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
	435098	A. BUILDING _____ B. WING _____	09/28/2023

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

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F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/25/23 through 9/28/23. Good Samaritan Society Tyndall was found not in compliance with the following requirement: F686, F690, and F692.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure two of two sampled residents (23 and 42) who were identified as at risk for developing pressure ulcers indicated by the Braden Scale for Prediction Pressure Ulcer scores had interventions in place to prevent those residents acquiring a pressure ulcer. Findings include: 1. Observation on 9/25/23 at 4:00 p.m. of resident 42 revealed he was seated in his recliner with his feet elevated.	F 686	In response to F686, for resident 42, resident's pressure area is healed as of 10-3-23 and turning and repositioning has been added as a task to resident's' care plan and is documented by CNAs. Resident is currently using a pressure reducing cushion in wheelchair and recliner. Resident is being encouraged to lay down in bed on his side in afternoons and CNAs are documenting. Resident currently has pressure reducing mattress.	10-27-23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Julie Schenkel
TITLE: Administrator
(X6) DATE: 10-20-23

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 686	Continued From page 1 -Continued observation at 4:30 p.m. revealed he was seated in his wheelchair and was alert. -Continued observation at 6:00 p.m. revealed he was seated in his wheelchair and was in the dining room. *Observation on 9/26/23 at 8:00 a.m. he was not in his room. Registered nurse (RN) H stated he was at a telemedicine appointment with his daughter. Continued observations revealed: -He returned to his room from the appointment at 10:00 a.m. and was seated in his wheelchair. -At 11:30 a.m. he was seated in his wheelchair in his room. -At 11:36 a.m. interview with RN H revealed he had a facility acquired stage II pressure ulcer to his left buttock. It looked much better than when she had last observed it two weeks ago. -At 2:40 p.m. he was seated in his wheelchair in his room. Observation of his recliner at that time revealed a flat gel filled cushion placed in the recliner. -At 4:30 p.m. he was seated in his wheelchair in his room. *On 9/27/23 at 9:00 am. he was seated in his wheelchair in the dining room. -Continued observation at 10:44 a.m. certified nursing assistant (CNA) I and RN G transferred resident 42 from his wheelchair to the toilet with the E-Z stand. Noted to have a flat gel filled cushion in his wheelchair. He was assisted to sit in his wheelchair after he used the toilet. -At 11:40 a.m. observation of RN H during the wound care treatment to his left inner buttock pressure ulcer revealed the following: *An area to his left inner buttock with red tissue in the middle and gray/white edges. *The wound was measured and had a depth of 0.2 centimeters (cm), width of 0.7 cm, and a length of 1.0 cm.	F 686	For Resident 23, currently is showing progress with wound healing is currently a healing stage 2 wound with granulation. Resident care plan has been updated to include turning and repositioning was moved to the proper focus in the care plan. The CNAs are documenting. Resident uses soft spacer between knees to reduce rotation that puts pressure on R) outer ankle. Resident wears pressure reducing boots on both legs at all times and resident's heels are floated using u-pillow while in bed. Resident has pressure relieving mattress. Residents wheelchair pedals have foot cradles to protect heels. All residents have Braden scale completed at least quarterly and with significant change. All Braden scores have been reviewed on 10-2-23 to identify other residents at risk and care plans have been updated and interventions put into place.	

