**GOOD SAMARITAN SOCIETY CANISTOTA**

**STREET ADDRESS, CITY, STATE, ZIP CODE**
700 WEST MAIN ST
CANISTOTA, SD 57012

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>PREVIOUS TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>Surveyor: 26180 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/11/18 through 6/13/18. Good Samaritan Society Canistota was found not in compliance with the following requirements: F644, F657, F684, F689, and F880.</td>
<td>F 000</td>
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<tr>
<td>F 644</td>
<td>Coordination of PASARR and Assessments</td>
<td>CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure one of three sampled residents (37) with a Level 11 Pre-Admission Screening and Resident Review</td>
<td>F 644</td>
<td></td>
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<td>6-14-18</td>
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**LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

Mina Iskandar, MPA, LNHA

**TITLE**
Administrator

**DATE**
7-12-18

---

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 patient. See Memorandum for Surveyors above, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is filed. In nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the public. When these documents are used, an approved plan of correction is requisite to continued program participation.

---

Facility ID: 0103

If continuation sheet Page 1 of 38
Continued From page 1

(PASARR) had supplemental documentation to support the determination that had been made. Findings include:

1. Review of resident 37's 6/11/18 physician's orders revealed:
   * His diagnoses included: schizoaffective disorder, chronic obstructive pulmonary disease (COPD), gastroesophageal reflux disease, and anxiety disorder.
   * There was no diagnosis related to dementia.
   * He received the following medications for his mental health diagnoses:
     - Divalproex sodium ER tablet 24 hour, 500 milligrams (mg) for schizoaffective disorder.
     - Hydroxyzine HCL tablet 50 mg, one tablet as needed for anxiety.
     - Quetapine fumarate tablet 400 mg, 0.5 tablet three times a day for schizoaffective disorder.
     - Risperidone microspheres Suspension 50 mg, injection one time every fourteen days for schizoaffective disorder.
     - Trazadone HCL tablet 1.5 mg daily for insomnia.

Review of resident 37's 5/7/18 Minimum Data Set assessment revealed:

* There was no diagnosis related to dementia.
* He had a Brief Interview of Mental Status score of fifteen indicating his cognition was intact.

Review of resident 37's 2/15/18 pre-placement history and physical revealed:

* "He had an evaluation and was found to have uncontrolled schizoaffective disorder with behavioral disturbance unlikely related to medical or neurological cause."
* His diagnoses included: schizoaffective disorder, COPD, and history of lung cancer.

The audit will be immediately submitted to the QAPI Coordinator upon completion, for review of any deficiencies. All audit results will be submitted and reviewed by the QAPI Committee for further recommendations in order to identify root causes for resolution. Initiated M.I. (7/12/18)
**GOOD SAMARITAN SOCIETY CANISTOTA**

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<th>F 644</th>
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<td>Review of resident 37's 4/23/18 PASARR revealed:</td>
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<td>*He required a Level 11 screening.</td>
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|       | *The categorical determination revealed: "A primary diagnosis of dementia, including Alzheimer's disease or a related disorder; or anon-primary diagnosis of dementia without a primary diagnosis that is a serious mental illness."
|       | Interview on 6/13/18 at 9:05 a.m. with the administrator revealed: |
|       | *The social worker (SW) was responsible for the oversight of the PASARR |
|       | *Their current SW was new in her position. |
|       | -6/11/18 was her first day, but she had been in another facility and would have been familiar with the PASARR. |
|       | Interview on 6/13/18 at 9:30 a.m. with the SW regarding resident 37 revealed she would have questioned the appropriateness of the determination that was made on the PASARR. At that time, she called the case worker with Department of Social Services (DSS) that had made the determination and left an inquiry on her voice mail. |
|       | A return phone call was received on 6/13/18 at 11:30 a.m. from DSS caseworker F. A review of the PASARR revealed she was unsure why she had completed that review. She had and would need to look further into it, but she agreed it was not correct. |
|       | On 6/13/18 at 2:00 p.m. a document was given to the surveyor the facility had just received from DSS caseworker F which had not been available to the facility until identified by the surveyor.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**GOOD SAMARITAN SOCIETY CANISTOTA**

