. New wheelchair. Medical doctor to review medications. -Attached Fall Scene Huddle Worksheet had blank areas. *On 10/31/22 the resident had been found sliding out of bed and was assisted to seated position by staff. *Date of investigation had not been filled out.	F 610		

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F 610	Continued From page 42 -Corrective actions taken to prevent recurrence of this incident: --Employee education/training or re-instruction had been checked. --Resident education/training or re-instruction had been checked. --Narrative comments: Family to bring new mattress. Medication to be reviewed. -Attached Fall Scene Huddle Worksheet had blank areas. *On 11/2/22 the resident had an unwitnessed fall. *Date of investigation had not been filled out. -List of caregivers/employees for past 72 hours had not been completed. -Corrective actions taken to prevent recurrence of this incident: --Employee education/training or re-instruction had been checked. --Resident education/training or re-instruction had been checked. *Narrative comments: Physician to review medications and address pain. -Attached Fall Scene Huddle Worksheet had blank areas. Review of resident 204's 10/21/22 care plan revealed: *Focus: The resident is at risk for falls related to impaired mobility and cognition. Date Initiated: 10/21/22. -Goal: Resident will be free from falls through the review date. Initiated: 10/21/22. -Interventions: --Educate resident/family about safety reminders and what to do if a fall occurs. --Educate resident/family/interdisciplinary team as to cause of fall. Initiated: 10/21/22. --Educate/instruct resident and family on the safe use of assistive devices. Initiated: 10/21/22.	F 610		

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F 610	Continued From page 43 --Remind resident not to bend over to pick up dropped items. Encourage use of grabber or to ask for assistance. Initiated: 10/21/22. --Modify environment to maximize safety. High back wheelchair with anti-roll brakes. Initiated: 10/27/22. --Review and modify environmental hazards (tubing, electrical supply cords, etcetera) that could cause or contribute to fall. Initiated: 10/21/22. *Focus: The resident has had actual fall with no injury related to history of falls. Initiated: 10/23/22 Revised: 10/24/22. -Goal: Resident will resume usual activities without further incident through review date. Initiated: 10/24/22. -Interventions: --Educate/instruct resident and family on safe use of assistive devices. Initiated: 10/24/22. --Ensure that resident is wearing appropriate footwear gripper socks and/or shoes when ambulating or mobilizing in wheelchair. Initiated: 10/24/22. --Monitor resident for significant changes in gait, mobility, positioning device, standing/sitting balance, and lower extremity joint function. Initiated: 10/24/22. *The care plan had not been revised to include interventions to prevent falls other than reminders, education, and the use of gripper socks after repeated falls had taken place. 3. Review of resident 92's EMR revealed: *The resident had falls since her admission on 4/1/21 including: -6/4/22 at 1:45 a.m. -7/3/22 at 6:15 p.m. -7/15/22 at 2:50 a.m. -8/19/22 at 7:10 a.m.	F 610		

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F 610	Continued From page 44 -9/7/22 at 1:35 a.m. 9/8/22 at 10:45 a.m. Review of resident 92's fall investigation reports revealed: *On 6/4/22 at 1:45 a.m. the resident had an unwitnessed fall. -Minimal injury marked. -The date of investigation had not been completed. -List of caregivers/employees for past 72 hours had not been completed. -Summarize factors that may have contributed to this incident: Had not been completed. -Corrective actions taken to prevent recurrence of this incident: Had not been completed. -Narrative comments: Just finished antibiotics for urinary tract infection. Toilet charting looks appropriate for that time. Continue current care plan. -Attached Fall Scene Huddle Worksheet had blank areas. *On 7/3/22 at 6:15 p.m. the resident had an unwitnessed fall in the dining area. -Entire form left uncompleted except for narrative comments: Will provide grabber for resident. Did interview resident and she stated she will just let someone help next time, but a grabber is a nice option. -Attached Fall Scene Huddle Worksheet had blank areas. *On 7/15/22 at 2:50 a.m. the resident had an unwitnessed fall. -Date of investigation had been left blank. -List of caregivers/employees for past 72 hours had not been completed. -Summarize factors that may have contributed to this incident: Had not been completed. -Corrective actions taken to prevent recurrence of	F 610		

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F 610	Continued From page 45 this incident: Had not been completed. -Narrative comments: Will put glow in the dark tape on call light. -Attached Fall Scene Huddle Worksheet had blank areas. *On 8/19/22 at 7:10 a.m. the resident had an unwitnessed fall. -The date of investigation had not been completed. -List of caregivers/employees for past 72 hours had not been completed. -Summarize factors that may have contributed to this incident: Had not been completed. -Corrective actions taken to prevent recurrence of this incident: Had not been completed. -Narrative comments: Will put glow in the dark tape on call light. -Attached Fall Scene Huddle Worksheet had blank areas. *On 9/7/22 at 1:35 a.m. the resident had an unwitnessed fall. -Corrective actions taken to prevent recurrence of this incident: Resident education/training or re-instruction. -Narrative comments: Resident prefers lying in bed. Ask staff to ask resident if she would like to go to bed. -Attached Fall Scene Huddle Worksheet had blank areas. *On 9/8/22 at 10:45 a.m. the resident had an unwitnessed fall. -Corrective actions taken to prevent recurrence of this incident: Get a new pressure pad. -Attached Fall Scene Huddle Worksheet had blank areas. Review of resident 92's 10/6/22 care plan revealed: *Focus: The resident is at risk for falls related to	F 610		

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F 610	Continued From page 46	F 610		

history of falls. Initiated: 4/1/21.
-Goals: Resident will be free of falls through the review date: Initiated: 4/1/21. Revised: 9/26/22.
-Interventions:
--Educate resident/family about safety reminders and what to do if a fall occurs. Initiated: 4/1/21.
--Ensure that resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair. Initiated: 4/1/21.
--Ensure/provide a safe environment. Call light and personal items within reach, encourage use of call light, floor clear of clutter. Call don't fall signs in room. Initiated: 4/1/21. Revision on 10/5/21.
*Focus: The resident has had an actual fall with minimal injury related to Parkinson's Disease evidenced by poor balance and mobility, impulsive, resident states she is impatient or "I will do what I want". Initiated 7/6/22.
-Goal: Resident will be free from major injuries related to falls through review date. Initiated: 7/15/22. Revised 9/26/22.
-Interventions:
--Provide activities that promote exercise and strength building where possible. Initiated: 5/6/21.
--Educate resident not to bend over to pick up dropped items. Encourage use of grabber or to ask for assistance. Will get resident grabber to use and encourage her to ask for help with dropped items if she does not have grabber with her. Initiated: 7/6/22.
--Ensure that resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair. Initiated: 5/6/21.
--Wheelchair next to bed. Remove foot pedals when in room. Call light in reach. Anti-roll brakes on wheelchair. Sensor pad in wheelchair. Glow in dark tape on call light. Initiated: 7/15/22.
--Monitor resident for significant changes in gait,

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F 610	Continued From page 47 mobility, positioning device, standing/sitting balance, and lower extremity joint function. Initiated: 5/6/21. --Review and modify environment hazards (tubing, electrical supply cords, etc.) that could cause or contribute to fall. Dye in wheelchair. Initiated: 8/30/21. --Review bowel and bladder continence status and establish and/or review toileting plan based on resident needs. Initiated: 8/4/21. *The mattress alarm had been care planned but had not been used recently. Interview on 11/1/22 at 3:17 p.m. with clinical care leader E revealed: *Fall forms and fall investigation forms were to be completed in entirety and then routed through the administration. *An investigation should be thorough to figure out what caused the event and to prevent further issues in the future. *The care plan should be reviewed and revised for needed interventions and interventions should be followed. *Those reports are reviewed by administration, supervisor of social services H, and DON C. *If the forms had not been filled out completely, they should have been.	F 610		
F 656 SS=F	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656	By 11/30 residents 19, 26, 50, 51, 63, 65, 102, 113, 131, and 133 care plans were updated to ensure they are person-centered and reflected the care needs of each resident.	12/8/2022

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F 656	Continued From page 48 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 656	All residents have the potential to be affected by this deficient practice. Audit will be conducted by 12/8/22, by DNS or designee, to identify other residents identified to have been affected by this deficient practice. All residents care plans identified will be updated to ensure they are person-centered and reflective the care needs of each resident by 12/8/22. To ensure the deficient practice will not recur, by 12/8/22, DNS or designee will educate all nursing staff regarding person-centered care planning. During morning clinical meetings, nursing leadership will identify changes in resident care needs and ensure care plans are updated to reflect current care needs. To monitor performance and ensure on going compliance the DNS or designee, will audit 10% of resident population to ensure care plans are person-centered and reflective of the current needs of each resident. Audits will occur weekly x 4 weeks, every other week x2, monthly x1 and quarterly x1.	

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	435045	A. BUILDING _____ B. WING _____	11/08/2022

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F 656	Continued From page 49 Based on observation, interview, record review, and policy review the provider failed to ensure care plans had been updated to ensure they were person-centered and reflected the care needs for ten of ten sampled residents (19, 26, 50, 51, 63, 65, 102, 113, 131, and 133). Findings include: 1. Observation on 11/1/22 at 1:31 p.m. resident 26 revealed: *She was sitting in her wheelchair talking to herself. *Had long, unshaven hair on her chin and her hair combed forward toward her face. Observation on 11/2/22 at 4:42 p.m. of resident 26 revealed: *She continued to have facial hair and her hair combed in the same direction. Observation on 11/3/22 at 10:00 a.m. of resident 26 continues to have facial hair and does not appear to be groomed. Record review of resident 26's bathing task revealed in a 30 day look back she had received one bed bath on 10/30/22. Interview on 11/2/22 at 5:33 p.m. with registered nurse (RN) EE regarding resident 26 bathing revealed: *She said they have to sweet talk her into bathing. *Agreed that there was nothing in her care plan on how to approach for bathing. Interview on 11/7/22 at 9:34 a.m. with certified nursing assistant (CNA) FF regarding bathing for resident 26 revealed: *She has never given her a shower or a bath.	F 656	The results of those audit findings will be brought to the monthly QAPI Committee meeting by the DNS or designee and will continue until the facility demonstrates sustained compliance as determined by the committee.	

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F 656	Continued From page 50 *Resident 26 had only been living in the 600-wing hallway for about two weeks. *She is not even sure if resident 26 had a razor. Interview on 11/7/22 at 1:20 p.m. with clinical care leader (CCL) F regarding activities of daily living (ADL's) for resident 26 revealed: *Staff were to re-approach her or try another staff member if she refused cares. *Staff were to document attempts in electronic medical record (EMR). *Staff were educated to document attempts and approach techniques. *Agreed that no documentation was found in resident's EMR to indicate any refusals made by resident 26. Review of resident's care plan initiated on 8/12/22 regarding ADL's revealed: *Focus: Resident has an ADL self-performance deficit related to schizoaffective disorder evidence by confusion and needs for assistance with some ADL's. *Goal: bed mobility, transfers, eating, dressing, toilet use and personal hygiene. *Interventions: Bathing-resident requires extensive assistance for bathing. -Dressing/grooming-resident needs assistance of 1 for dressing/grooming. *There were no interventions to help staff with refusal of cares or how to re-approach resident to provide cares. Interview on 11/8/22 at 8:20 a.m. with Minimum Data Set (MDS) GG and MDS AA regarding resident 26's care plan: *Stated that care plans are diagnosis generated. *Both agreed that interventions for resident's refusal of cares had not been on her care plan.	F 656		

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F 656	Continued From page 51 *They were not aware of the policy for person centered care plans. *They were going to speak with director of nursing (DON) C regarding the care plan policy. Interview on 11/8/22 at 3:38 p.m. with administrator A, B, and DON C regarding residents' care plans revealed: *They were not aware the MDS coordinators did not know the policy regarding person- centered care plans. 2. Observation and interview on 11/1/22 at 3:51 p.m. resident 113 revealed: *She was sitting in her wheelchair in her room. *Had signs in her room with cues for staff to have resident answer questions with head nods. *She did have an electronic tablet to communicate with staff. *Her speech was very faint and sometime hard to understand. *She would answer questions yes or no by nodding her head or using a thumbs up or thumbs down. Review of resident's care plan dated September 2022 did not have any focus on her communication difficulties or interventions in place to aid with communication. *Her care plan had been created by MDS GG. Interview on 11/7/22 at 9:36 a.m. with CNA FF regarding communication with resident 113 revealed: *She would get close to try and listen to her otherwise the resident will use her tablet. Interview on 11/8/22 at 7:29 a.m. with CCL F regarding resident's care plan revealed:	F 656		

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F 656	Continued From page 52 *Agreed that interventions had not been added to her care plan to aid with communication. *She felt that information was important to have on the care plan to help with communicating with the resident. *She would only update care plans for immediate issues and does not review care plans for accuracy related to the resident. *She agreed that MDS coordinator created the resident's care plan, and information for care plans are generated for MDS coding and review of resident's progress notes. Interview on 11/8/22 at 8:20 a.m. with MDS GG regarding care plans for resident 113 revealed: *She does an interview with residents. *She will speak with the CNA's and nurses' that work with the resident. *Used a diagnosis generated care plans. *Agreed that the care plans did not address the resident by name or specific interventions for them. *Agreed that care plans could be updated any time and not with just with quarterly reviews. Interview on 11/8/22 at 3:38 p.m. with administrator A, B, and DON C regarding resident care plans: *They were not aware the MDS coordinators did not know the policy regarding person- centered care plans. Review of provider's September 2022 Care Plan policy revealed: *Person-centered care is the focus on the resident as the focus of control and supporting the resident in making his or her own choices a having control over their daily life. *Each resident will have an individualized,	F 656		

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F 656	Continued From page 53 person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. *Any problems, needs, and concerns identified will be addressed through us of departmental assessments, the resident assessment instrument and review of the physician's orders. *The care plan will be modified to reflect the care currently required to provide for the resident. *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 facility responsibility for providing these services. 3. Review of resident 19's November 2022 care plan revealed: *The resident had received dialysis. -Her hospital preference had not been included as stated in their dialysis contract. Refer to F698. *Her care plan had not mentioned her history of trauma or trauma triggers. *Her care plan had not mentioned her interests such as: -Westerns. -Late night television. -Playing cards. *She had the same interventions repeating in multiple focus areas on her twenty-six-page care plan. 4. Review of resident 50's November 2022 care plan revealed: *There were incomplete sentences, such as: -"Assist resident in developing/provide resident	F 656		