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F 686	Continued From page 2 -At 12:30 p.m. he was seated in his wheelchair in the dining room. *At 2:30 p.m. resident 42 was seated in his wheelchair in his room. *On 9/28/23 at 9:00 a.m., 11:30 a.m., and 2:45 p.m. resident 42 was seated in his wheelchair in his room. -At 9:00 a.m. the bed had no bedding but a flat gel-filled cushion that covered the mattress half-way from the top and bottom and approximately three-quarters from side-to-side. Interview on 9/25/23 at 4:54 p.m. with RN H revealed resident 42 had a stage III pressure sore (Full-thickness skin loss, in which fat is visible in the ulcer and granulation tissue and rolled wound edges are often present) to his left inner buttock. He had acquired it in August 2023 of this year. His wound care orders were managed by the wound care clinic at the hospital. Interview on 9/27/23 at 10:44 a.m. with CNA I revealed resident 42 was usually in either sitting in his wheelchair or recliner when she arrived for the day shift in the morning. He could not tolerate lying in bed very much. He had pain in both of his shoulders. She was not aware he was to have lay down after lunch. She had only ever put him in his recliner. Interview on 9/28/23 at 4:53 p.m. with director of nursing (DON) B revealed: *Resident 42 had a decline in April 2023 after he had gotten COVID-19. *He was more at risk to develop a pressure ulcer as he could not ambulate anymore. *His cognition had also changed and he had more resistive behaviors to lying down in bed. *She agreed his care plan stated he was to have	F 686	All nursing staff will be educated on 10-24-23 or prior to their next shift worked by DNS/designee regarding pressure ulcers and pressure ulcer prevention, including staff responsibilities, assessments and interventions, documentation, re-assessment and where to find individualized resident needs. MDS Coordinator or designee will monitor Braden Scale quarterly and as needed. Appropriate care plan interventions will be implemented and communicated to staff in nursing report. DNS or designee will monitor CNAs doing repositioning and ensure proper documentation is taking place. Residents who are at risk will be monitored and reviewed to determine if care plan interventions are in place and being implemented. DNS or designee will complete audits on at least 3 residents identified at risk using Braden Scores for turning and repositioning through observation and staff interviews. Audits will be completed weekly for 4 weeks and then monthly for 3 months. Audits will be reported monthly at QAPI meeting for review and revision as warranted.	

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F 686	Continued From page 3	F 686		

laid down in bed after lunch each day.
*He was not laid down as he would not tolerate it. He had pain in both of his shoulders and was not able to lie on his sides. Most of the time he slept in his recliner. His family had informed them he had usually slept on the couch when he lived at home.
*They used the T-Gel pads as a preventative measure in wheelchairs, recliners, and in beds. These were the products they used most often.
*Review of the T-Gel pads in the product catalog with DON B revealed it was to reduce shearing. She thought those pads were pressure relieving.

Review of the manufacturer's website revealed the T-Gel pads the provider had been using were to reduce shearing.

Review of resident 42's medical record revealed:
*He was admitted on 1/31/20.
*He had diagnoses that included: diabetes, dementia with agitation, previous stroke, and pain in bilateral shoulders.
*His "Braden Scale for Predicting Pressure Sore Risk" on:
-9/27/22 was 17 which indicated he was at mild risk.
-9/11/23 was 14 which indicated he was at moderate risk.
*No new interventions had been put in place when his risk score changed.
*He acquired the left buttock pressure ulcer on 8/13/23.
*The pressure ulcer measured 0.2 cm depth, 1.7 cm width, and 2.0 cm length.
*A gel cushion was placed on his bed and recliner at that time after the pressure ulcer had developed.
*The intervention to have him lie down in bed on

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F 686	Continued From page 4 his side after the noon meal was initiated at that time. There were no other turning and repositioning interventions prior to the 8/13/23 identification of the stage III pressure ulcer. *He first attended the wound care clinic starting on 8/22/23. -The wound care clinic managed the type of dressing or other treatments. Review of resident 42's care plan revealed: *Focus: "The resident has potential/actual pressure ulcer development R/T [related to] increased need for assistance with ADLs [activities of daily living], frequent incontinence." Revised on 9/21/23. *Goal: "The resident will have intact skin free of redness, blisters, or discoloration by the review date." Revised on 8/9/23. *Interventions included "Provide t gel in recliner. and t gel on bed. lay down in afternoon and lay on side." Revised on 8/13/23. 2. Observations of resident 23 in her room at the following times revealed: *On 9/26/23 at 4:16 p.m.: -She was in her bed covered with a blanket with her eyes closed. -She was lying half-way on her right side with her knees together and bent in a fetal position. -Her wheelchair was next to her bed with a cushion in the seat. *On 9/27/23 at 9:19 a.m.: -She had been seated in her wheelchair watching TV. -She was not able to have been interviewed. -There had been a pressure relieving pad on her bed. -Both of her feet had protective boots on that rested on the wheelchair foot pedals. -The right protective boot had a sheepskin lining.	F 686		

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*On 9/28/23 at 9:40 a.m.:
-She was in her bed with her eyes closed.
-A pillow was positioned between her knees.
-Her bilateral protective boots were on with her legs resting on a pillow to protect her heels.
-Her wheelchair was located next to her bed with a cushion in the seat.