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<tr>
<td>Review of the provider's September 2017 PASARR policy revealed:</td>
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<td>&quot;The purpose of the PASARR was to: &quot;Ensure that individual's with retardation, serious mental disorder or intellectual disability receive the care and services they need in the most appropriate setting.&quot;&quot;</td>
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<td>&quot;&quot;The Level 11 PASARR screening is conducted by the agency designated by the state. This screening will determine whether the prospective resident requires the level of services provided by the location and whether the individual requires specialized services.&quot;&quot;</td>
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<td>For resident 14 and 45, care plans were reviewed and updated on 7/3/18 to reflect that these residents are not at risk for elopement. The care plan for resident 43 was reviewed, however, it could not be corrected and updated as the resident passed away.</td>
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| | | | 7/9/18 |
| | | | (Initialled M.I. 7/12/18) |

| F 657 | 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 |

| | | | 7/9/18 |
| | | | (Initialled M.I. 7/12/18) |
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
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<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
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<td>435087</td>
<td>A. BUILDING</td>
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**DATE SURVEY COMPLETED**

| 06/13/2018 |

**NAME OF PROVIDER OR SUPPLIER**

GOOD SAMARITAN SOCIETY CANISTOTA

**SUMMARY STATEMENT OF DEFICIENCIES**

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Each deficiency must be preceded by full regulatory or LSC identifying information.

**PROVIDER'S PLAN OF CORRECTION**

Each corrective action should be cross-referenced to the appropriate deficiency.

**COMPLETION DATE**

| 06/13/2018 |

_F 657_ Continued From page 4

or as requested by the resident.

(iii) Reviewed and reviewed by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

This REQUIREMENT is not met as evidenced by:

Surveyor: 32355
Based on observation, interview, record review, and policy review, the provider failed to ensure 4 of 19 sampled residents (4, 14, 43, and 45) had their care plans updated and revised to reflect their current status and care needs. Findings include:

1. Random observations on 6/11/18 from 2:45 p.m. through 5:40 p.m., on 6/12/18 from 7:45 a.m. through 5:10 p.m., and on 6/13/18 from 8:10 a.m. through 2:20 p.m. of resident 14 revealed he:
   * Had been alert with confusion to time and place.
   * Was capable of ambulating with staff support and the use of a wheeled walker.
   * Had been observed ambulating throughout various areas of the facility.
   * Had not attempted to exit or leave the facility without staff support or knowledge.
   * Had not been wearing a RoomAlert to notify the staff if he attempted to leave the facility without their knowledge.

Review of resident 14's medical record from 1/1/18 through 6/12/18 revealed:
* No documentation to support exit seeking behaviors and elopements from the facility had occurred.
* On 1/10/18 the quality of life (QOL) committee had reviewed his medical record and documented the use of a roam alert.
* On 1/25/18 a faxed document had been sent to

For all other potentially-affected residents, care plans were reviewed and updated to reflect their current condition.

Smoking assessments are completed and in place for all residents who are known to smoke.

An assessment is completed and in place for all residents with any one-quarter or transfer bars in use.

Education will be provided by the DNS/Staff Development Coordinator Nurse to include a review of organizational policy and procedure for care planning including reviewing, evaluating, and updating care plans as changes in residents occur. Education will also include when to and to whom reporting must be made with regards to the use of equipment such as one-quarter side rails and transfer bars and when a resident smokes so that the appropriate assessments, orders, and documentation can be completed.
**GOOD SAMARITAN SOCIETY CANISTOTA**

**STREET ADDRESS, CITY, STATE, ZIP CODE**
700 WEST MAIN ST
CANISTOTA, SD 67012

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

**X(1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:**
435087

**X(2) MULTIPLE CONSTRUCTION**

**A. BUILDING:__**

**B. WING:__**

**X(3) DATE SURVEY COMPLETED:**
06/13/2018

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| F 657  |            | Continued From page 5
the physician requesting his roam alert to be discontinued due to no exit seeking behaviors documented since 8/3/14.  
- The physician had signed the faxed document and supported the discontinuation of the RoamAlert.

Review of resident 14’s 1/25/18 comprehensive care plan revealed:
- Focus area: "The resident has potential for elopement r/t [related to] cognitive impairment, history of elopement."
- That focus area had been initiated on 8/6/15 and supported his last elopement was on 8/3/15.  
- Goal for the focus area: "Resident will not leave facility unattended."
- That goal had been initiated on 8/5/15 and revised on 1/25/18. The same date the physician had discontinued the roam alert.
- Interventions for the focus area:
  - "Offer to take resident for a walk outdoors.
  - Provide diversionary activity: table games, tv [television], music.
  - Resident needs 1:1 [one-on-one] supervision while outdoors."
- Those interventions had been initiated on 8/5/15 with the same revision date of 8/5/15.

Interview on 06/13/18 at 8:35 a.m. with the director of nursing (DON) regarding resident 14 confirmed the resident had not exhibited any exit seeking behaviors for approximately two years.
He would have expected the care plan to have been updated to support the resident was no longer an elopement risk. He stated "He only eloped once and never again."

Interview on 6/13/18 at 11:15 a.m. with the assistant director of nursing (ADON) and

The DNS/QAPI Coordinator/designee will complete audits on 5 random residents to ensure that care plan revisions or assessments are completed as indicated. This will occur weekly for 4 weeks, monthly for 2 months, and quarterly, for 3 quarters.