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F 656	Continued From page 54 with a program of activities that is meaningful and interest such as. Encourage..." –The program of activities that would be meaningful to resident 50 was not listed. *Next to interventions it stated, "Resident does refuse at times." *She had the same interventions repeating in multiple areas on the forty-three-page care plan. 5. Review of resident 63's November 2022 care plan revealed: *The care plan had not informed staff they would need to talk loudly and give her time to respond related to hearing issues. *There was no mention of her bathing preference. *There were repeated interventions in multiple areas on her twenty-one-page care plan. *There was no mention of her continuous positive airway pressure (CPAP) use every night. *There had been no mention of her likes and dislikes. 6. Review of resident 65's November care plan revealed: *There had been no mention of his likes or dislikes. *He had multiple repeated interventions on his twenty-five-page care plan. 7. Review of resident 102's November 2022 care plan revealed: *There had been no mention of her preference of bathing. *The care plan had informed staff to observe for stressors but had made no mention of what her stressors might be. *She had a history of making suicidal statements. -There had been no mention of that on her care plan.	F 656		

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F 656	Continued From page 55 *There had been no mention she was often tearful or crying and what interventions staff should utilize. *There had been multiple repeated interventions throughout her twenty-two-page care plan. 8. Review of resident 133's November 2022 care plan revealed: *The resident had multiple inappropriate behavior towards staff and other residents. Refer to F657. -This had not been mentioned on the care plan. -There had been no mention of interventions staff should utilize towards this behavior. *There was no mention of his likes and dislikes. *He had multiple instances of the same intervention being repeated throughout his twenty-two-page care plan. 9. Review of resident 131's November care plan revealed: *She had the same interventions repeated throughout her nineteen-page care plan. *There had been no mention of her likes and dislikes. 10. Observations on 10/31/22 from 5:05 p.m. to 6:15 p.m. of supper service in the Friendship Lane dining room revealed: *Resident 51 was sitting at a table with three other residents. *She did not touch her food at all. *Several staff members refilled her hot chocolate mug at least three different times. *Resident 51 appeared happy with her hot chocolate. Interview on 11/1/22 at 3:00 p.m. with certified nurse assistant X about resident 51 revealed: *Resident 51 enjoyed sweets, like chocolate.	F 656		

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F 656	Continued From page 56 *She would consistently consume 100 percent of her fluids but would often spit out other foods if it was not sweet. Interview on 11/7/22 at 10:18 a.m. with registered dietitian Y about resident 51's dietary patterns revealed: *Resident 51's medical condition was declining with age, and she was more accepting of fluids over foods. *She loved sweets. *She was involved with developing and updating resident's nutrition care plans. Interview on 11/7/22 at 10:48 a.m. with clinical care leader (CCL) F about resident 51 revealed: *Resident 51 was very particular about foods. *She liked hot chocolate, nutrition supplement drinks, and coffee. *CCL F oversaw keeping her assigned residents' care plans up to date. *Resident 51's care plan could be more person-centered by including up-to-date eating trends, and directions for staff on what to do if resident 51 was refusing her meals. Review of resident 51's care plan revealed: *The care plan did not include descriptions that explained the resident required assistance with meals, she had a habit of drinking her fluids more than eating her food, and what staff should do if she was refusing her foods. *The interventions under the focus area of "The resident has nutritional problem of inadequate protein calorie intake [related to] decreased appetite and alertness [with] progressing dementia [as evidenced by] documented intake and [history] of weight loss," included: --"Resident has order for a texture modified diet."	F 656		

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F 656	Continued From page 57 --"Resident has order for medical nutritional supplement. See [electronic medication administration record]." --"Enjoys juice, coffee, water, [two percent] milk, and [orange juice]." --"Offer snack of choice ...8 [ounces] milk, half cup ice cream, [half] cup fruit (soft and cut up), 6 [ounces] yogurt." --"Offer 4 [ounces] ice cream- any flavor." -The interventions under the focus area of "The resident has potential fluid deficit [related to] variable fluid intake [with] meals and use of diuretic," included: --"Offer drinks of choice during resident interactions." --"Offer resident drinks of choice between meals (enjoys milk, [orange juice], coffee, water)." --"Offer resident drinks of choice with meals. Prepare hot chocolate [with] whole milk." Review of provider's September 2022 Care Plan policy revealed: *Person-centered care is the focus on the resident as the focus of control and supporting the resident in making his or her own choices and having control over their daily life. *Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. *Any problems, needs, and concerns identified will be addressed through us of departmental assessments, the resident assessment instrument and review of the physician's orders. *The care plan will be modified to reflect the care currently required to provide for the resident.	F 656		

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F 656	Continued From page 58 *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 facility responsibility for providing these services.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657	By 12/8/2022 care plans for residents 23,50, 76, 86, 92, 113, 133, 136, 138, 204, and 362 will be reviewed and revised by nursing leadership to ensure they accurately reflect each residents care needs. All residents have the potential to be affected by this deficient practice. Audit will be conducted by 12/8/22, by DNS or designee, to identify other residents identified to have been affected by this deficient practice. All resident care plans identified will be updated to ensure they are person-centered and reflect the care needs of each resident by 12/8/22. To ensure the deficient practice will not recur, by 12/8/22, DNS or designee will educate all nursing staff regarding person-centered care planning. During morning clinical meetings, nursing leadership will identify changes in	12/8/2022

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F 657	Continued From page 59 Based on observation, interview, record review, and policy review the provider failed to ensure care plans had been reviewed and revised to ensure they accurately reflected the residents care needs for 11 of 60 sampled residents (26, 50, 76, 86, 92, 113, 133, 136, 138, 204, and 362). Findings include: 1. Review of resident 26's care plan initiated on 8/12/22 regarding ADL's revealed: *She had an ADL self-performance deficit related to schizoaffective disorder evidence by confusion and needs for assistance with some ADL's. *Her care plan had not been revised to help staff with refusal of cares or how to re-approach resident to provide cares. 2. Review of resident 113's care plan dated September 2022 did not have any focus on her communication difficulties or interventions in place to aid with communication. *Had been revised with cues for staff to have resident answer questions with head nods. *Had not been revised that would include the use of an electronic tablet to communicate with staff. *Had not included resident's speech was very faint and sometime hard to understand and interventions to use to communicate. *Had been revised to include she would answer questions yes or no by nodding her head or using a thumbs up or thumbs down. 3. Review of resident 133's November 2022 care plan revealed: *He had multiple inappropriate interactions with a cognitively impaired female resident. -This had not been on his care plan. -There were not any interventions on how staff should respond when faced with this behavior.	F 657	resident care needs and ensure care plans are updated to reflect current care needs. For residents exhibiting behaviors or rejection of care, IDT team will review their care plans monthly to ensure interventions are appropriate and reflect the needs of these residents. To monitor performance and ensure on going compliance the DNS or designee, will audit 10% of resident population to ensure person-centered and reflected the care needs of each resident. Audits will occur weekly x 4 weeks, every other week x2, monthly x1 and quarterly x1. The results of those audit findings will be brought to the monthly QAPI Committee meeting by the DNS or designee and will continue until the facility demonstrates sustained compliance as determined by the committee.	

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F 657	Continued From page 60 4. Review of resident 362's July 2022 care plan revealed: *Her care plan had not been revised to inform staff of her suicide attempt in the facility. *After her suicide attempt new interventions had not been added for staff to be able to use as a reference. 5. Review of resident 136's November 2022 care plan revealed her care plan had not been revised to include the multiple inappropriate interactions between her and another resident. 6. Review of resident 50's November 2022 care plan revealed her care plan had not been revised to ensure staff keep her feet off the floor to prevent wounds due to her inability to feel her feet. 7. Observation on 10/31/22 at 4:57 p.m. of resident 76 seated in her wheelchair in the 200-hallway revealed: *She had been sitting next to the nurse station. *She had not been engaged in an activity. *She had been watching others walk by. *Nursing staff had been near her in and next to the nurse station. Review of resident 76's 8/5/22 care plan revealed: *She had admitted on 2/4/21. *She had diagnoses of dementia, congestive heart failure, altered mental status, history of stroke. -Interventions: provide opportunity for positive interaction, attention. Initiated: 4/28/22. --Resident prefers the following diversional activities: provide her with busy blanket, or towel	F 657		

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

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F 657	Continued From page 61 folding. Initiated: 4/28/22. Interview on 11/8/22 at 10:24 a.m. with activities supervisor KK revealed: *Resident 76 and some of the other residents had been put in the hallway near the nurses' station to keep an eye on them for falls. *She had been "a get up and fall girl", but now it had become habit for her. *The nursing staff should be offering her some type of activity to keep her busy. *She agreed the care plan should be revised because the resident had not liked to use the busy blanket or to fold towels. *Those interventions had not been used for a while. *The care plans should be updated to include the resident's current needs. *She had been a person to attend most group activities offered. *They had planned to offer more one-to-one activities for the residents to keep them occupied. 8. Review of resident 204's 10/21/22 care plan revealed: *Focus: The resident is at risk for falls related to impaired mobility and cognition. Date Initiated: 10/21/22. -Goal: Resident will be free from falls through the review date. Initiated: 10/21/22. -Interventions: --Educate resident/family about safety reminders and what to do if a fall occurs. --Educate resident/family/interdisciplinary team as to cause of fall. Initiated: 10/21/22. --Educate/instruct resident and family on the safe use of assistive devices. Initiated: 10/21/22. --Remind resident not to bend over to pick up dropped items. Encourage use of grabber or to	F 657		

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F 657	Continued From page 62 ask for assistance. Initiated: 10/21/22. --Modify environment to maximize safety. High back wheelchair with anti-roll brakes. Initiated: 10/27/22. --Review and modify environmental hazards (tubing, electrical supply cords, etcetera) that could cause or contribute to fall. Initiated: 10/21/22. *Focus: The resident has had actual fall with no injury related to history of falls. Initiated: 10/23/22 Revised: 10/24/22. -Goal: Resident will resume usual activities without further incident through review date. Initiated: 10/24/22. -Interventions: --Educate/instruct resident and family on safe use of assistive devices. Initiated: 10/24/22. --Ensure that resident is wearing appropriate footwear gripper socks and/or shoes when ambulating or mobilizing in wheelchair. Initiated: 10/24/22. --Monitor resident for significant changes in gait, mobility, positioning device, standing/sitting balance, and lower extremity joint function. Initiated: 10/24/22. *The care plan had not been revised to include interventions to prevent falls other than reminders, education, and the use of gripper socks after repeated falls had taken place. 9. Review of resident 92's 10/6/22 care plan revealed: *Focus: The resident is at risk for falls related to history of falls. Initiated: 4/1/21. -Goals: Resident will be free of falls through the review date: Initiated: 4/1/21. Revised: 9/26/22. -Interventions: --Educate resident/family about safety reminders and what to do if a fall occurs. Initiated: 4/1/21.	F 657		

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F 657	Continued From page 63 --Ensure that resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair. Initiated: 4/1/21. --Ensure/provide a safe environment. Call light and personal items within reach, encourage use of call light, floor clear of clutter. Call don't fall signs in room. Initiated: 4/1/21. Revision on 10/5/21. *Focus: The resident has had an actual fall with minimal injury related to Parkinson's Disease evidenced by poor balance and mobility, impulsive, resident states she is impatient or "I will do what I want". Initiated 7/6/22. -Goal: Resident will be free from major injuries related to falls through review date. Initiated: 7/15/22. Revised 9/26/22. -Interventions: --Educate resident not to bend over to pick up dropped items. Encourage use of grabber or to ask for assistance. Will get resident grabber to use and encourage her to ask for help with dropped items if she does not have grabber with her. Initiated: 7/6/22. --Ensure that resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair. Initiated: 5/6/21. --Wheelchair next to bed. Remove foot pedals when in room. Call light in reach. Anti-roll brakes on wheelchair. Sensor pad in wheelchair. Glow in dark tape on call light. Initiated: 7/15/22. *The mattress alarm had been on the care plan but had not been used recently. Interview on 11/1/22 at 3:17 p.m. with clinical care leader E revealed: *The care plans should be reviewed and revised for needed interventions and those interventions should be followed by staff.	F 657		

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F 657	Continued From page 64 Observation and interview on 11/7/22 at 2:07 p.m. with LPN QQ regarding resident 92 revealed: *She knew the resident well. *She had a history of falls. *A pressure pad had been placed under on her mattress to alert staff if she got up. *She had not had the alarm anymore. *She could not remember the last time she saw the alarm placed on her bed. *She confirmed the alarm had been on the care plan but was no longer used. Interview on 11/7/22 at 2:13 p.m. with clinical care leader E revealed: *The resident had not used the alarm recently. *The care plan should have been updated to reflect her current status. 10. Review of resident 138's 9/30/22 care plan revealed: *Focus: The resident is at risk for falls related to dementia: Initiated: 6/15/22. -Goals: Resident will be free of falls through the review date: Initiated: 6/15/22. Revised 6/28/22. -Interventions: -Ensure that resident is wearing appropriate footwear rubber soled shoes or gripper socks when ambulating. Initiate: 6/15/22. -Review and modify environmental hazards keep floor free of clutter/debris that could cause or contribute to fall. Initiated: 6/15/22. -Ensure/provide a safe environment. Resident has a history of going down on knees to clean/pickup items on the floor. Sister has tried to offer resident a carpet sweeper that was an ineffective diversion. Low bed, soft call light. Initiated: 9/20/22. *Focus: The resident has had an actual fall with no injury. Initiated: 9/26/22.	F 657		

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F 657	Continued From page 65 -Goal: Resident will resume usual activities without further incident by review date. Initiated: 9/26/22. -Interventions: --Provide activities that promote exercise and strength building where possible. Encourage restorative when able, staff to assist with ambulation if resident is anxious. Use overbed table with different activities like coloring, towel folding, busy box. Initiated: 10/11/22. --Review and modify environmental hazards (tubing, electrical supply cords, etc.) that could cause or contribute to fall. Initiated: 9/26/22. --If resident is anxious provide diversional activity to keep resident busy, example: overbed table with washcloths to fold, deck of cards to go through, etc. Initiated: 9/26/22. --Review resident's/client/S history of recent or recurrent falls. Initiated: 9/26/22. *The resident had been on hospice care and her care plan had not reflected that information. *The plan had not been effective in keeping the resident occupied in activity and to prevent falls. 11. Review of resident 86's care plan revealed: *She was to receive restorative therapy exercises, like active range of motion and a walking program, at least five to seven days a week. *The restorative therapy interventions were added to her care plan in 2020. *She had been admitted to hospice in January 2022. Interview on 11/7/22 at 10:53 a.m. with clinical care leader (CCL) F about resident 86's care plan revealed: *They usually downgraded resident's restorative programs to "as needed" if a resident was	F 657		

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F 657	Continued From page 66 admitted to hospice. *She forgot to revise resident 86's care plan to reflect the above. *Resident 86 had not been offered restorative therapy exercises in at least one month. Interview on 11/7/22 at 4:32 p.m. with director of nursing C about resident 86 and restorative therapy revealed: *Staff coordinated with residents and their families on whether to continue restorative therapy, downgrade it to "as needed," or discontinue it altogether. *She was not aware that resident 86's care plan still indicated she was to receive restorative therapy. Interview on 11/8/22 at 10:30 a.m. with senior nurse aide W about the restorative therapy schedule confirmed that resident 86's restorative therapy exercises were marked "as needed" in the provider's electronic medical record. Review of provider's September 2022 Care Plan policy revealed: *Person-centered care is the focus on the resident as the focus of control and supporting the resident in making his or her own choices and having control over their daily life. *Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. *Any problems, needs, and concerns identified will be addressed through us of departmental assessments, the resident assessment	F 657		