Review of resident 23's medical record revealed:
*She had been admitted on 3/30/16.
*She had no pressure injuries at the time of her admission.
*Her Brief Interview for Mental Status (BIMS) assessment score was four which indicated she had severe cognitive impairment.
*She had a history of skin integrity issues and was frequently incontinent of bowel and bladder.
*Staff used a mechanical full-body lift to transfer her.
*Her diagnoses included the following:
-Mild intellectual disability.
-Retention of urine.
-Osteoarthritis.
-Anemia.
-Generalized anxiety disorder.
-Chronic kidney disease stage 3.
-Dementia
-History of methicillin-resistant staphylococcus aureus (MRSA).
-A pressure ulcer to her right lateral ankle that was identified on 10/10/22.
-It measured 0.7 length centimeters (cm) by 1.2 cm width by 0.1 cm depth.
-It currently measured 0.6 cm length by 0.7 cm width by 0.1 cm depth.
-A second unstageable pressure ulcer was identified on her left heel on 5/16/23 and was healed on 7/11/23.
-MRSA was found in the wound on her left heel

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F 686	Continued From page 6 on 5/30/23. Review of resident 23's 7/19/22, 10/19/22, 1/10/23, 4/6/23, and 6/29/23 Minimum Data Set (MDS) assessments revealed: *She had been dependent on staff to assist her with: -Toileting. -Rolling from side to side. -Lying to sitting. -Sitting to standing. *Interventions included pressure-reducing devices in her chair and her bed. *There had been no intervention for turning or repositioning. *A nutrition and hydration intervention had not been added until the 1/10/23 MDS assessment. Review of resident 23's Braden Scale for Predicting Pressure Sore Risk assessments revealed: *On 7/16/22, she scored a 16, which placed her at mild risk for developing pressure ulcers. *On 10/9/22, 1/9/23, 4/6/23, she scored a 15 which placed her at mild risk of developing pressure ulcers. *On 6/28/23, and 9/18/23, she scored a 14 which placed her at moderate risk of developing pressure ulcers. Review of resident 23's 6/29/23 revised care plan revealed: *"Focus area: The resident has actual impairment to skin integrity R/T [related to] pressure EB [evidenced by] soft tissue injury to right outer ankle. Date initiated: 10/30/22. *Goal: -Resident will be free from skin injury through the review date. Date initiated: 10/30/22. Revision on	F 686		

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F 686	Continued From page 7 1/20/23. -Resident will have no complications R/T soft tissue injury of the right out [sic] ankle through the review date. Date initiated: 10/30/22. Revision on 1/20/23. *Interventions: -Elevate heels and ankle off bed. Date initiated: 10/30/22. -Resident needs protection for the right foot, sheepskin boot. Date initiated: 10/30/22. *Focus area: The resident has potential for/actual pressure ulcer development R/T needing extensive assistance with ADL's and being frequently incontinent, history of pressure areas to bilateral heels post COVID illness, open area to right lateral ankle. History of left heel wound. Date initiated: 2/17/20. Revision on 8/28/23. *Goal: -Resident will have intact skin, free of redness, blisters or discoloration by the review date. Date initiated: 2/17/20. Revision on: 1/20/23. *Interventions: -Inform resident/family of any new area of skin breakdown. Date initiated: 2/17/20. -Provide t-gel on chair. Cushion in wheelchair. Date initiated: 10/11/22. Revision on: 8/28/23. -Provide pressure relieving boots to bilateral lower extremities. U-pillow to float heels when in bed. Soft spacer between knees to reduce internal rotation of left leg onto right leg. Date initiated: 8/28/23. Revision on 8/28/23. -Notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care. Date initiated: 02/17/20. -Treatment/medication as ordered for skin issues. Treatment at wound clinic as ordered. Date initiated: 12/22/21. Revision on 9/18/23." *Her care plan had not included re-positioning.	F 686		