The audit will be immediately submitted to the QAPI Coordinator upon completion, for review of any deficiencies. All audit results will be submitted and reviewed by the QAPI Committee for further recommendations in order to identify root causes for resolution. Initiated M.I., 7-12-18
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| F 657  |            | Continued From page 6  
Minimum Data Set (MDS) assessment coordinator regarding resident 14 confirmed and supported the above interview with the DON.  
2a. Observation on 6/11/18 at 2:35 p.m. of resident 43 revealed:  
*He had appeared:  
  - Very thin, weak, and frail with his bones easily identified through the skin.  
  - To be able to move his arms minimally, but no spontaneous movement of his legs was observed.  
*He had been laying:  
  - In his bed resting and was positioned on his back.  
  - On top of an air mattress overlay.  
*Attached to both sides of his bed had been one-quarter sized side rails.  
Observation on 6/11/18 at 3:50 p.m. of certified nursing assistants (CNA) A and B with resident 43 revealed:  
*They had assisted the resident with personal care.  
*They had to move the resident from side-to-side to assist him with personal care.  
*The resident had been able to use the side rails to help the CNAs turn him from side-to-side.  
Review of resident 43's medical record revealed no documentation to support the resident used side rails to assist the staff with bed mobility.  
Review of the resident's 3/12/18 comprehensive care plan revealed:  
*He had been dependent on the staff to assist him with all activities of daily living.  
*That had included bed mobility and transfers.  
*No documentation to support he had:
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<tr>
<td></td>
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<td>- Side rails attached to his bed.</td>
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<td>- Used side rails to assist the staff with bed mobility.</td>
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Interview on 6/13/18 at 11:00 a.m. with the ADON/MDS assessment coordinator regarding resident 43 revealed:
*She would have expected:
- A side rail assessment to have been completed on the resident to support the proper and safe use of the side rails.
- The care plan to have supported the use of those side rails.

Interview on 6/13/18 at 3:05 p.m. with the DON regarding resident 43 confirmed and supported the interview with the ADON/MDS assessment coordinator.

b. Random observations on 6/11/18 from 2:35 p.m. through 5:10 p.m., on 6/12/18 from 7:50 a.m. through 5:03 p.m., and on 6/13/18 from 8:05 a.m. through 2:15 p.m. of resident 43 revealed he had remained in his bed the entire time.

Interview on 6/11/18 at 3:45 p.m. with CNA regarding resident 43 revealed:
*The only time he would have gotten out of bed was when his family came to visit on the weekends.
*She stated:
"He will get out of bed when his family is here."
"He goes outside and smokes with them."
*She confirmed he smoked cigarettes but only when his family came on the weekends.

Interview on 6/11/18 at 4:00 p.m. with the administrator regarding residents who smoked in the facility revealed there were only two residents...
**GOOD SAMARITAN SOCIETY CANISTOTA**

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<td>F 657</td>
<td>Continued From page 8 in the facility who had smoked cigarettes. One of those residents had to be supervised, and the other resident had been independent with smoking. He had not mentioned resident 43 as a resident who had smoked cigarettes. Interview on 6/12/18 at 10:58 a.m. with resident 43 confirmed: *He remained in bed at all times except for when his family came to visit on the weekends. *He would have gotten out of the bed to go outside and smoke with them. Review of resident 43's entire medical record revealed no documentation to support: *A smoking assessment to support he was a smoker and was capable of smoking without supervision. *He would have gotten out of his bed on the weekends to go outside and smoke with his family. *The physician had been aware he smoked. Review of resident 43's 3/12/18 comprehensive care plan revealed no documentation to support he smoked and the interventions he required from the staff while he was smoking. Interview on 6/12/18 at 2:15 p.m. with the administrator regarding resident 43 revealed he had not been aware the resident had been smoking. He would have expected an assessment and the care plan to have been completed by the staff to support that activity. Interview on 06/12/18 at 3:43 p.m. interview with licensed practical nurse (LPN) D and registered nurse (RN) E regarding resident 43 confirmed the above interviews with CNAs A and C. They</td>
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F 657

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agreed the care plan should have been updated to support he smoked with interventions in place for safety.

Interview on 6/13/18 at 8:45 a.m. with the DON regarding resident 43 revealed he was not aware the resident had been smoking on the weekends when his family visited. He would have expected the care plan to have been updated to support that activity.

Surveyor: 26180

3. Random observation of resident 45 from 6/11/18 at 2:50 p.m. through 6/13/18 at 11:30 a.m. revealed:
   * She ambulated independently with a wheeled walker.
   * She required no assistance with mobility or moving from one surface to another.
   * She was alert and oriented to person, place, and time with some forgetfulness.
   * She knew the code to go outside but frequently told the staff she was going out.
   * She frequently sat outside alone and smoked cigarettes.