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F 657	Continued From page 67 instrument and review of the physician's orders. *The care plan will be modified to reflect the care currently required to provide for the resident. *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 facility responsibility for providing these services.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: A. Based on observation and interview, the provider failed to ensure three of seven observed residents (26, 120, 134) had been assisted with or provided the means to complete facial hair grooming and bathing per their preference. Findings include: 1. Observation on 11/1/22 at 1:31 p.m. of resident 26 revealed her face had unshaven facial hair on her chin. Observation on 11/2/22 at 4:42 p.m. of resident 26 continued to have facial hair. Observation on 11/3/22 at 10:00 a.m. of resident 26 continued to have facial hair. Record review of the bathing task for resident 26 for the past 30 days revealed she was given a bed bath on 10/30/22.	F 677	By 11/28/22 assistance was provided for resident 26, 120, & 134, to complete facial hair grooming and bathing per their preferences. By 11/30/22 these preferences were added to resident 26, 120, & 134 care plan. All residents who require assistance with facial hair grooming and bathing have the potential to be affected by deficient practice. By 12/8/22 DNS or designee, will audit to identify other residents who require assistance with facial hair grooming and bathing. By 12/8/22 those residents identified will have facial hair grooming and bathing completed, with their bathing preferences care planned.	12/8/2022

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F 677	Continued From page 68 Interview on 11/2/22 at 5:33 p.m. with registered nurse (RN) EE regarding resident 26 bathing revealed: *She said they have to sweet talk her into bathing. *Agreed that was not in her care plan on how to approach for bathing. Interview on 11/7/22 at 9:34 a.m. with certified nursing assistant (CNA) FF regarding bathing for resident 26 revealed: *She has never given her a shower or a bath. *Resident 26 had only been down living on the 600 wing hallway for about two weeks. *She is not even sure if resident has a razor. Interview on 11/7/22 at 1:20 p.m. with clinical care leader (CCL) F regarding resident 26's activities of daily care (ADL) revealed: *Stated were to re-approach her or try another staff member if she refused cares. *Document the attempts in resident's electronic medical record (EMR). *Staff were educated to document attempts and re-approach techniques. *Agreed that had not been any nurse notes or CNA documenting refusals. Review of resident's care plan initiated on 8/12/22 regarding ADL's revealed: *Focus: Resident has an ADL self-performance deficit related to schizoaffective disorder evidence by confusion and needs for assistance with some ADL's. *Goal: bed mobility, transfers, eating, dressing, toilet use and personal hygiene. *Interventions: Bathing-resident requires extensive assistance for bathing.	F 677	To ensure the deficient practice will not recur, bathing preferences will be obtained and care planned upon admission utilizing new admission checklist. We will initiate Angel Rounding utilizing leadership in all resident care areas to assess residents are or provided the means to complete facial hair grooming and bathing per their preference. To monitor performance and ensure ongoing compliance the DNS or designee will audit 10% of resident population who require assistance in completing facial hair grooming and bathing per their preferences, ensuring these are completed and care planned. Audits will occur weekly x 4 weeks, every other week x2, monthly x1 and quarterly x1. The results of those audit findings will be brought to the monthly QAPI Committee meeting by the DNS or designee and will continue until the facility demonstrates sustained compliance as determined by the committee.	

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F 677	Continued From page 69 Dressing/grooming-resident needs assistance of 1 for dressing/grooming. *There had been no interventions to help with refusal of cares or how to re-approach resident to provide cares. *No preference regarding her facial hair was found in the care plan. 2. Observation on 10/31/22 at 5:15 p.m. with resident 134 revealed: *The resident was seated in the large main dining area at a table waiting to eat. *His hair had not been combed and looked matted. *His beard looked scruffy and unkept. *His clothing had stains. Observation on 11/1/22 at 3:26 p.m. and again on 11/2/22 at 12:10 p.m. of resident 134 revealed: *His hair had been long and not combed. *He had not been shaved. *His fingernails were not clipped and extended about one fourth of an inch beyond his fingertips. *His fingernails brown stains had brown stains under the ends. *There was a brown stain around the outside of his lips. Observation on 11/2/22 at 3:28 p.m. with resident 134 returning from a Bingo activity revealed: *He was seated in his wheelchair in the reception area between the 200 and 300 hallways. *Resident had worn a t-shirt with stains on it. *His sweatpants had a white stain covering the entire area of his lap. *His fingernails were not clipped and extended about one fourth of an inch beyond his fingertips. *There was a brown substance under them. *He had not been shaved.	F 677		

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F 677	Continued From page 70 Review of resident 134's electronic medical record (EMR) revealed: *He was admitted on 3/22/22. *An admission photo of the resident clean shaven and with short, groomed hair. -He had not looked like the same person on his admission photo. *Diagnoses of dementia, Alzheimer's disease, and heart disease. *A BIMS score of 2 which indicated he had severe cognitive impairment. *There had not been charting provided to indicate the resident had refused grooming assistance. Review of resident 134's revised 9/26/22 care plan revealed: *He required assistance of: -One staff for showering. -One to two staff for dressing. -Set up for meals. -Set up for his mouth care. -One staff for personal hygiene. *There had been no mention of the resident refusing or being uncooperative with grooming. 3. Observation and interview on 10/31/22 at 5:09 p.m. with resident 120 in the large main dining area revealed: *The resident was seated in a wheelchair at a table with another resident. *The resident had a scruffy beard and appeared to not have shaved in a while. *His fingernails were very long; some extend about one-half inch past his fingertips. Observation and interview on 11/01/22 at 7:46 a.m. with resident 120 seated in dining area revealed:	F 677		

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F 677	Continued From page 71 *He was seated in his wheelchair eating breakfast. *When asked if he had been growing out his beard, he stated he was not growing it out, but he had not been shaved for a while. *He could not remember the last time he had been shaved. *He thought his fingernails were too long and he wanted them to be clipped. *He hoped staff would take care of that today. Review of resident 120's revised 9/12/22 care plan revealed: *Resident required: -Extensive assist of one with bathing, prefer sponge baths but encourage to take shower for hair washing. -Extensive assistance of one with dressing and grooming. -Set-up assistance with meals. -Extensive assistance with cleaning and care of teeth. -Extensive assistance of one with personal hygiene. *Rejection of care at times: declining bathing. -Offer another time/option for bathing, approach again later with different staff. *One refusal had been documented on the bathing task on 10/21/22. -He was later documented as taking a shower on 10/25/22 and 10/28/22. *No other charting had been provided regarding his refusal for grooming assistance. Interview on 11/2/22 at 12:46 p.m. with clinical care leader E regarding staff completion of resident grooming revealed: *The CNAs were responsible to ensure residents activities of daily living (ADLs) were completed.	F 677		

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F 677	Continued From page 72 *She would expect nursing staff to assist residents daily to be dressed in clean clothing, have hair combed, shaving completed, nails clipped and clean, and to be showered or bathed as scheduled and/or as needed. *The residents had their own razors to use, but staff should help if they see a shave was needed. *Fingernails were clipped on bath days. *There were times the CNAs asked the nurses to clip the resident's fingernails if they had not been comfortable doing so. *They had not had an area to mark grooming skills separately for the residents in charting. *If residents had refused care, it would likely not be documented since there had not been a task for that in their charting system. *Agreement that if a resident had refused care, it should have been documented in their chart. *She agreed their system had not tracked resident grooming assistance well. Review of provider's April 2022 Activities of Daily Living policy revealed: *Purpose was to provide residents with the appropriate treatment and services to maintain or improve abilities of daily living for the well-being of mind, body, and soul. -To specify the requirement for nursing assistants to be annually trained on accurately coding the MDS. *Policy: Any resident who is unable to carry out activities of daily living will receive necessary services to maintain nutrition, grooming, personal and oral hygiene. *ADLs are necessary tasks to conducted in the normal course of the resident's daily life. Include the following: -General personal, daily hygiene and grooming care includes hair, hands, face, shaving, applying	F 677		

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F 677	Continued From page 73 makeup, skin, nails, and oral care. -Bathing is the activity of washing and drying the body as well as transferring into and out of a tub or shower. -Eating to nourish and hydrate oneself. -Communication with the use of speech and language or communication system for requests, opinions, problems, or social conversation. B. Based on observation, interview, and policy review, the provider failed to ensure one of one observed resident (51) had been assisted with eating per the resident's care plan. Findings include: 1. Observations on 10/31/22 from 5:05 p.m. to 6:15 p.m. of supper service in the Friendship Lane dining room revealed: *Resident 51 was sitting at a table with three other residents. *At 5:38 p.m., she was served ground meat, gravy, pureed green beans, and cinnamon applesauce. *She did not touch her food at all. *Several staff members refilled her hot chocolate mug at least three different times, however no one assisted her with eating her meal. *There were three members of the nursing staff assisting in the dining room: certified nurse assistant (CNA) X, CNA HH, and another unidentified CNA. -CNA X was assisting two residents with eating at a different table. -CNA EE and the other unidentified CNA were passing meal trays to residents. *At 6:12 p.m., resident 51 wheeled herself out of the dining room without having received assistance to eat her meal.	F 677		

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	435045	A. BUILDING _____ B. WING _____	11/08/2022

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F 677	Continued From page 74 An interview on 11/1/22 at 3:00 p.m. with CNA X about the previous night's meal service revealed: *The number of staff available to assist in the dining room depended on how many residents wanted to eat in the dining room. *Whichever CNA brought a resident down to the dining room was then responsible to assist that resident with their meal, if the resident needed any assistance. *She did not bring resident 51 to the dining room the previous night. *Resident 51 generally would try the food if she was prompted, or if someone fed it to her. *However, resident 51 would often spit the food out if it was not sweet. *Resident 51 was better at drinking her fluids rather than eating her food. Interview on 11/7/22 at 10:48 a.m. with clinical care leader F about resident 51's need for mealtime assistance revealed: *She was unaware that resident 51 did not receive assistance at supper on 10/31/22. *Resident 51 required verbal directions and sometimes physical assistance with meals. *Resident 51 accepted fluids better than food. *She was on a restorative eating program where one of the restorative aides would sit with her, usually at breakfast, to assist with food intake. Review of resident 51's 9/6/22 MDS assessment indicated that during the assessment period, she required extensive assistance of one staff person to physically help her eat. Review of resident 51's 9/6/22 resident dining assessment indicated she "Needs cueing and encouragement for eating."	F 677		

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F 677	Continued From page 75 Review of registered dietitian Y's quarterly nutrition assessment for resident 51 from 9/9/22 at 10:50 a.m. revealed: *Resident 51's meal intake had decreased since the previous quarter. *"Eating Ability: Staff providing cues and [as needed] assistance [with] meals." *"Occasionally has good meal intake but requires assistance at all meals." Review of resident 51's care plan revealed: *Focus area: "The resident has an ADL self-care performance deficit [related to] altered mental status, dementia." -Intervention: "EATING: Resident requires supervision to extensive assistance with eating. Needs encouragement." Review of the facility's 12/2/21 "Dining Assistant - Rehab/Skilled" policy revealed: *Under the "Policy" section of the document: -"An RN completes an assessment of the resident before the services of a dining assistant are used for the first time." -"Appropriateness for this program should be reflected in the comprehensive care plan." *Under the "Procedure" section of the document: -"2. Dining assistants will feed only those residents who have no complicated feeding problems, such as difficulty swallowing, recurrent lung aspirations and tube or parenteral/ [intravenous] feedings." -"3. Dining assistance can be provided for any resident by licensed nurses, certified nurse aides, certified medication aides, speech language pathologists and occupational therapists without additional education and training." -"4. Resident selection is based on the resident's latest assessment and plan of care and an	F 677		

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F 677	Continued From page 76 assessment of the resident's current condition." -"5. When a resident is selected, an assessment must be completed by a RN before allowing a dining assistant to provide services to the resident. The assessment must be reviewed and updated whenever there is a change in dining ability and, at a minimum, reviewed quarterly." -"6. Dining assistants are supervised by a registered nurse or licensed practical nurse to evaluate, on an ongoing basis:" --"That resident being fed by the dining assistants remain appropriate for the service and exhibit no signs of change in condition potentially affecting their eating ability." --"Their use of appropriate feeding techniques." --"Whether they are assisting assigned residents according to their identified eating and drinking needs." --"Whether they are providing assistance in recognition of the rights and dignity of the resident." --"Whether they are adhering to safety and infection control practices." --"To identify the need for updated training, techniques and technical skills." Review of the facility's 4/25/22 "Dining Room Service - Rehab/Skilled" policy revealed: *The purpose of the policy was to: -"Provide residents opportunity for socialization in a pleasant environment." -"Stimulate residents' appetites." -"Encourage as much independence in dining as possible, offering assistance as needed with eating." -"Monitor residents for chewing, swallowing or choking problems." *Under the procedure section: -"6. Assist residents with dining tasks (as they	F 677		

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F 677	Continued From page 77 prefer), such as buttering bread, cutting meat and pouring beverages; however, encourage and allow the resident to do as much as possible per self and provide adequate time to complete meals." -"7. Encourage adequate fluids, get second helpings and wipe up any spills as needed. Offer food alternatives for items not consumed." -"8. If dining assistance is needed by a resident, employees are to sit next to the resident; do not stand and feed resident...Employees can assist two residents and offer assistance as needed."	F 677		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to provide an individualized activity program for four of four sampled residents (19, 118, 138, and 204) that were interviewed. Findings include: 1. Observation and interview on 10/31/22 at 5:00 p.m. of resident 19 revealed she: *Wished the facility had more activities for her to attend.	F 679	By 12/2/22 a new Activity interest data collection will be completed for residents 19, 118, 138, 204, and care plans revised to reflect current activity needs and preferences. By 12/8/22 a Specialty Care Unit activity calendar will be created and implemented. All other residents have the potential to be affected by this deficient practice. All other residents in facility will be audited to ensure an Activity interest data collection has been completed in the last 90 days and that the care plan is reflective of the individual resident activity programming needs and preferences.	12/8/2022

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F 679	Continued From page 78 *Received hemodialysis services three times a week and felt that she missed out on activities. Interview on 11/1/22 at 1:57 p.m. with activity assistant (AA) revealed she: *Had marked resident 19 down for an activity on 10/31/22. *Stated she went to dialysis, and she marked that as her activity. -Resident 19 talks to her van driver and is out in the community. *Was unsure if resident 19 agreed that dialysis counted towards her activities. 2. Review of resident 19's activity log revealed she: *Had been marked to receive a group activity on 10/31/22, the activity stated it involved: -Community, sensory, and stem. 3. Review of resident 118's electronic medical record (EMR) revealed he: *Had a diagnosis of early onset Alzheimer. *Was younger than other residents. *Had 11 resident to resident interactions in the month of October 2022. *Did not have a lot of activities to keep him busy. 4. Observation on 10/31/22 at 4:52 p.m. of the special care unit (SCU) revealed the television (TV) was showing an older TV show, but none of the seven residents in the lounge were engaged in watching the show. Interview on 11/2/22 at 10:50 a.m. with certified nursing assistant YY revealed: *The activity aide was not working that day. *At 9:00 a.m. the residents watched game shows	F 679	To ensure the deficient practice will not recur, Activity supervisor or designee will educate activity assistances and Specialty Care Unit staff to provide an individualized activity program including by 12/8/22. Going forward, Activity Interest Data collection will be completed with all new admissions, annual and significant changes. Activity supervisor will review Special care unit activity calendar for approval during monthly one to one meetings. To monitor performance and ensure on going compliance the Activities Supervisor or designee will randomly audit/interview 10% of resident population for satisfaction of meaningful and individualized activities weekly x 4 weeks, every other week x2, monthly x1 and quarterly x1. Audit findings will be brought to the monthly QAPI Committee meeting by the Activity supervisor or designee and continue until the facility demonstrates sustained compliance as determined by the committee.	