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F 686	Continued From page 8 Interview on 9/28/23 at 3:22 p.m. with nutrition and food services manager C regarding resident 23 revealed: *The registered dietician followed up with her monthly. *They met to discuss any residents that had been at risk for weight concerns or skin issues. *Changes were made as needed for her nutrition. *She had usually eaten well. *Her weight had remained stable. *She had good health otherwise, so they were not sure why her skin had not healed. Interview on 9/28/23 at 2:48 p.m. with RN H regarding resident 23 revealed: *The resident had COVID on 7/1/21 and again on 4/28/23 and has had issues with her skin since then. *The wound had been facility acquired and discovered on 10/10/23 on the right lateral ankle bone. *The physician was notified for the treatment options. *She tended to place her knees together and bent over to the right side. *The nursing staff had floated her legs and had placed a cushion between her knees to prevent friction. *Bath aides watched for any new skin concerns and would notify the RN. *The RN completed weekly skin assessments but also completed a daily in-depth UDA (user defined assessment) of the wound. *The wound started to heal and then would open up again. *She had been up and down with progress since it was discovered. *The wound clinic had seen her for the first time	F 686		

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F 686	Continued From page 9 on 11/1/22 and she was scheduled every week to two weeks for treatment. Interview on 9/28/23 at 4:35 p.m. with medication aide/CNA and administrative assistant K revealed: *She had often worked the floor to help out with open shifts. *The residents were well-known to her. *Residents that had skin issues were to have been repositioned and that would have been included in the care plan. *She confirmed an intervention for repositioning resident 23 had not been her in the care plan and should have been. *The care plan was what had driven the tasks for the CNAs. *Information flowed from the care plan into the Kardex and that was how the tasks for residents were assigned to the CNAs for what needed to have been done for the resident's care. *There should have been interventions in place prior to the development of the pressure ulcer. Interview on 9/28/23 at 4:43 PM with CNA L regarding care for resident 23 revealed: *The CNAs checked the assigned tasks in the Kardex for what care was to have been provided for the residents. *She wore bilateral protective boots, and the right heal was floated. *When asked if resident 23 was repositioned she stated no, but she would have to check. *She pulled up resident 23's assigned tasks and confirmed there had not been a repositioning task. *Some of the residents had been repositioned but resident 23 had not been one of those residents.	F 686		

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F 686	Continued From page 10 Interview on 9/28/23 at 5:30 p.m. with DON B regarding resident 23 developing a pressure ulcer revealed: *Resident 23 was seen bi-weekly at a wound clinic for treatment. *She believed nursing staff repositioned resident 23 throughout the day. *She confirmed the care plan had not included an intervention for repositioning resident 23. *They had no documentation to support that repositioning resident 23 had taken place. *Her care plan should have been updated to reflect resident 23's current needs. *If an intervention had not been listed on the care plan, a task for the CNAs would not have been created in the Kardex system. *She agreed interventions should have been in place prior in order to prevent pressure ulcers from developing in the residents. Review of the provider's revised 4/26/23 Skin Assessment Pressure Ulcer Prevention and Documentation Requirements policy revealed: *"Residents who are unable to reposition themselves independently, should be repositioned as often as directed by the care plan approaches. Developing an individualized repositioning schedule is required for those residents unable to position themselves and is based on nutrition, hydration, incontinence, diagnoses, mobility and observation of the resident's skin over a period of time. The Positioning Assessment and Evaluation UDA [user defined assessment] is a required tool that is used to determine an individualized repositioning plan." *"The interdisciplinary team should determine any modifications that are necessary to the resident's plan of care. Interventions should focus on	F 686		