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F 679	Continued From page 79 on the TV. *At 10:15 a.m. the restorative aide led a group activity of ball toss. -She did not do it today because she was pulled to work on the floor. *After lunch staff play different movies on the TV for the residents to watch until supper time. *There is no set schedule of activities on the SCU. -"We kinda just go with the flow." Observation on 11/2/22 at 5:48 p.m. of the SCU revealed the TV was on with seven residents seated in the lounge and one resident focused on the TV. Another resident was seated in the dining room adjacent to the lounge not engaged in any activity and two residents were wandering in the hallway of the SCU. Observation on 11/3/22 at 9:37 a.m. of the SCU revealed activity aid (AA) ZZ in the dining room engaging two residents in a craft activity with yarn. Six other residents were in the adjacent lounge area with two residents engaged in watching the game show on the TV. Review of the SCU activities posted schedule revealed: *Breakfast *Clean up - Game Shows *Ball Toss / Exercise *Devotions / Hymn Sing *Lunch *Clean-up *Music / Movie *Snack Time *Table Activities: coloring, sorting, puzzles, folding, etc. *Supper / clean up.	F 679		

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F 679	Continued From page 80 Interview on 11/3/22 at 9:21 a.m. with AA ZZ revealed: *She works four days per week, from 6:45 a.m. through 11:45 a.m. *Yesterday, 11/2/22, she was not scheduled to work. *After breakfast the residents look at the plants/birds while she worked one-to-one with individual residents on sorting, coloring, etc. *Around 10:00 a.m. the residents gather for a large group ball toss. *After the ball toss, the group of residents participated in devotions before lunch. *She stated "group activities do not work" on the SCU. Interview on 11/3/22 at 9:46 a.m. with activities supervisor KK revealed: *She was the provider's activities supervisor for the past nine years. *The activity department was currently staffed with six activity assistants. -Five activity assistants worked full-time. -AA ZZ worked part-time on the SCU. *AA ZZ attended dementia training. Further discussion on SCU and the activity programming revealed: *AA ZZ worked four days per week on the SCU. *Three days each week had no activity personnel scheduled on the SCU. *She agreed they needed better activities on the SCU. *She agreed activity programming could prevent resident behavior issues, including resident to resident incidents on the SCU. 5. Observations of resident 138 seated in her wheelchair in the 200 hallway by the nurses'	F 679		

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F 679	Continued From page 81 station and not engaged in an activity: *10/31/22 at 4:57 p.m. with eyes closed. *11/1/22 at 8:56 a.m. with eyes closed. *11/1/22 at 3:33 p.m. with eyes open. *11/2/22 at 3:30 p.m. with eyes open. *11/7/22 at 10:28 a.m. with eyes closed. Review of resident 138's 8/5/22 care plan revealed: *Focus: The resident has a behavior symptom R/T (related to) dementia E/B (evidenced by) history of wandering in wheelchair up and down hall, restless ness, trying to get up on own often. Initiated: 4/28/22. -Goal: Resident will have fewer episodes of restless ness behavior by review date: Initiated: 4/28/22. Revised on 5/10/22. -Interventions: Provide opportunity for positive interaction, attention. Date initiated: 4/28/22. --Resident prefers the following diversional activities: provide her with busy blanket, or towel folding. Initiated: 4/23/22. Revised on 4/28/22. *Focus: The resident has alteration in activity involvement advanced dementia E/B (evidenced by) confusion, fatigue. Initiated: 4/23/22. -Goal: Resident will participate in programs, devotions, exercise 3 times by review date. Initiated: 4/23/22. Revised: 5/10/22. -Interventions: Invite and remind resident of scheduled activities, assisting to and from locations as needed. Initiated: 4/23/22. --Invite/encourage resident's family members to attend activities with resident in order to support participation. Initiated: 8/1/22. --Strengths: resident's preferred activities were: devotions, music programs. Initiated: 8/1/22. --Topics of interest may include: family (sons), librarian at downtown library Initiated: 8/1/22.	F 679		

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F 679	Continued From page 82 --Offer diversionary activities such as: newspaper, books. Initiated: 5/2/20. Revised 5/8/21. Interview with RN LL at 10:32 a.m. regarding resident 138 revealed: *She had worked at the facility for one and a half years. *The resident had been in the memory care unit prior to a recent hospitalization. -She moved to the 200 hallway because she needed more care than could be provided on the memory care unit. -She had been more mobile prior to her hospitalization. -She had recently been placed on hospice care. -She was resting in her wheelchair by the nurses' station since returning from breakfast that morning. -The resident had a history of falls and they liked to have her near the nurses' station to keep an eye on her. *They staff liked to keep residents at risk for fall nearby the nurses' station in their line of sight. *She agreed resident 138 had spent a good portion of the day in the hallway each day without activity. Interview on 11/8/22 at 10:24 a.m. with activities supervisor KK revealed: *Agreed resident 138 had spent a lot of time in the hallway by the nurses' station. *The staff should be offering the residents things to do if they are sitting idly. *She had not noticed if the nursing staff had offered her anything. *All residents should have care plans with current information regarding their interests for activities. *Residents should be offered meaningful	F 679		

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F 679	Continued From page 83 activities with mental stimulation whenever possible. *She felt they needed to provide more one-to-one activity for her and had been working on implementing that with her activity assistants. 6. Observations of resident 204 seated in his wheelchair in the 300 wing without activity: *10/31/22 at 4:04 p.m. with eyes open and restless. *11/1/22 at 7:40 a.m. with eyes open and fidgeting in his wheelchair. *11/1/22 at 11:15 a.m. positioned in the nurses' station. *11/1/22 at 4:15 p.m. reclined back and attempting to get up. *11/2/22 at 3:23 p.m. positioned in the nurses' station with eyes open. *11/2/22 at 6:38 p.m. positioned in the nurses' station staring off into space. *11/3/22 at 7:10 a.m. with eyes open and attempting to get up out of chair. *11/3/22 at 8:17 a.m. with head rested back on wheelchair sleeping. *11/7/22 at 8:34 a.m. alone in the nurses' station with eyes open. *11/7/22 at 9:22 a.m. alone in the nurses' station with eyes open. *11/8/22 at 7:05 a.m. with eyes open and attempting to get out of his wheelchair. *The resident had not been using a weighted blanket in any of the above observations. -The weighted blanket was to be offered at times the resident had been restless. Review of resident 204's 10/21/22 care plan revealed: *His admission on 10/21/22. *He had diagnoses of:	F 679		

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F 679	Continued From page 84 -Fracture of left femur. -History of falls. -Atrial Fibrillation. -Hypertension. -History of traumatic brain injury. -Dementia. -Psychotic disturbance. -Mood disturbance. -Anxiety. *Focus: Resident has a behavior symptom related to dementia, neurocognitive disorder evidenced by history of shaking fists, grabbing and inappropriately touching staff, swearing at others, rejecting cares, disrobing. Has periods of increased restlessness. -Goal: Resident will have no evidence of behavior problems by review date. Initiated: 10/31/22. -Interventions: --Behavior one: rejecting cares; leave safe and return later, try again with different staff. Date initiated: 10/31/22. --Behavior two: aggressive behaviors/restlessness; likes to watch westerns and sports (football/basketball) on TV, used to play softball and ride bike, lived in Wyoming and likes University of Wyoming, worked as a power lineman. Date Initiated: 10/31/22. --Behavior three: restlessness/agitation; offer weighted blanket when more restless. Initiated: 10/31/22. ---Restless/agitated: check for unmet needs; update nurse if resident appears in pain. Initiated: 10/31/22. *Focus: The resident has alteration in activity involvement related to dementia evidenced by confusion and is nonverbal. Initiated: 10/28/22. -Goals: Resident will show positive reaction to weekly music program through next review. Initiated: 10/28/22.	F 679		

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F 679	Continued From page 85 --Interventions: Invite and remind resident of scheduled activities, assisting to and from locations as needed. Date initiated: 10/28/22 ---Provide weekly one-to-one visits. Initiated: 10/28/22. ---Strengths: Resident's preferred activities are watching sports on TV. Attend catholic services and music programs. Initiated 10/2/8/22. Review of resident 204's one-to-one activities since his admission on 10/21/22 revealed: *Entries documented on: -11/2/22 for sensory stimulation at 3:40 p.m. and 4:32 p.m. -11/2/22 for social interaction at 3:41 p.m. -11/8/22 for social interaction at 4:01 p.m. -11/8/22 for sensory stimulation at 4:06 p.m. Interview on 11/2/22 at 9:53 a.m. with social services coordinator P regarding resident 204 revealed: *He had just admitted to their facility in the past couple of weeks. *The resident had admitted from the hospital due to a femur fracture from another facility. *Staff had been working with his family for ideas of what he was interested in. *He had been unable to answer questions for assessment of his needs. *Physical therapy had been working with him to get his strength back for walking. *He has a history of repeated falls. *They are working with his physician closely for his care. *The staff had kept him at the nurses' station so they can observe him. *They were still getting to know him and what interested him.	F 679		

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	435045	A. BUILDING _____ B. WING _____	11/08/2022

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

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F 679	Continued From page 86 Interview on 11/2/22 at 1:08 p.m. with activities assistant QQ regarding activities documentation for resident 204 revealed: *She had been the person to document activities for the resident under the task in his chart. *The sensory stimulation and social activities marked for the resident had been for times she had observed the resident seated in the nurses' station with staff around him. *They had been working on ideas for things to keep the resident occupied. *She had spoken with his daughter and found out he liked sports including football, basketball, hiking and running. *She agreed they had not had much success in keeping him occupied with activities that interested him. Interview on 11/8/22 at 2:30 p.m. with medical director D regarding resident 204 revealed she thought he would benefit from more stimulation throughout his day. Interview on 11/8/22 at 4:30 p.m. with administrator A revealed: *They had been getting to know resident 204 as he had recently admitted. *He would not expect staff to leave the resident alone in the nurses' station. *The staff should be offering the resident meaningful activities that he enjoys keeping him busy. Interview on 11/8/22 at 5:12 p.m. with resident 204's daughter revealed she thought he needed more stimulation and activities to keep him occupied.	F 679		
F 803	Menus Meet Resident Nds/Prep in Adv/Followed	F 803		

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F 803 SS=E	Continued From page 87 CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, menu review, substitution log review, and resident handbook review, the provider failed to follow written menus and serve a nutritionally balanced meal based on the menu which had the potential to affect all residents in the facility, and all residents at each of their satellite facilities. Findings include:	F 803	Education for dietary department personnel pertaining to menu requirements, menu substitution policy and procedures, and menu substitution list to ensure nutritionally comparable substitutions are provided will be completed by 12/8/22 by the Registered Dietitian. All residents have the potential to be affected by this deficient practice. The menu extension is approved and signed by the Registered Dietitian. Education for dietary department personnel pertaining to utilization of the approved menu extension will be completed by 12/8/22 by the Registered Dietitian to ensure adequate and accurate diet is provided. To ensure the deficient practice will not recur, the Dietary Manager and/or designee will validate prepared menu items to ensure meals are prepared as planned per approved facility menu. The cook will obtain approval from Dietary Manager or Dietary Supervisor prior	12/8/2022

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F 803	Continued From page 88 1. Observations and interview during supper on 10/31/22 from 5:05 p.m. to 6:13 p.m. in the Friendship Lane dining room revealed: *There was a menu binder in the kitchenette. -The main meal included: one each turkey pot pie, "perf spoodle" buttered green beans, wheat dinner roll, and four fluid ounces cinnamon apple slices. -The alternate meal included: one each baked pollock, two-ounce ladle lemon sauce, #12 dipper buttered white rice (about one-third cup), "perf spoodle" buttered capri vegetables, and a parmesan breadstick. *Lead food service assistant NN arrived in the dining room at 5:05 p.m. *For the main meal, he served a fish fillet, a half cup of rice, and a half cup of cinnamon baked apples. *For the alternate meal, he served a turkey pot pie, a half cup of green beans, and a half cup of cinnamon baked apples. *Interview at that time with lead food service assistant NN revealed the cook communicated with the dietary aides about what was on the menu for that meal, any substitutions for menu items, and the serving sizes. *He was informed by cook OO to serve the green beans with the turkey pot pie meal. *He confirmed: -There was no substitution for the wheat dinner roll or the parmesan breadstick. -There was no substitution for the buttered capri vegetables. -There was no substitution for the lemon sauce. *He thought the rice counted towards the vegetables for the baked pollock meal. *For a resident prescribed a dysphagia level two diet, like resident 51, he served a #10 scoop (about 3.2 ounces) of ground turkey, two fluid	F 803	to making menu substitutions to ensure that they are nutritionally comparable. Any menu substitutions will be communicated to Dietary Service staff prior to starting meal service. All dietary boards and daily menu sheets will be updated when substitutions happen. To monitor performance and ensure on going compliance, the Registered dietician or designee will complete audits regarding preparation of required menu items, completion menu, substitution logs, and meals served per approved menu extension. Audits will occur daily for 2 weeks, weekly for 2 weeks, monthly x2, and quarterly x1. The results of those audit findings will be brought to the monthly QAPI Committee meeting by the Registered dietician or designee and will continue until the facility demonstrates sustained compliance as determined by the committee.	

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F 803	Continued From page 89 ounces of turkey gravy, one-third cup of pureed green beans, and a half cup of cinnamon applesauce. -He expressed that he felt bad for the residents who were prescribed a mechanically altered diet because they do not have alternates if the resident did not like the meal, and they "basically get the same thing each day." An interview on 11/1/22 at 9:07 a.m. with resident 77 revealed that breakfast and lunch were usually good, but the evening meal was "awful" because they "couldn't get anything right." 2. Observations and interviews during supper on 11/2/22 from 4:42 p.m. to 5:58 p.m. in the Friendship Lane dining room revealed: *The menu binder was in the kitchenette. -The main meal included: six-ounce ladle vegetable soup, saltine crackers, one each roast beef deli plate, "perf spoodle" pickled sliced beets, one each corn muffin, four fluid ounces mandarin oranges. -The alternate meal included: six-ounce ladle cream of tomato soup, 1 each grilled cheese and tomato sandwich, four-ounce spoodle tater tots. *Lead food service worker NN arrived with the food at 5:23 p.m. *He said for the main meal, he was serving tomato soup, grilled cheese sandwich, pickled beets, and mandarin oranges. *He confirmed they did not have corn muffins or tater tots, and he did not have substitutions for either. *Dietary manager QQ was working on making changes to the menu to better meet the interests of residents. *Interview with administrator A during supper service revealed:	F 803		

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F 803	Continued From page 90 -He oversaw the dietary and environmental services departments. -They switched to their fall/winter menu on 10/31/22. -Their menus were created by their corporate headquarters. -They received their menus about one week before they were supposed to implement the menu, and they were having issues with getting the right food in. -Recently they were granted access to edit the menus, which they were not able to do before. -They were considering contracting with a food service company to manage their dietary department, rather than having an in-house dietary department. -He was aware of the food complaints. Interview on 11/3/22 at 10:13 a.m. with administrator A and dietary manager QQ about the overall dietary department revealed: *The facility's kitchen prepares food for their facility, as well as four satellite facilities throughout the city. *Dietary manager QQ had been in her position for just under a year. *She was aware of the food complaints and was actively working on their new fall/winter menu to meet he interests of residents. *She was not aware that there were no substitutions for the specific food items listed above from 10/31/22 and 11/2/22. -She indicated that the green beans were supposed to have been served with the fish filet on 10/31/22. *They sometimes had to make changes and substitutions to their menu due to supply chain issues. *She knew they were supposed to be recording	F 803		

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F 803	Continued From page 91 substitutions on a menu substitution log. *They agreed with each other that their staff needed retraining on the menus, how to serve, and what to do if they need to make a substitution. Interview on 11/7/22 at 10:18 a.m. with registered dietitian Y about the dietary department revealed: *She had been tasked with retraining all the dietary staff on: -How to read the menus. -Understanding the different therapeutic diets and why it is important to serve the correct diet for each resident. -Where to look to find pertinent information, like the menus and serving sizes for each meal. Review of provider's "Menu Substitution Log" for 2022 revealed: *There were four substitutions in May. *There were no substitutions recorded in June or July. *There were two substitutions in August and September. *There were three substitutions in October. Review of the provider's November 2020 "Resident Handbook" revealed: *On page 16, under the "Food and Nutrition Services" section: -"Each resident is provided with a balanced meal three times per day ...Special diets are provided per physician's orders. Menus are posted daily. The meal schedule is posted in the dining room." Refer to F804 and F812.	F 803		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)	F 804		

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

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F 804	Continued From page 92 §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the facility failed to ensure the food was appetizing and served at a satisfactory temperature. Findings include: 1. Interview on 10/31/22 at 6:09 p.m. with resident 86 in the Friendship Lane dining room revealed: *For supper, she was served ground turkey with gravy, pureed green beans, and cinnamon applesauce. *She said, "The turkey was so salty that I shuddered when I tasted it. I could not eat it. The green beans tasted horrible." *She liked the applesauce and ate all of it. *She did not know if she could get anything else, so she ate one of the peanut butter cups from the condiment basket. *At that time, lead food service assistant NN asked resident 86 how her meal was. -Resident 86 informed him that she did not enjoy her meal and she was still hungry. *Lead food service assistant NN said he could mash up some fish and give her mashed potatoes and gravy. *He later expressed that he felt bad for the residents who were prescribed a mechanically altered diet because they do not have alternatives	F 804	An available menu was posted in each dining room on 11/28/22 to notify residents of alternative options that may be requested if scheduled meal provided is not preferred. The Registered Dietitian will provide education for dietary personnel pertaining to food preparation, food temperature monitoring, and dining service standards policy and procedures by 12/8/22. All residents have the potential to be affected by deficient practice. The Registered Dietitian will provide education for dietary personnel pertaining to utilization of the menu extension to ensure alternative options are available, offered, and are appropriate for ordered diet by 12/8/22. To ensure the deficient practice will not recur, the cooking staff will prepare alternative choices for modified diets as directed per the approved menu extension. The cooking staff will routinely sample food before it is served to ensure good taste texture, temperature, and	12/8/2022

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F 804	Continued From page 93 if the resident did not like the meal, and they "basically get the same thing each day." 2. Observation and interview on 10/31/22 at 5:09 p.m. with resident 120 revealed: *The resident stated he was not that happy with the food that was served there. *It had been okay sometimes but most times the food did not taste good. *The pancakes were rubbery. *The food was not appetizing and was served slowly. *A lot of the time the food was not hot when it was served. Observation and interview again on 10/31/22 at 5:44 p.m. with resident 120 revealed: *The resident had only eaten a couple of bites of his food. *He was served turkey pot pie which was mostly untouched. *His saucer of baked apples was not eaten. *He usually did not eat much in the evenings. *He was not that hungry at night but would eat better if the food had tasted decent. *He ate better and more at breakfast and lunch. Observation and interview on 11/01/22 at 7:46 a.m. with resident 120 revealed: *Resident was seated at a dining room table with sausage patties, and toast with peanut and butter and jelly. *He had a cup of hot tea. *He stated he ordered his eggs 45 minutes ago and he still did not have them. *His sausage was cold, his toast was cold, and he wanted to eat those items with his eggs. *He asked administrator B for help to get his eggs served.	F 804	quality per facility food preparation policy and procedure. All Dietary personnel will successfully complete food temperature monitoring competency check by 12/8/22. To monitor performance and ensure on going compliance, the Registered Dietician and/or designee will complete audits of test tray to evaluate food quality, taste, appearance, and appropriate temperature at point of service daily for 2 weeks, weekly x 2 weeks, monthly x 2 months, quarterly thereafter. The Registered Dietician and/or designee will complete meal observation and resident interviews to ensure alternative meal items are available, offered, and appropriate for ordered diet. Audits will occur daily for 2 weeks, weekly for 2 weeks, then monthly for 2 months, and quarterly x1. The results of those audit findings will be brought to the monthly QAPI Committee meeting by the Registered dietician or designee and will continue until the facility demonstrates sustained compliance as determined by the committee.	

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F 804	Continued From page 94 -She was assisting with the meal service that morning and inquired at the food service window about his eggs. *An unidentified food service worker brought his eggs to him at 7:58 a.m. -By that time, his sausage and toast were cold. *He ate his eggs and the rest of the food on his plate. 3. An interview on 11/1/22 at 9:07 a.m. with resident 77 revealed that breakfast and lunch were generally good, but the evening meal was "awful" because they "couldn't get anything right." 4. Interviews on 11/1/22 at 1:49 p.m. with resident 88, and at 2:18 p.m. with resident 144 revealed that the food was not good. 5. A resident council meeting was held on 11/2/22 at 2:00 p.m. Please refer to the first finding in tag F565 for more information on resident's concerns regarding the food service. 6. Observation and interview on 11/2/22 at 5:20 p.m. with food service assistant J revealed: *He pushed a food cart into the 400-wing kitchen. *He turned the steam table on and stated, "I forgot to turn it on before I brought the food down." *Surveyor asked if it takes a while to heat up, he said, "ugh, not too long." *After approximately 7 minutes he placed the food into the steam table. *He began serving the residents the food. -He had not taken the temperature of the food to ensure it was at the correct temperature before serving. Further observation and interview on 11/2/22 at	F 804		

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F 804	Continued From page 95 5:40 p.m. with food service assistant J revealed: *There was a resident who was on a moist, soft foods diet so he was just going to give the resident some beets to eat. -He thought the grilled cheese might have been too hard. -CNA T stated she would give the resident some mashed potatoes as well. *CNA T had inquired why the mashed potatoes looked like soup. *A resident was supposed to receive fortified foods. -Surveyor inquired about the fortifying process and he stated that the kitchen does all of that. --Surveyor asked if all the food on the steam table was fortified and he stated, "I guess." *A resident was supposed to receive cut-up foods and she received a whole grilled cheese sandwich. *A resident was supposed to use weighted silverware and cups with lids. -Surveyor inquired about these items and CNA T stated that they do not use those, they just use regular. *A resident was to receive a "dental soft" diet and only received mashed potatoes and beets. *Surveyor inquired why they were not serving all the menu items. Food service assistant J was not sure. 7. Interview on 11/2/22 at 5:41 p.m. wit lead food service worker NN about food quality revealed: *Surveyor had asked if he tasted the food before serving it to the residents. He said he usually did not taste the food. *He followed up with, "Would you taste the food if you were serving this?" as he motioned to the mechanically altered foods. -Surveyor responded, "Yes, when I worked in	F 804		

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F 804	Continued From page 96 food service I would taste the food, even the pureed food, because if I did not like the food, the residents sure would not like it either." -He responded, "Oh that makes sense." 8. A test tray was requested on 11/2/22 at 6:03 p.m. from lead food service worker NN. *Requested food items included: grilled cheese sandwich, tomato soup, pickled beets, mandarin oranges, vegetable soup, and pureed grilled cheese. *Surveyors 46453, 42477, 41088, and 45383 conducted a taste test and concluded: -The grilled cheese was soggy. -The tomato soup did not have much tomato flavor and tasted watered-down. -The vegetable soup was very salty. -The pureed grilled cheese was not pureed consistency as it was not smooth in texture. --It tasted like macaroni and cheese rather than a grilled cheese. 9. Interview on 11/3/22 at 10:13 a.m. with administrator A and dietary manager QQ about food quality concerns revealed: *They were aware of resident complaints of food quality. *Dietary staff were supposed to be taste testing foods to review palatability. *To address complaints of food temperatures, they bought and implemented plate pellets that were designed to keep the plates and food warm. *They reintroduced the "always available" menu to give residents more choice in what they ate. *Dietary staff were supposed to be taking the temperature of the food when it arrived to each dining room kitchenette. *Registered dietitian Y was in charge of conducting test trays to assess the palatability,	F 804		

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F 804	Continued From page 97 temperature, and to see if dietary staff are serving the correct foods per the different diet orders. 10. Review of the provider's November 2020 "Resident Handbook" revealed: *On pages 16 and 17, under the "Food and Nutrition Services" section: -"Each resident is provided with a balanced meal three times per day. Each resident's nutritional needs are monitored regularly by a Registered Dietitian as well as a Director of Food and Nutrition Services. Special diets are provided per physician's orders. Menus are posted daily. The meal schedule is posted in the dining room. The center also offers selective menus which allow the resident at least two choices of what he/she would like to eat for each meal. Snacks are available. Food brought to the facility by family members for friends is never prepared, reheated, or served from the facility's satellite kitchens." 11. Review of a grievance form submitted by resident 364 on 9/6/22 regarding food quality revealed: *Chicken sandwiches had been served with no bun. *Spaghetti had been served with meat sauce but no noodles. *Administrator B had written the following on the grievance form: -"In interviewing staff, they ran out of noodles. [The cook] was making more when the food service assistant...decided to serve just spaghetti sauce with no noodles... [Administrator A] verified information with [dietary manager QQ]. They walked through the weekend, talked about solutions. [Dietary manager QQ] to educate staff." -"Note: This concern was also discussed by other residents during resident [council] on 9/7/22..."	F 804		

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	435045	A. BUILDING _____ B. WING _____	11/08/2022

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

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F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to: *Maintain one of one main kitchen and one of four kitchenettes in a manner that met professional food service cleanliness standards. *Properly temp foods to prevent the spread of cross-contamination by one of one observed dietary staff, and to ensure the foods being served were at an appropriate temperature. *Ensure personal beverages for two of three dietary staff members reviewed (dietary manager QQ and food service assistant SS) were kept away from food storage and food preparation areas. *Properly store foods that were labeled "Refrigerate after opening."	F 812	Resident items and chemicals found beneath sink were relocated to appropriate location 11/2/22. The cupboard beneath the sink was repaired and a lock was installed on 11/4/22. Bottles of sauce and syrup stored in the cupboard were removed and disposed of. The floors behind kitchen equipment, shelving across from ovens, and hand washing sink were cleaned on 11/5/22. Coffee stains located in cupboard area beneath the juice and coffee machines were repaired on 11/9/22. Bottles of sauce and syrup stored in the cupboard were removed and disposed of. Dietary personnel were educated, on 11/28/22, that personal food and beverages are not allowed in kitchen area and informed of personal food and beverage designated areas. All residents have the potential to be affected by deficient practice. The Registered Dietitian will provide education for dietary personnel pertaining to food temperature monitoring procedure and dietary personnel with successfully complete policy competency check by 12/8/22.	12/8/2022

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F 812	Continued From page 99 Findings include: 1. Observation on 10/31/22 at 3:35 p.m. in the main dining room kitchenette revealed: *There were coffee stains in the cupboards beneath the juice and coffee machines. -Items for resident use were stored in those cupboards, like water pitchers. *The cupboard beneath the sink was rotting away and was speckled with an unknown black substance. 2. Observation on 10/31/22 from 3:46 p.m. to 4:15 p.m. in the main kitchen revealed: *Items for resident use were stored next to cleaning chemicals underneath a sink. -The items included a tub of assorted silverware, eight porcelain mugs, and one case of nosey cups and sippy cups. -The cleaning chemicals included a bottle of window cleaner, a spray can of stainless-steel cleaner and polisher, and a tub of "add your own chemical" wipes. *The floors throughout the kitchen, especially underneath and behind the ovens, flattop grill, fryer, and underneath the sinks were soiled with scattered food particles, dirt, dust, grease splatters, and rust-colored flakes. *There was a layer of dust and food crumbs on the equipment storage shelves located across from the ovens. -The storage shelves contained food preparation equipment like metal cake pans and attachments for the stand mixers. *The hand washing sink located near the ovens was stained with an unidentified brown and tan substance. *Throughout the kitchen cupboards and dry storage areas, several opened bottles of sauces	F 812	To ensure deficient practice will not recur, the cleaning check list was updated to include noted findings on 11/30/22. The Registered Dietitian will provide education for dietary personnel pertaining to food temperature monitoring procedure and dietary personnel with successfully complete policy competency check by 12/8/22 and then annually. Additional education will be completed by Registered Dietician regarding cleaning schedule completion, required documentation, food and chemical storage by 12/8/22. To monitor performance and ensure on going compliance the Dietary Manager and/or designee will complete observations and audits of kitchen and dining areas to verify cleaning tasks and documentation are complete. Audits will occur daily for 2 weeks, weekly for 2 weeks, then monthly for 2 months, or until 100% compliance. The Dietary Manager and/or designee will complete audit of kitchen storage areas to ensure proper storage of food and chemical	

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F 812	Continued From page 100 and syrup were found with the label reading "Refrigerate after opening." -Two bottles of teriyaki sauce, one bottle of soy sauce, and one bottle of blueberry syrup. 3. Observation on 10/31/22 from 5:05 p.m. to 6:13 p.m. in the Friendship Lane dining room kitchenette revealed: *Lead food service worker NN arrived with the food at 5:05 p.m. and placed the food in the steam table. *He took a food thermometer out of his pocket. Without cleaning the probe, he placed it in the fish to measure the temperature. *He took the thermometer out of the fish and wiped the probe with a dry cloth, then placed the probe into the rice. *He took the thermometer out of the rice and wiped the probe with the same dry cloth, then placed the probe into the green beans. *He used the same dry cloth throughout the above process to wipe off the thermometer probe. *He continued to temp the food without properly cleaning the probe in between each food item. 4. Observation on 11/2/22 at 5:30 p.m. revealed food had not been temped prior to serving to residents. Refer to F804, finding 6. 5. Observation and interview on 11/2/22 from 4:42 p.m. to 5:58 p.m. with lead food service worker NN in the Friendship Lane dining room kitchenette revealed: *Lead food service worker NN arrived with the food at 5:23 p.m. and placed the food in the steam table. *Without cleaning the thermometer, he placed the probe into the grilled cheese.	F 812	items. Audits will occur daily for 2 weeks, weekly for 2 weeks, then monthly for 2 months, and quarterly x1. The results of those audit findings will be brought to the monthly QAPI Committee meeting by the Dietary Manager or designee and will continue until the facility demonstrates sustained compliance as The facility's QAPI committee will review and oversee documentation of progress and ongoing compliance.	