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F 686	Continued From page 11 physical, mental and psychosocial aspects that may be impacted."	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as	F 690	In response to F690, resident 14 has had neurogenic bladder added to her diagnosis list and physician has confirmed that this is reason for catheter remaining in place on 10-2-23. All residents, with catheters, have been reviewed for proper diagnosis. MDS coordinator will review new residents upon admission and all residents quarterly with MDS to ensure proper diagnosis for catheter is present. HIM will monitor for any new orders weekly and ensure proper diagnosis is provided. DNS or designee will audit for appropriate dx with catheter order weekly for 4 weeks and monthly for 3 months and will report to QAPI monthly for review and revision as warranted.	10-27-23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435098	A. BUILDING _____ B. WING _____	09/28/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 12	F 690		

possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (14) had a diagnosis for the continued use of an indwelling urinary catheter after her wounds had healed.
Findings include: t

1. Observation and interview on 9/25/23 at 3:55 p.m. with resident 14 revealed she was in her room and was seated in a wheelchair. There was a urinary catheter bag that was inside a cloth bag. It was attached to the lower side of her wheelchair. She stated she had been in the hospital for sores on her legs and a bladder infection earlier in the year. That was when they put in the Foley catheter. She had bladder infections since then and was hospitalized. She was unsure of the exact dates.

Observation of resident 14 on 9/26/23 at 8:30 a.m. she was asked if the surveyor could be present during personal cares, she declined th request.

Review of resident 14's hospital discharge summaries revealed:
*She had been admitted to the hospital on 1/27/23 and discharged back to the nursing home on 2/1/23. Her hospital admission diagnoses included:
-Sepsis from a urinary tract infection (UTI).
-Yeast dermatitis in her lower abdominal folds, below her breasts, and behind her right knee.
-Cellulitis of her right lower leg.
-Her discharge instructions included: Foley (urinary catheter) indication - skin integrity

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	435098	A. BUILDING _____ B. WING _____	09/28/2023

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

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F 690	Continued From page 13 compromise. Foley removal instructions - Until follow-up with (physician name) for wound evaluation. *She had been admitted on 6/20/23 and discharged on 6/23/23. Her admission diagnoses included: Sepsis secondary to left lower extremity cellulitis, pneumonia, and possible UTI in the setting of a chronic indwelling Foley catheter. -Her discharge summary indicated a "CT [computerized tomography] scan showed no obstructive uropathy [when urine cannot drain through the urinary tract]. Her urinary incontinence will need to be addressed by her primary care physician and urology as this is a constant source of infection." Review of an infectious disease progress note for resident 14 on 5/12/23 revealed a discussion regarding asymptomatic bacteriuria frequency in elderly patients. The factors that complicate included the high-rate of indwelling catheter use. Review of resident 14's primary care provider's (PCP) nursing home recertifications revealed a diagnosis of neurogenic bladder on the 2/13/23, 4/28/23, and 9/8/23 visits. That diagnosis was not associated with her use of a urinary catheter. Review of resident 14's Wound Registered Nurse (RN) Assessment documentation revealed on 8/29/23 the last wound she had was documented as healed. That wound was to her left buttock and was a healed stage II pressure ulcer. Weekly RN assessments were discontinued on that date. Interview on 9/27/23 at 10:04 a.m. with director of nursing B revealed: *She was not aware resident 14's PCP had added the diagnosis of neurogenic bladder.	F 690		

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	435098	A. BUILDING _____ B. WING _____	09/28/2023

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GOOD SAMARITAN SOCIETY TYNDALL	2304 LAUREL STREET TYNDALL, SD 57066

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F 690	Continued From page 14 *The diagnosis of neurogenic bladder was not on her nursing home's current list of diagnoses. *The catheter was used due to her skin breakdown and recurrent UTIs. *She agreed the resident had UTIs after the catheter was placed. It had not reduced her UTIs. *Her skin was presently healed. *Due to her previous incontinence, impaired skin integrity, and frequent UTIs it had not been discussed to remove her catheter. Review of the provider's 2/10/23 Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation, Specimen policy revealed: *"To provide short-term skin and wound protection in cases where incontinence is delaying healing." *"Catheter Removal: -Indication for usage has been resolved (e.g., pressure ulcer healed). -To prevent potential complications (such as urinary tract infections and kidney stones) associated with the long-term use of indwelling catheters."	F 690		10
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte	F 692	In response to F692, for residents' 16 and 35, table change for residents 16 and 35 were made to accommodate closer monitoring. Dining room evaluation was done by DNS, Dietary Manager and Administrator and table rearrangements were made along with meal time adjustments to allow optimal staff assistance.	10-27-23