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F 812	Continued From page 101 *He took the probe out of the grilled cheese and wiped it off with a dry cloth. *He then placed the probe into the soup. *He used the same dry cloth throughout the above process to wipe off the thermometer probe. *He continued to temp the food without properly cleaning the probe in between each food item. *Alcohol-based thermometer probe cleansing wipes were available in the drawer under the microwave in the kitchenette. *He was aware he was supposed to clean the thermometer probe in between foods. *He did not know the alcohol-based thermometer probe wipes were in that drawer. 6. Observations and interviews on 11/3/22 from 9:31 a.m. to 9:55 a.m. in the main kitchen revealed: *There was a bottle of water and an opened can of energy drink on a food preparation counter. -Food service assistant SS was preparing a fruit dessert at that counter. --She had been working there for about six months. --Her general orientation training on the computer included some food safety topics. --She was unaware personal beverages should be kept away from food preparation areas. *Someone's to-go coffee cup was sitting on a shelf in the dry storage room. Interview on 11/3/22 at 10:13 a.m. with dietary manager QQ revealed: *It was her coffee cup that was found in the dry storage room. *She was aware personal beverages should not be kept in food storage and food preparation areas.	F 812		

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F 812	Continued From page 102 *She would remind all her staff to store their beverages in the designated area. Continued interview on 11/3/22 at 10:21 a.m. with administrator A and dietary manager QQ revealed: *They were both relatively new in their positions at the facility. -Dietary manager QQ had been getting rid of inventory that they no longer needed or used, such as small wares, replacing dining utensils, plates and bowls, and other kitchen equipment. -Neither of them had been aware of the state of the cupboards in the main dining room kitchenette. *Administrator A oversaw both the dietary and environmental services departments. *They were working on hiring more dietary staff to address the food complaints. *Their dietary staff needed a refresher with food safety training topics like cleanliness. *Dietary supervisor RR was tasked with auditing the cleaning schedules. -Dietary manager QQ said she thought dietary supervisor RR was keeping up with the cleaning schedules but was unable to confirm this. *They had made some improvements recently, like installing new juice machines and reimplementing the "always available" menu. *The cleanliness of the kitchen needed to be worked on. *Administrator A ensured they would start on deep cleaning the kitchen right away. Review of the provider's 2/15/22 policy "Cleaning Schedule-Food and Nutrition Services" revealed: *Under the "POLICY/PROCEDURE" section: -"Cleaning schedule" --"1. The director of food and nutrition services	F 812		

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F 812	Continued From page 103 (DFN), senior living dining director or designee is to post written daily, weekly and monthly cleaning assignments in the kitchen areas." --"2. Employees are responsible for knowing his or her assigned duty and carrying it out during the designated work shift." --"3. Employees will initial the schedule after completing his or her cleaning duties each day." --"4. Completed cleaning schedules will be kept in the department office for one year ..." --"5. The DFN, food and nutrition supervisor, senior living dining director, senior living manager or person in charge is responsible for monitoring employees to ensure that cleaning duties are completed in a satisfactory and timely manner." -"Guidelines for Kitchen and Equipment Cleaning" --"17. Cabinets, drawers and counter tops:" —"a. Clean and sanitize between uses and at the end of the day." —"b. Empty and clean drawers weekly." -"Rehabilitation/Skilled Care Required Competencies" --"Food and nutrition employees are in-services periodically and on an as-needed basis with written verification of competency for required job duties related to this procedure." Review of the provider's 6/23/21 "Food-Supply Storage - Food and Nutrition Services" policy revealed: *The purpose was to "ensure that food is stored properly." *Under the "POLICY" section: -"Personal food is not considered approved food and is not stored in the food preparation kitchen or location refrigerators and storage areas." *Under the "PROCEDURE" section: -"2. Designate common areas for storage of personal food (e.g., refrigerator and cupboards).	F 812		

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F 812	Continued From page 104 These areas will not be in the food preparation kitchen... Location food supplies will not be stored with personal food items." -"20. Employee and personal resident food/fluids are not stored in the preparation kitchen cooler/freezer or dry storage."	F 812		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, policy review, and job description review, the provider failed to ensure the facility was operated and administered in a manner that ensured the safety and overall well-being of all 156 residents in the facility throughout the following dates and times of the survey: -10/31/22, 3:00 p.m. until 5:30 p.m. -11/1/22, 7:00 a.m. until 5:30 p.m. -11/2/22, 7:00 a.m. until 7:15 p.m. -11/3/22, 8:00 a.m. until 12:45 p.m. -11/7/22, 7:30 a.m. until 5:00 p.m. -11/8/22, 7:30 a.m. until 6:00 p.m. Findings include: 1. Observations, interviews, record reviews, and policy reviews throughout the survey revealed administrators A and B, and director of nursing C had not ensured the safe management and overall well-being of all the residents who lived in the facility.	F 835	On 12/2/2022, Administrator A and B, Director of Nursing C, and interdisciplinary team met with Medical Director and Governing Body representatives (Executive Director, Clinical Services Direction, Human Resources Advisor, Quality Improvement Advisor, and Accreditation Specialist) to review 2567 and complete RCA themes related lack of communication including, dignified and respectful communication to and with residents and family members, clear and timely person to person communication between staff, communication via written/electronic medical record and not following or addressing policy and procedures. By 12/8/2022, Administrator Director of nursing and designees will complete education to all–staff on survey findings, results of RCAs, and systematic changes addressed in POC. All residents have the potential to be affected by deficient practices.	12/8/2022

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F 835	Continued From page 105 Interview on 11/2/22 at 2:59 p.m. with director of nursing (DON) C revealed she: *Agreed proper infection control practices had not been followed during resident 50's dressing change. Refer to F880. *Stated resident 50 can be manipulative. *Agreed if residents refused cares or services, staff should document the refusals in their records. *Agreed it was unacceptable for staff to talk to residents the way surveyors had overheard them talking to them. *Was unsure why they were having so many issues with the dietary department, there had been a lot of staff turnover. *Stated they have four other facilities to serve before they have to serve their residents. -Once they are done serving those four facilities, they still have 150 residents to feed. Interview on 11/3/22 at 11:36 a.m. with administrators A, B, and DON C revealed: *Certified nursing assistant (CNA) Q is a current travel staff working at the facility. *They had been aware of complaints regarding CNA Q. *Specifically, they had been aware of two incidents, which were: -A long call light for a resident. -Her conduct and how she acted regarding taking personal calls at work and had earbuds in while working with the residents. *Administrator B believed she had renewed her contract before these incidents. *Surveyors voiced concerns regarding CNA Q working on the memory care unit with residents who could not voice their grievances. -DON C was not aware she was working on the	F 835	To ensure deficient practice will not recur, by 12/8/2022, Administrator A, with input from interdisciplinary team, will revise general orientation to ensure all new hires are instructed on expectation for communication, Infection Control, reporting concerns, responsibilities of reporting abuse and neglect, and standards of care. By 12/8/2022, Administrator will establish weekly department head meetings, monthly one to one meetings with department leaders to review goals and outcomes, address regulatory and organization compliance, and provide direction on financial and operation stability. By 12/8/2022, Director of Nursing will revise weekly clinical review meetings to include clinical care leaders and MDS coordinators in an intentional review to care delivery and resident needs and from that meeting provide information to department heads and administrators in matters related to nursing services and strategies during weekly department head meetings. To monitor performance and ensure on going compliance, Clinical services director or designee will audit by staff interview, resident interview, observation, and review of department head meeting minutest to ensure corrective actions outlined in previous paragraph are properly implemented.	

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F 835	Continued From page 106 memory care unit. -They agreed it was troubling to have her work with residents who were unable to voice their concerns. *Regarding the suicide attempt with resident 16: -DON C stated she was called about it around midnight. --Surveyors verified the incident happened at 6:20 p.m. and resident 26 was transferred to the hospital around 8 p.m. -DON C stated they had her on a one-to-one resident to staff ratio. -She was unsure who the CNA was that was watching her, and she stated it had not been documented. -Administrator B agreed that would be good information to include in their incident report. Further interview on 11/8/22 at 3:07 p.m. with administrators A, B, and DON C revealed: *They had been aware of the issues with dining. -Administrator A had been working closely with dietary to address the issues. *They had been working on the care plan issues. *Surveyors asked who was in charge of ensuring the care plans were completed and revised. -It was a team effort, there was no one who oversaw that they were all completed as they needed to be. -DON C asked surveyors who we would recommend overseeing it as they have over 150 residents. *Administrator B stated Social Services Supervisor H was in charge of the grievances. Review of the provider's job descriptions for administrator for long term care revealed: *This position is responsible for the overall leadership and management of the location,	F 835	Audits will occur weekly x 4, every other week x2, monthly x1 and quarterly x1. Clinical services director or designee will report audit findings to QAPI committee monthly, and to regional leaders to include Executive Director, Human Resources Advisor and Quality Advisor monthly. The QAPI committee will determine ongoing monitoring and interventions.	

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F 835	Continued From page 107 including meeting established goals and outcomes, ensuring regulatory and organization compliance, directing and coordinating work, financial and operational stability, and demonstrating leadership. Review of the provider's job description for the director of nursing for long term care revealed: *Administers the nursing program in a long term care facility to maintain standards of resident care. Facilitates the optimization of the geriatric care process to improve the quality and efficiency of service. Responsible for the overall quality of care provided by the organization's nursing personnel. Advise medical staff, department heads, and administrators in matters related to nursing service and strategies. Review of the provider's job description for clinical care leader for long term care revealed: *The clinical care leader is responsible for utilizing the nursing process (assessment, diagnosis, outcome/planning, implementation and evaluation) to provide individualized nursing care in the home setting. Review of the provider's job description for Minimum Data Set (MDS) nurse for long term care revealed: *The MDS nurse uses independent judgement in the planning, organizing, directing, and evaluation of activities of the professional and supportive nursing staff engaged in resident plan of care. Evaluates care provided to each resident and keeps care plans current. Is the direct lead in regards to the Resident Assessment Instrument (RAI) process, MDS nurse assists in assessment and evaluation of potential admissions. Upon admission, quarterly, and annual, the MDS nurse	F 835		

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F 835	Continued From page 108 completes resident assessments. Collaborates with the resident, family or advocate, other inter-disciplinary colleagues, including providers, to assure ongoing care of each resident to provide the best quality of life possible. Review of the provider's job description for the infection preventionist revealed: *Work collaboratively with infection and prevention and control staff under leadership, to accomplish the goals and objectives of the Infection Prevention program. Review of the provider's job description for the registered nurse (RN) for long term care revealed: *The RN is responsible for utilizing the nursing process (assessment, diagnosis, outcome/planning, implementation and evaluation) to provide individualized nursing care to residents. Collaborates with resident and family, other inter-disciplinary colleagues, including providers, to plan, implement and evaluate care. Review of the provider's job description for the licensed practical nurse (LPN) revealed: *The LPN provides professional nursing care for residents of all ages in long term care, under the supervision of a RN, advanced practice provider, or physician. Review of the provider's job description for the nursing assistant (NA) in long term care revealed: *The NA serves as caregivers to the resident during the scheduled work period in long term care. Provides resident-centered nursing care of daily living assistance to assigned resident under the direct supervision of a RN. Knowledge of and	F 835		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 109 delivers age-appropriate care related to the physical and psychosocial needs of the resident as per the care plan. Considered a member of the nursing team and is expected to know, and will be held accountable for, following infection prevention and control policies and personal protective equipment use. Review of the job description for the supervisor, nutrition and food services revealed: *Supervises the quality of performance for employees on one's team. Assists with the interviewing, hiring, counseling, disciplining and performance reviews according to healthcare organization requirements. Assists in the training of new staff members and development of existing staff members. Oversees adequate staffing and scheduling issues. Ensures department meets all regulatory requirements. Review of the provider's job description for the manager, nutrition and food services revealed: *Manages the day to day operations of the nutrition and food service department, contributing to the strategic planning process. Oversees all dietary and related food services functions. Oversees diet and menu planning. Review of the provider's job description for the lead cook revealed: *Performs all duties in food preparation as assigned. Provides daily direction to cooks and other assigned areas ensuring all departmental standards and goals are met. Prepares cooks, seasons and portions food for residents, staff, and visitors of the designated facility, preparing and serving food with guidelines of menu and dietary requirements.	F 835		

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F 835	Continued From page 110 Review of the provider's job description for the cook revealed: *Prepares, assemble bake goods, cooks, seasons and portions food for residents, staff and visitors of the designated facility, preparing and serving food within guidelines of menu and dietary requirements. Review of the provider's job description for the lead food service assistant revealed: *Providers direction to food service staff according to quality standards. Responsibilities include, but are not limited to, monitoring and recording temperature of food, setting up and maintaining a clean and sanitized serving area, preparing and serving food items, restocking food areas, cleaning and sanitizing equipment, receiving payment for food and beverages using a computerized register and other related responsibilities. Review of the provider's job description for the food service assistant revealed: *The food service assistant is responsible for certain duties including, but not limited to, monitoring and recording proper temperature of food, setting up and maintaining a clean and sanitized serving area, preparing and serving food items, restocking food areas, cleaning and sanitizing equipment, receiving payment for food and beverage items using a computerized register and other related responsibilities. Review of the provider's job description for the supervisor, social services revealed: *Possesses expert knowledge and clinical skill in order to oversee the day to day operations of the department, ensuring quality and compliance of all policies, procedures, and regulatory agencies.	F 835		

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F 835	Continued From page 111 Review of the provider's job description for the social worker revealed: *Provides supportive services/counseling on healthcare and home care programs and services. Serves as a member of the interdisciplinary team in providing assistance with social, emotional and economical concerns of patient/clients/residents and families/caregivers, thus enabling them to achieve or maintain an optimal level of functioning by coordinating and planning programs. Review of provider's job description for the supervisor, activities revealed: *Creates and implements resident activities and events. Manages activities staff schedules and coordinates volunteer staffing activities. Refer to F550, F565, F585, F600, F604, F610, F656, F657, F677, F679, F803, F804, F812, F865, and F880.	F 835		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to	F 865	On 11/29/22 Quality Subcommittee members collaborated to determine performance improvement priorities to submit to Quality Committee Meeting on 12/6/22. On 12/1/22 QAPI Plan was updated to include the dialysis care unit. All residents have the potential to be affected by the deficient practice.	12/8/2022

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F 865	Continued From page 112 systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and	F 865	To ensure deficient practice will not recur, Quality Improvement Advisor or designee will provide Performance Improvement Plan (PIP) education for Quality Committee Members 12/8/22. By 12/8/22 a PIP will be selected and initiated by Quality Committee Members. PIP activity will be monitored for progress and sustainability by the quality committee members. PIP project will either be in development, on-going or completed annually. Dialysis care unit will included in the QAPI plan. To monitor performance and ensure on going compliance the Administrator or designee, will ensure performance improvement projects (PIP) had been thoroughly implemented, examined, and resolved with an effective quality assurance performance improvement (QAPI) process and the QAPI plan had included the dialysis care unit by auditing PIP meeting outcomes for sustained improvement weekly x 4, biweekly x2, monthly x 1 and quarterly x1. The results of those audit findings will be brought to the	

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F 865	Continued From page 113 facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information.	F 865	monthly QAPI Committee meeting by the Administrator or designee and continued until the facility demonstrates sustained compliance as determined by the committee.	

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F 865	Continued From page 114 A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure performance improvement projects (PIP) had been thoroughly implemented, examined, and resolved with an effective quality assurance performance improvement (QAPI) process and the QAPI plan had included the dialysis care unit. Findings include: 1. Interview and QAPI record review on 11/8/22 at 3:08 p.m. with administrator A, administrator B, administrative assistant DD, and director of nursing (DON) C revealed: *The QAPI committee met monthly. *The QAPI committee members were: -The QAPI coordinator. -Administrator A. -Administrator B. -The DON. -The infection preventionist. -The medical director. -The dietary manager. -The dietician. -The pharmacist. -The environmental services manager. -The health information management supervisor. -The activities supervisor.	F 865		

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F 865	Continued From page 115 -The social services director. *The QAPI meeting consisted of reviewing the PIPs they had been working on. See QAPI plan PIPs as listed below. -In addition to those identified PIPs, they had been working on resident food concerns and infection control. *The QAPI coordinator had been the person in charge of gathering data regarding the PIPs they worked on. *The committee discussed and decided the criteria for completion of a PIP and when to move on to another area. *Due to the administration being new in the last few months, they were trying to get a handle on areas of concern to prioritize at the facility. *They agreed that investigations and grievances had not been completed or handled per their policy. -There had been confusion as to who was in charge of the grievances. *They had identified care plans as needing work. -A staff member had not been chosen to be in charge of ensuring all care plans had been updated for the residents. --They agreed the current system of completing and updating care plans had not worked effectively. *They agreed the call light system needed to be resolved as soon as possible. *Discharge summaries had also been identified as a problem. Review of the provider's 3/8/22 QAPI plan revealed: *They had been working on the following PIPs: -Medication regimen review. -Incident safety. -Continuous Survey Readiness Program (CSRP).	F 865		

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F 865	Continued From page 116 -Staff quality concern trends. -Survey results/plan of correction monitoring. -QAPI plan priorities. -Resident and family suggestion/concern trends. -CMS (centers for Medicare and Medicaid services) 5-star rating. *There had been mention of the dialysis care unit or PIPs in place for the dialysis care unit. Review of the provider's revised 6/22/21 QAPI policy revealed: **Purpose: To define and communicate the requirements of the Quality Assurance and Performance Improvement (QAPI) program that is data driven, addresses the unique needs of those served and the full range of care and services provided. 1. Program design and scope: a. The QAPI program is ongoing, comprehensive, and data-driven, and addressed the complexity and uniqueness of the care and services provided. b. Capable of showing measurable improvement and focuses on safety, choice, outcomes, quality of care and quality of life as applicable to each location. c. The QAPI program will measure, analyze and track quality indicators, including adverse events, and other aspects of performance that enable the location to assess processes of care, services and operations. d. Staff education, to all new and existing staff (including contract staff), regarding the QAPI program's responsibilities, communication, and clients/residents/tenants' rights. e. Location will document QAPI governance and structure in an annual written QAPI plan. ...3. Program Data Systems and Monitoring: The QAPI program uses data to monitor the	F 865		

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F 865	Continued From page 117 effectiveness and safety of services and quality of care; identify and prioritize problems and process improvement opportunities and takes action to address areas in need of improvement. 4. Performance Improvement Projects: At a minimum one performance improvement project will either be in development, on-going or completed annually utilizing the improvement model adopted by the location. Performance Improvement project activity will be monitored for progress and sustainability by the location. a. Performance improvement activities will focus on high risk, high volume, or problem-prone areas. b. Consider incidence, prevalence, and severity of problems in those areas; and c. Led to an immediate correction of any identified problem that directly or potentially threaten the health and safety of clients/residents/tenants. 5. Quality Assurance and Performance Improvement (QAPI) Committee: a. The QAPI Committee is responsible to track and trend performance, systematically analyze and prioritize quality deficiencies, develop action plans and monitor for effectiveness and sustainability. ...c. General QAPI Committee oversight activities include: i. Setting clear expectations around safety, quality, rights, choice, and respect. ii. Identify quality of care and safety concerns through the review of multiple venues including but not limited to, safety event reports, grievances, feedback from staff, annual facility or program assessments and department specific initiatives. iii. Recognize and prioritize high risk, high volume, or problem prone improvement opportunities.	F 865		

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F 865	Continued From page 118 iv. Systematically analyze underlying root causes of improvement opportunities. v. Develop and implement action plans. vi. Monitor and evaluate the effectiveness of action plans and ensure sustainability." *The dialysis care unit at the facility had not been included in the QAPI plan. Refer to F550, F565, F585, F600, F604, F610, F656, F657, F677, F679, F803, F804, F812, F835, and F880.	F 865		
F 880 SS=D	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 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	F 880	**Directed Plan of Correction** **Good Samaritan Society Sioux Falls Village** **F880** **Corrective Action:** 1. For the identification of lack of: *Appropriate procedural technique and hand hygiene/ glove use during dressing change. **Please do read 2567 findings.** All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by **date by 12/8/2022 by Director of Nursing or designee.** 2. **Identification of Others:** ALL residents and staff have the potential to be affected by lack of: *Appropriate procedural technique and hand hygiene/glove use during dressing change. *Appropriate communication between nursing home and dialysis den staff about infection control precautions.	12/8/2022

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F 880	Continued From page 119 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 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	F 880	Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by **12/8/22 by Administrator, Director of Nursing or designee.** **System Changes:** 3. Root cause analysis conducted answered the 5 Whys: **Through RCA of concerns in F880:** **Facility determined staff member did not have proper supplies needed for wound dressing change. Facility will implement rolling treatment carts to facilitate proper set up of wound dressing supplies and hand sanitization solution available during wound dressing changes.** **Increase number of audits and use staff roster for hand hygiene/IP observations to ensure all staff are being observed. Re-education to staff on proper hand hygiene and infection control practices.** Administrator, DON, 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 and documentation. **Administrator and Director of Nursing** contacted the South Dakota Quality Improvement Organization (QIN) on **11/30/22** and include **brief detail of discussion. Reviewed 5 Whys, and received feed back on ideas for plan of corrections. QIN reiterated focus on being prepared with supplies. QIN provided training resources, tracking tools, and invitation for continued collaboration.**	

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F 880	Continued From page 120 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure: *One of one licensed practical nurse (LPN) G had performed a dressing change for one of one (50) sampled resident and had been completed in a sanitary manner. *One of one resident (26) who had Methicillin-resistant Staphylococcus aureus (MRSA) in her wound had communication between dialysis and nursing home regarding infection control precautions. Findings include: 1. Observation on 11/1/22 at 9:31 a.m. with LPN (G) performing a dressing change revealed she: *Used a towel from the bathroom to create a barrier to place the dressing supplies on. *Washed her hands. *Put on a pair of gloves and grabbed personal hygiene wipes and the garbage can. *Removed the old dressing and packing from the resident's wound. *Removed her gloves and washed her hands. *Put on a new pair of gloves. *Used paper towels and wound cleanser to wash the wound and wipe the wound. *Opened gauze rope dressing and sterile swab used to insert the dressing into the wound. *Inserted gauze into the wound with a sterile swab. *Applied the foam dressing to the wound opening. *Applied hydrocolloid wound paste to the outer wound bed. *Wiped surrounding skin with personal hygiene wipe and applied Dynashield lotion to the area. *Removed her gloves and washed her hands.	F 880	**Monitoring:** 4. Administrator, DON, and/or designee will conduct auditing and monitoring of above identified items 2-3 times weekly over all shifts. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. *Staff compliance in the above identified area. *Any other areas identified through the Root Cause Analysis. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by administrator, DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	

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F 880	Continued From page 121 *Put on a new pair of gloves and assisted with placing a brief on the resident. *Continued to use the same gloves to pick up supplies, removed soiled linens, and placed in a soiled linen bag. *Grabbed clean clothes out of the resident's closet and placed the clothes on the resident's bed. *Removed her gloves and used hand sanitizer. *Exited the room. Interview on 11/1/22 at 9:59 a.m. with LPN G following the observation revealed she: *Had not realized she used the same pair of gloves to apply wound paste and to apply Dynashield lotion to resident's skin. *Agreed that she should have changed her gloves after applying the gauze to the wound. *Should have changed her gloves and performed hand hygiene more frequently during the dressing change. -She agreed she had missed opportunities of hand hygiene. Interview on 11/2/22 at 2:58 p.m. with director of nursing (DON) C regarding the above observation revealed she agreed that LPN G had missed hand hygiene and glove change opportunities. Review of the provider's October 2021 Wound Dressing Change policy revealed: *Equipment required: -Gloves. -Dressing. -Tape. -Plastic bag for disposal of soiled dressings. -The solution to clean the wound. -Gauze wipes.	F 880		

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	435045	A. BUILDING _____ B. WING _____	11/08/2022

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

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F 880	Continued From page 122 2. Observation on 10/31/22 at 5:00 p.m. of resident 26's doorway to her room revealed: *She was on enhanced precautions. *Staff were to use gloves and gowns while providing care to the resident. Interview on 11/1/22 at 8:21 a.m. with dialysis RNs SS, TT, UU, VV, and WW revealed: *They had not been aware that resident 26 had MRSA in her wound. *They had not been aware resident 26 often took off her wound dressing leaving her wound exposed. *They were unable to run dialysis treatments for residents who required isolation precautions. 3. Interview on 11/8/22 at 9:00 a.m. with infection preventionist AAA revealed she: *Had been in charge of overseeing infection control for the facility. *Was not involved with dialysis nor did she complete dialysis infection control audits. *Agreed they should have been involved with dialysis. -"They kind of just do their own thing." *Regarding resident 26's wound, she assumed nursing talked to the dialysis staff about the MRSA in her wound. *Agreed LPN G had not performed the dressing change for resident 50 appropriately.	F 880		

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

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E 000	Initial Comments 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 10/31/22 through 11/3/22 and on 11/7/22 through 11/8/22. Good Samaritan Society Sioux Falls Village was found in compliance.	E 000		12/8/22

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

Dawn Ballinger — Administrator — 12/03/2022

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

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	435045	A. BUILDING 01 - SIOUX FALLS GOOD SAMARITAN VILLAGE B. WING _____	11/02/2022

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 11/2/22. Good Samaritan Society Sioux Falls was found not in compliance with 42 CFR 483.70(a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System date 11/7/22. Please mark an F in the completion date column for the K252 deficiency identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K321, K345, K347, K353, K354, K522, K712, and K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 252 SS=C	Number of Exits - Corridors CFR(s): NFPA 101 Number of Exits - Corridors Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4	K 252		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Ballenger | TITLE: Administrator | (X6) DATE: 12/03/2022

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

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K 252	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and record review, the provider failed to maintain two conforming exits from the basement. Findings include: 1. Observation on 11/2/22 at 9:15 a.m. revealed the basement level was not provided with two conforming exits. One exit was through the boiler room (hazardous area), and the other discharged into the main level kitchen area. Review of previous survey data confirmed those conditions. This deficiency would affect a small number of maintenance staff. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K 252	**K321 Hazardous Areas –** It is the policy of the facility to maintain hazardous areas smoke barriers within hazardous areas enclosures. Corrective Action: Installation of a self-closing device was installed on or all combustible materials where removed from resident room 304. Completed: 12/1/2022 Installation of a self-closing device was installed on the 4 wing south storage room. Completed: 12/1/2022 The Environmental Services Director and/or designee conducted a routine hazardous areas inspection to meet this requirement. Any hazardous area self-closing doors identified as not meeting this requirement will be repaired immediately. Completed by 12/8/2022. The Environmental Services Director and/or designee will ensure hazardous areas are inspected and maintained in accordance with NFPA, Life Safety Code and the facilities preventative maintenance program. The facilities safety committee will review and oversee documentation that shows egress inspections are maintained and completed.	12/8/22
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9	K 321		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 321	Continued From page 2 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to continuously maintain hazardous room requirements in two of two locations (resident room 304 and 400 wing south storage room). Findings include: 1. Observation and interview on 11/2/22 at 9:10 a.m. revealed resident room 304 had copious amounts of combustible material (boxes and plastic) kept inside. The room was over 100 square feet in area and the door was standing open. Testing of the door revealed it was not self-closing. Interview with the maintenance director revealed the contractor working on installing a new call light system was using the room for storage of their supplies while working in the building. 2. Observation, testing, and interview, on 11/2/22 at 10:00 a.m. revealed the 400 wing south storage room was over 100 square feet in area and held copious amounts of combustible supplies. Testing of the door revealed it was not self-closing. Interview with the environmental	K 321		