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	435098	A. BUILDING _____ B. WING _____	09/28/2023

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GOOD SAMARITAN SOCIETY TYNDALL	2304 LAUREL STREET TYNDALL, SD 57066

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F 692	Continued From page 15 balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure two of seven residents (16 and 35) who were at nutritional risk received ongoing monitoring of nutrition and revisions in care as their nutritional intake, dining assistance, and revisions in care as their nutritional status changed. Findings include: 1. Observation on 9/26/23 at 12:00 p.m. of resident 16 in the dining room revealed: *She was seated at an assist table with four other residents. *Her meal was served to her at 12:11 p.m. *The meal consisted of: -A Philly steak sandwich. -Mashed potatoes. -Green beans. -A glass of cranberry juice. -A cup of cocoa. *She made no attempt to eat her meal. *At 12:24 p.m. certified nursing assistant (CNA) D came over to the table and tried to cue resident 16 to eat something. *She picked up her cup of cocoa took a drink and sat it back on the table. *CNA D then returned to the table she was assisting.	F 692	Staff will be educated on 10-24-23 by Administrator and DNS about prompting and assisting residents as soon as their meals are served and revising meal times and order of service to assure that staff are available to assist residents with meals in a timely manner. Administrator or designee will audit residents needing assistance with meals for timely assistance at various meals weekly for 4 weeks and monthly for 3 months and be reported to QAPI monthly for review and revision as warranted.	

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F 692	Continued From page 16 *At 12:35 p.m. CNA D came back to the table and asked resident 16 to try her lunch. *She picked up part of her sandwich took a bite and sat it back on her plate. *At 12:42 p.m. CNA D went back to resident 16 table, picked up her spoon and assisted her in eating two bites of mashed potatoes. *At 12:45 p.m. CNA E came into the dining room and assisted resident 16 with her meal. *She ate two more bites of mashed potatoes and was finished eating. *The resident sat in the dining room for over 45 minutes without consistent meal assistance from staff. Interview on 9/26/23 at 12:52 p.m. with CNA D revealed: *Staff were assigned to assist tables during meals. *CNA E was called to help a resident in his room during lunch which took her away from an assist table. *She agreed it was not an ideal situation for residents needing assistance. Interview on 9/26/23 at 2:07 p.m. with CNA E revealed: *She was in the dining room to help assist residents with the noon meal. *Another staff member needed assistance helping a resident, who was an assist of two, in his room. *She stated it was a high priority to get all residents to meals. *She agreed it was an issue if assisted residents were not helped with their meals in a timely manner. Interview on 9/26/23 at 3:35 p.m. with nutrition	F 692		

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F 692	Continued From page 17 and food services supervisor C revealed: *Resident 16 had been hospitalized at the end of July with a urinary tract infection (UTI) and received intravenous (IV) fluids. *She knew the resident was not eating well since returning from the hospital. *She was aware resident 16 was at risk for weight loss. *She was receiving supplements the contracted dietitian had recommended to address her weight loss issue. Observation on 9/27/23 at 12:00 p.m. of resident 16 in the dining room revealed: *The menu consisted of: -Barbecued chicken. -Mashed potatoes. -Mixed vegetables. -Apple cobbler. *At 12:24 p.m. she received her food. *An unidentified CNA was sitting across the table assisting another resident. *The CNA had not prompted or cued any other residents at the table. *At 12:31 p.m. CNA D came to the table and offered resident 16 her first drink of juice. That was 31 minutes after the resident came to the dining room, *CNA D picked up the spoon and assisted her with two bites of mashed potatoes. *CNA D left the table to get another resident a cup. *At 12:38 p.m. CNA D sat back down and cued resident 16 to drink her juice. *She picked up a cup of cocoa and took a drink. *She then stated she was done eating. Review of resident 16's medical record revealed: *An admission date of 9/13/22.	F 692		

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F 692	Continued From page 18 *Her diagnosis included: chronic kidney disease, stage 3, anemia, mild cognitive impairment of unknown etiology, hypokalemia, vascular dementia, and dysphagia. *Her weights were recorded as follows: -8/4/23 was159 pounds. -8/11/23 was 147 pounds. -8/18/23 was 147 pounds. -8/25/ 23 was 146 pounds. -9/1/23 was 146 pounds. -9/8/23 was 146.3 pounds. -9/15/23 was 145 pounds. -9/22/23 was 142.8 pounds She had lost 16.2 pounds which was 10.1% of her body weight in two months which was a significant weight loss. Review of resident 16's interdisciplinary progress notes revealed she: *Had been admitted to the hospital on 7/27/23. *Was diagnosed with a urinary tract infection (UTI). *Returned to the provider on 7/30/23. *Refused to eat at meals after returning from the hospital. *Would only consume cocoa and her supplement. Review of resident 16's 8/18/23 care plan revealed: *The goals were: -To not have weight loss or complications related to refusing food. -To maintain weight at 155 pounds +-10 or more. *Interventions included: -Praise any efforts made towards reaching goal. -Explain importance of prescribed diet to resident and the need for adequate nutritional intake. -Monitor for poor intake of meals/fluids/supplements, food dislikes, meal	F 692		

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

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F 692	Continued From page 19	F 692		

refusal.
-Monitor for weight loss or gain.
-Weigh weekly.
-Trial ground meats, soft fruits, no raw vegetables unless processed fine as recommended by speech until the next visit.
-House supplement three times a day (TID) by nursing restarted after the hospital return.
-Offer cranberry juice at noon and evening meal 4 oz.
-Cut up meats in the kitchen and prepare food.
-Offer food highest in calories in added fats, sugars, fortified potatoes, and whole milk.

Interview on 9/28/23 at 10:59 a.m. with registered dietitian (RD) F and nutrition and food services supervisor C regarding resident 16's meal intake revealed:
*Resident 16 had recently been moved to an assist table.
*RD F had recommended supplements as needed instead of three times a day (TID) to try to get her to consume more calories.
*Initially the physician had not agreed with decreasing the supplements to as needed.
*Nutrition and food services supervisor E had the charge nurse resend the order to the physician.
*The provider had a card system to organize resident dining.
*The CNAs pulled the cards from the rack to notify kitchen staff who they could serve.
*The CNAs were responsible for ensuring the residents were supervised accordingly.
*They agreed the resident should not have waited that long for staff assistance once she was served her meal.

Interview on 9/28/23 at 11:22 a.m. director of nursing (DON) B regarding resident 16's meal

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	435098	A. BUILDING _____ B. WING _____	09/28/2023

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GOOD SAMARITAN SOCIETY TYNDALL	2304 LAUREL STREET TYNDALL, SD 57066

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F 692	Continued From page 20 intake revealed: *She knew she had been moved to an assist table. *RD F had recommended an increase in supplements to increase her caloric intake. *Nursing staff were encouraging her to eat snacks and cookies between meals. *Nursing staff could get called away from the dining room to help other staff with resident care. *Staff should communicate with each other to ensure assist tables were supervised if a staff member needed to leave the dining room to assist other residents. *It was her expectation that the CNAs assist the residents who need assistance in the dining room once they were served their meal. 2. Observations of resident 35 on: *9/26/23 at 12:22 p.m. received her lunch. *9/26/23 at 12:26 p.m. unidentified CNA came over from another table, stood over the resident to get her started with eating and then went back to sit down by another resident. The resident never started eating. *9/26/23 at 12:34 p.m. the unidentified CNA came over again and stood over the resident and the resident next to her and then left. Another unidentified CNA came over and stated "Grandma aren't you going to eat?" Assisted to reposition the resident to a more upright position in the wheelchair. The resident had not eaten or drank anything. -No staff person attempted to give her any food on her fork or spoon or a drink. *9/27/23 at 8:32 AM assisted in dining room for breakfast by an unidentified CNA there was one CNA assisting two residents. The resident had	F 692		