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K 321	Continued From page 3 services supervisor at the time of the observation and testing confirmed that condition. This deficiency has the possibility of affecting 100 percent of the occupants of the smoke compartment.	K 321		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to test and provide the correct data for the fire alarm system as required. Findings include: 1. Record review on 11/2/22 at 8:30 a.m. revealed there was no documentation showing that an annual fire alarm inspection had been performed since 7/1/21. Test results must include the following information for alarm initiating, supervisory alarm initiating, and notification for the device type, address, location, and test results as required. Testing must also include magnetic delayed egress door locks and magnetic hold-opens fire-rated doors that are tied into the fire alarm system. The environmental services supervisor was	K 345	**K354 Sprinkler Systems –** It is the policy of the facility to continuously maintain automatic fire sprinkler systems in a reliable operating condition in all areas. Corrective Action: The Environmental Services Director and/or designee made repairs to or contacted the facilities general contractor for the repairs of the damaged suspended ceiling and ceiling tiles in the basement women's locker room. Repairs to the ceiling will be completed by: 12/8/2022 The Environmental Services Director and/or designee will inspect all areas of the facility to assure all Fire Sprinkler Systems and areas have been maintained and inspected, and meet NFPA, Life Safety Code and the facilities preventative maintenance program. The facilities safety committee will review and oversee documentation that shows Fire Sprinkler System inspections are maintained and completed.	12/8/22

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 345	Continued From page 4 present when the deficiency was identified. A fire alarm inspection was then scheduled for 11/4/22 with that contractor. Failure to test the fire alarm system as required increases the risk of death or injury due to fire.	K 345		
K 347 SS=D	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain corridor smoke detection in one of one locations (administrative assistant's office). Findings include: 1. Observation on 11/2/22 at 11:15 a.m. revealed the administrative assistant's office had two roll-down windows open to the corridor. The bulkhead for the roll-down windows was approximately 20 inches from the ceiling to the bottom of the bulkhead. The room was not equipped with a system smoke detector. Interview with the maintenance director revealed neither of the two roll-down windows were operable and always remained open. The environmental services supervisor was present when the deficiency was identified. Failure to maintain egress corridor smoke detection as required increases the risk of death or injury due to fire.	K 347	**K347 Smoke Detection –** It is the policy of the facility to continuously maintain the Fire Alarm Systems in reliable operating condition and to ensure Fire Alarm Systems are located properly throughout the facility, inspected, tested and maintained periodically. Corrective Action: The Fire Alarm System contractor was contacted and scheduled to install a smoke detector in the administrative assistant's office. Completed: on 11/23/2022 The smoke detector was installed. Completed: 11/23/2022 The Environmental Services Director and/or designee will inspect all areas of the facility to assure all Fire Alarm Systems and devices meet NFPA, Life Safety Code and the facilities preventative maintenance program. The facilities safety committee will review and oversee documentation that shows Fire Alarm System inspections are maintained and completed.	12/8/22

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

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K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the provider failed to maintain testing requirements for automatic sprinklers as required in one of one areas (basement riser location). Findings include: 1. Observation on 11/2/22 at 8:45 a.m. revealed the basement automatic fire sprinkler riser did not have a five-year internal obstruction inspection tag from the sprinkler contractor. The gauges on the riser also were not dated (indicating a five-year inspection date) as required. Document review did not reveal when a five-year internal inspection was last performed. Interview with the environmental services	K 353	**K353 Sprinkler Systems –** It is the policy of the facility to assure fire sprinkler systems are tested and maintained in accordance with NFPA and Life Safety Code standards and requirements. Corrective Action: The facilities Fire Sprinkler System contractor was contacted to conduct an internal 5-year Fire Sprinkler System inspection to include internal obstruction inspection of the fire sprinkler riser and inspection of the gauge on the riser. Completed: 11/9/2022 The fire year inspection was conducted. Completed 11/9/2022 The Environmental Services Director and/or designee will inspect all areas of the facility to assure all Fire Sprinkler Systems and devices have been maintained and inspected, and meet NFPA, Life Safety Code and the facilities preventative maintenance program. The facilities safety committee will review and oversee documentation that shows Fire Sprinkler System inspections are maintained and completed.	12/8/22

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

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K 353	Continued From page 6 supervisor at the time of the observation confirmed that condition. Failure to continuously maintain automatic sprinklers as required increases the risk of death or injury due to fire. This deficiency has the possibility of affecting 100 percent of the occupants of the building.	K 353		
K 354 SS=F	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the provider failed to continuously maintain automatic sprinklers in a reliable operating condition in one area (basement women's locker area). Findings include: 1. Observation on 11/2/22 at 9:45 a.m. revealed the basement women's locker area had approximately twelve lay-in ceiling tiles that were damaged or incomplete. The ceiling is a feature	K 354	**K354 Sprinkler Systems –** It is the policy of the facility to continuously maintain automatic fire sprinkler systems in a reliable operating condition in all areas. Corrective Action: The Environmental Services Director and/or designee made repairs to or contacted the facilities general contractor for the repairs of the damaged suspended ceiling and ceiling tiles in the basement women's locker room. Completed 12/8/2022 Repairs to the ceiling were completed: 12/8/2022 The Environmental Services Director and/or designee will inspect all areas of the facility to assure all Fire Sprinkler Systems and areas have been maintained and inspected, and meet NFPA, Life Safety Code and the facilities preventative maintenance program. The facilities safety committee will review and oversee documentation that shows Fire Sprinkler System inspections are maintained and completed.	12/8/22

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

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K 354	Continued From page 7 of the fire protection system that prevents smoke and heat from escaping to the space above the tiles and delaying the sprinkler response. As such, the ceiling tiles are required to be maintained. Review of the previous life safety survey dated 6/14/21 revealed the deficiency existed at the time of that survey. Failure to continuously maintain automatic sprinklers as required increases the risk of death or injury due to fire. The environmental services supervisor was present when the deficiency was observed and acknowledged it. This deficiency has the possibility of affecting 100 percent of the occupants of the smoke compartment.	K 354	**K522 HVAC –** It is the policy of the facility to continuously maintain combustion fresh air devices.	
K 522 SS=D	HVAC - Any Heating Device CFR(s): NFPA 101 HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to continuously maintain combustion fresh air in one on one laundry room	K 522	Corrective Action: The Environmental Services Director and/or designee made repairs to or contacted the facilities HVAC contractor for the repairs of the ceiling louver in the laundry room. Repairs to the ceiling louver will be completed by 12/8/2022. The Environmental Services Director and/or designee will inspect all areas of the facility to assure all fresh air systems and areas have been maintained and inspected, and meet NFPA, Life Safety Code and the facilities preventative maintenance program. The facilities safety committee will review and oversee documentation that shows Fresh Air System inspections are maintained and completed.	12/8/22

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

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K 522	Continued From page 8 (six gas-fired laundry dryers). Findings include: 1. Observation on 11/2/22 at 9:50 a.m. revealed the laundry department utilized six Speed Queen natural gas fired 165,000 btu dryers to heat and dry laundered items. There was a ceiling louver measuring approximately 24 inches by 24 inches in the closed position with three dryers operating at the time. Testing of the louver revealed it was fixed in a closed position. Combustion fresh air must be provided when any one or more of the gas-fired dryers was in operation. The environmental services supervisor was present when the deficiency was observed and acknowledged it. He revealed the fresh air damper was not in the preventive maintenance system checklist. This deficiency has the possibility of affecting 100 percent of the occupants of the smoke compartment.	K 522	**K712 Fire Drills –** It is the policy of the facility to perform and assure Monthly/Quarterly Fire Drills conducted in accordance with NFPA standards and requirements. Corrective Action: The Environmental Services Director and/or designee and team will be properly trained to follow NFPA fire drill testing requirements. Completed: 12/1/2022. Quarterly fire drills will be conducted one per shift per quarter. Drills will completed at varying times of day, with no drill being done within 2 hours of time of last recorded drill. Drills will be conduct on different days of the week and at different areas of the facility. Assurance of On-Going Compliance: The Environmental Services Director and/or designee will conduct and assure fire drills are performed to meet this NFPA standards, Life Safety Code and the facilities preventative maintenance program requirements. The facility safety committee will review and oversee documentation that shows that the fire drills are performed as required.	12/9/22
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced	K 712		

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	435045	A. BUILDING 01 - SIOUX FALLS GOOD SAMARITAN VILLAGE B. WING _____	11/02/2022

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

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K 712	Continued From page 9 by: Based on document review and interview the provider failed to conduct fire drills as required (timing of the drills). Findings include: 1. Document review on 11/2/22 at 8:35 a.m. revealed fire drills were held on a one drill per shift per quarter schedule. First shift drills were held: *October 13, 2021 at 10:00 a.m. *January 28, 2022 at 10:15 a.m. *April 21, 2022 at 10:05 a.m. *July 29, 2022 at 10:15 a.m. *October 26, 2022 at 10:40 a.m. Second shift drills were held: *November 30, 2021 at 2:47 p.m. *February 28, 2022 at 2:37 p.m. *May 31, 2022 at 2:45 p.m. *August 30, 2022 at 2:50 p.m. Third shift drills were held: *September 17, 2021 at 5:30 a.m. *December 23, 2021 at 5:40 a.m. *March 25, 2022 at 5:45 a.m. *June 30, 2022 at 5:30 a.m. *September 23, 2022 at 5:45 a.m. The times of the drills for each shift must be varied. The environmental services supervisor was present when the deficiency was noted and acknowledged it. This deficiency affected one of numerous requirements for conducting fire drills.	K 712		
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		

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 01 - SIOUX FALLS GOOD SAMARITAN VILLAGE B. WING _____	11/02/2022

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
K 918	Continued From page 10 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and interview, the provider failed to maintain generator testing and	K 918	**K918 Electrical Systems –** It is the policy of the facility to perform Monthly and Annual Emergency Generators Inspections and Testing to assure Essential Electrical Systems "Emergency Generators" are tested in accordance with NFPA standards and requirements. The Environmental Services Director and/or designee and team will be properly trained to follow NFPA generator testing requirements. Completed: 12/1/2022 Monthly generator testing will be conducted and include a run time of the generator of 30 minutes or longer moving forward. Generator battery conductivity will be tested and documented monthly moving forward. Monthly generator testing will attain at least 30 percent of the nameplate KW rating and be documented, or an annual load bank test will be conducted and documented moving forward. An annual generator load bank test was conduction. Completed: 12/2/2022 The Environmental Services Director and/or designee will conduct and assure emergency generator test are performed to meet this NFPA standards and requirements and as identified in our preventative maintenance program. The facility safety committee will review and oversee documentation that shows that the generator testing and maintenance are performed as required.	12/2/22

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K 918	Continued From page 11 documentation as required (monthly load test runs, monthly battery conductivity testing, load run percentage of the generator rating). Findings include: 1. Document review of the generator log on 11/2/22 at 7:50 a.m. revealed the generator was not being run for at least thirty minutes each month under load per the log sheets. The testing was noted as follows: *September 30, 2021 (16 minutes under load) *October 22, 2021 (17 minutes under load) *November 10, 2021 (16 minutes under load) *December 17, 2021 (17 minutes under load) *February 23, 2022 (18 minutes under load) *March 26, 2022 (17 minutes under load) *April 27, 2022 (16 minutes under load) *May 20, 2022 (18 minutes under load) *June 10, 2022 (16 minutes under load) *July 22, 2022 (17 minutes under load) *August 19, 2022 (21 minutes under load) *September 9, 2022 (20 minutes under load) *October 27, 2022 (16 minutes under load) 2. Document review of the generator log on 11/2/22 at 7:50 a.m. revealed there was no documentation of the generator battery conductively monthly as required. 3. Document review of the generator log on 11/2/22 at 7:50 a.m. revealed there was no documentation of the percent (of the diesel generator nameplate kilowatt rating) the load runs were attaining as required. The generator load runs must attain at least 30 percent of the nameplate kW rating to avoid an annual load bank for the generator. The environmental services supervisor was	K 918		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 918	Continued From page 12 present when the deficiency was noted and acknowledged it. This deficiency affected three of numerous requirements for generator testing.	K 918		

South Dakota Department of Health

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	10680	A. BUILDING: _____ B. WING _____	11/08/2022

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

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 10/31/22 through 11/3/22 and on 11/7/22 through 11/8/22. Good Samaritan Society Sioux Falls Village was found not in compliance with the following requirements: S157 and S443.	S 000		
S 157	44:73:02:13 Ventilation Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation in one of one observed rooms (400 wing south shower room). Findings include: 1. Observation on 11/2/22 at 9:55 a.m. revealed the exhaust ventilation for the 400 wing south shower room was not functioning. Testing of the grille with a tissue paper at the time of the observation confirmed that finding. Interview with the environmental services supervisor on 11/2/22 at the time of the observation confirmed that finding. He revealed he was unaware why the exhaust ventilation was not working at that location.	S 157	S 157 By 12/2/2022, maintenance technician cleaned and repair exhaust vent and return to it to working order. By 12/8/2022, maintenance technician or designee will inspect remain vents, clean as needed and ensure are operational. To ensure deficient practice does not recur, by 12/8/2022, maintenance technician or designees will add exhaust ventilation to monthly routine inspections. To monitor for compliance, environmental services supervisor or designee, will audit inspection log for task completion and test 5 random exhaust vents for proper functioning. Audits will be completed monthly x3 and quarterly x1. Environmental services supervisor or designee will report finding to QAPI committee monthly. QAPI committee will determine ongoing monitoring and interventions.	12/8/22
S 443	44:73:12:34 Vacuum Breakers An antisiphon device or backflow preventer shall	S 443		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dana Bauman — TITLE: Administrator — (X6) DATE: 12/03/2022

STATE FORM 6899 HX1E11 If continuation sheet 1 of 2

South Dakota Department of Health

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S 443	Continued From page 1 be installed on any hose bib and on any fixture to which hoses or tubing can be attached such as janitor sink, bedpan flushing attachment, and handheld shower. An antisiphon device or backflow preventer shall be installed on all plumbing and equipment where any possibility exists for contamination of the potable water supply. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to provide a vacuum breaker in one of one randomly observed rooms (400 wing south shower room). Findings include: 1. Observation on 11/2/22 at 9:57 a.m. revealed the 400 wing south shower room did not have a visible vacuum breaker for the hand-held hose. Interview with the environmental services supervisor on 11/2/22 at the time of the observation revealed he thought the vacuum breaker was built into the plumbing behind the wall. He added he could not be sure of that condition.	S 443	S 443 By 12/8/2022, maintenance technician or designee will ensure a vacuum breaker is in place for hand-held hose in the 400 south shower room. By 12/8/2022, maintenance technician or designee will inspect janitor sinks, hoppers, and handheld showers, to ensure vacuum breaker is in place. To ensure deficient practice does not recur, by 12/8/2022, maintenance technician or designees will add vacuum breakers to quarterly inspections. To monitor for compliance, environmental services supervisor or designee, will audit inspection log for task completion and observe 5 random plumbing fixtures for properly functioning vacuum breakers. Audits will be completed quarterly x2. Environmental services supervisor or designee will report finding to QAPI committee quarterly. QAPI committee will determine ongoing monitoring and interventions.	12/8/22
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 10/31/22 through 11/3/22 and on 11/7/22 through 11/8/22. Good Samaritan Society Sioux Falls Village was found in compliance.	S 000		