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F 692	Continued From page 21 drank all of her resource drink. Review of resident 35's Bedside Kardex report revealed on 7/14/23 she required extensive assistive of one staff person with eating. Review of resident 35's weight record revealed: *On 8/23/2023 she weighed 138.5 lbs. and on 9/26/2023 she weighed 128.7 pounds which was a 7.08 % loss in one month. *On 5/30/2023 she weighed 152.5 lbs. and on 9/26/2023 she weighed 128.7 pounds which was a 15.61 % loss in six months. Review of the provider's 4/26/23 Resident-Assisted Dining policy revealed: *"Purpose -To help resident to maintain or regain independence in eating skills. -To encourage independence with dining, providing assistance as needed. 10. Encourage residents in feeding self, assisting as needed, following care plan approaches. If the specific state has an approved paid feeding assistant program, then the resident's individual care plan must state if a feeding assistant is appropriate. 11. When assisting the resident, employees are to sit next to the resident; do not stand and feed the resident. Employees can assist two residents and offer assistance if needed. 12. Do not rush. You can start with liquids by having resident try to use a straw or hold a half-filled glass and drink. With solid foods, have resident start with foods that are easy to get on spoon or fork. Note care plan approaches, which are individualized to the resident. Offer alternatives for items not consumed."	F 692		

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
	435098	A. BUILDING _____ B. WING _____	09/28/2023

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

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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 9/25/23 through 9/28/23. Good Samaritan Society Tyndall was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Julie Schenkel
TITLE: Administrator
(X6) DATE: 10-20-23

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

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10695	A. BUILDING: _____ B. WING _____	09/28/2023

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

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 9/25/23 through 9/28/23. Good Samaritan Society Tyndall was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 9/25/23 through 9/28/23. Good Samaritan Society Tyndall was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Julie Schenkel

TITLE: Administrator

(X6) DATE: 10-20-23

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
	435098	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 9/26/23. Good Samaritan Society Tyndall was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K321 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
K 321 SS=E	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 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet)	K 321	In response to K0321, automatic door closures have been installed on Rooms 214 and 215 as of 10-18-23. Facility is working with vendor to secure door replacements for affected areas (see separate letter) by 11-30-23. Facility audit revealed that one other resident room was being used for storage and an automatic closure was installed as of 10-18-23. Administrator will review/educate maintenance personnel regarding requirements for interior doors. Maintenance director will continue with monthly preventive maintenance protocols and doors will be monitored. Administrator or designee will audit monthly for 3 months and report to QAPI monthly.	10-27-23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Julie Schenkel
TITLE: Administrator
(X6) DATE: 10-20-23

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435098	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/26/2023**

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

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K 321	Continued From page 1 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 and interview, the provider failed to maintain three separate hazardous areas (laundry and patient rooms 214 and 215, both were being used for storage) as required. Findings include: 1. Observation on 9/26/23 at 9:15 a.m. revealed the laundry was over 100 square feet, contained combustible items and did not maintain corridor separation. a. The corridor door between the corridor and soiled laundry was not smoke-tight. The door had been damaged over time by carts so it was no longer of adequate size to fill the space in the door frame. b. The door between the soiled laundry room and the laundry room was not able to be closed due to damage to the door. A closer was present, but was not able to close the door. b. The corridor door between the clean laundry and the corridor was not smoke-tight. The door had been damaged over time by carts so that it was longer of adequate size to fill the space in the door frame. 2. Observation on 9/26/23 at 10:25 a.m. revealed resident room 214 was used for storage. The room was over 100 square feet and contained combustible items. The door was not furnished	K 321		

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K 321	Continued From page 2 with a closer. 3. Observation on 9/26/23 at 10:30 a.m. revealed resident room 215 was used for storage. The room was over 100 square feet and contained combustible items. The door was not furnished with a closer. Interview with the director of maintenance at the time of the above observations confirmed those findings. He said they had attempted to get new doors for the laundry, but the price came back much higher than expected. He was aware he needed to put closers on resident rooms used for storage. The deficiencies affected two of numerous requirements for hazardous rooms.	K 321		