Review of resident 45's entire medical record revealed a smoking assessment had been completed on 5/8/18. She was determined to have been able to smoke unsupervised.

Review of resident 45's 5/5/18 care plan revealed:
   * Focus: "The resident has potential for elopement r/t [related to] verbalization of not wanting to be in facility. Exit seeking behavior." That had been initiated on 4/26/18.
   **Focus: The resident has fracture right side,
**GOOD SAMARITAN SOCIETY CANISTOTA**

| (X4) ID | TAG |.kill*Continued From page 10

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**ID SUMMARY STATEMENT OF DEFICIENCIES**

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- **Multiple rib fractures traumatic r/t recent fall on steps prior to admission.**

- Interventions: Handle gently when moving or positioning. Maintain body alignment.

Interview on 6/13/18 from 10:18 a.m. with the ADON/MDS assessment coordinator revealed the care plan had not been updated. They no longer considered her an elopement risk.

4. Random observations of resident 4 from 6/11/18 at 2:50 p.m. through 6:00 p.m. and 6/13/18 at 11:30 a.m. revealed:

- He was alert to person, friendly but confused to place and time.
- He sat in a wheelchair out in the dining room (DR), lounge area most of the day.
- He had foot pedals on his wheelchair that he frequently did not use.
- His feet extended past the pedals to the floor.

Review of resident 4’s fall reports revealed he had falls on:

- 2/26/18: He slid out of his wheelchair.
- 3/4/18: He slid out of his wheelchair.
- 3/6/18: He slid out of his wheelchair.
- 3/7/18: He slid out of his wheelchair.
- 5/6/18: He was found on the floor next to his bed.
- 5/14/18: He was found on the floor in his room.

Interview on 6/12/18 at 4:27 p.m. with the DON regarding resident 4 revealed:

- When he first started to fall they had noted he was falling in the morning, so we discovered if he heard staff he would roll out of bed.
- He was ready to get up.
- Staff were instructed to check on him.
- If he was ready to get up and they were to bring
Continued From page 11

him out to the DR.
-Then he started having falls in the late afternoon.
-In reviewing the falls they had discovered the staff were putting him to bed too early.
---They had told them to leave him up later.

Interview on 6/13/18 at 10:00 a.m. with CNA G revealed:
*He stayed up all day.
*He did not like to lay down, but he preferred to be in his room.
*He was the first person they got up each morning, because he was ready to get up.
*-If you did not get him up when he is ready he would try to get out of bed on his own and possibly fall.
*They brought him out to the dining room, so they could keep an eye on him.

Review of resident 45's 6/12/18 care plan revealed:
*Focus: The resident had actual falls with no injury on: 5/16/18, 3/18/18, 3/6/18, 3/4/18, 2/26/18, 2/13/18, 10/22/17, 8/13/17, and 7/16/17.
-There were additional dates of falls prior to that.
*Interventions included:
-Staff would encourage the resident to lay in bed in the afternoon to watch TV for comfort.
-Resident would be the first one checked by day staff to see if awake, ready to get dressed, and up in w/c [wheelchair].
*It did not address:
-To leave him up later in the evening.
-To avoid dressing him in non-slippery slacks.
-To remove his foot pedals after he is transported.
-That he preferred to be in his room.
-That he stayed up all day usually.

Interview on 6/13/18 at 10:30 a.m. with the
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA
IDENTIFICATION NUMBER: 436087

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

(X3) DATE SURVEY COMPLETED

06/13/2018

NAME OF PROVIDER OR SUPPLIER

GOOD SAMARITAN SOCIETY CANISTOTA

STREET ADDRESS, CITY, STATE, ZIP CODE

700 WEST MAIN ST
CANISTOTA, SD 57012

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
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ID PREFIX TAG
F 657 Continued From page 12
restorative coordinator regarding resident 45
revealed:
"He was cooperative and came into do exercises
every morning about 7:00 a.m.
"They had discovered they needed to have him
not wear pants that were slippery, because he
slid out of his wheelchair.
"They were supposed to make sure his foot
pedals were on his wheelchair when they were
transporting him up and down the halls.
-They could take them off after he was in the
dining room.

5. Review of the provider's December 2010
Individual Care Plan policy revealed "Each client
will have a care plan prepared during the
admission process. The care plan will be
reviewed and revised minimally every three
months after the date of entrance or whenever
there is a significant change in the client's
condition."

ID PREFIX TAG
F 657

F 684 Quality of Care
CFR(s): 483.25

§ 483.25 Quality of care
Quality of care is a fundamental principle that
applies to all treatment and care provided to
facility residents. Based on the comprehensive
assessment of a resident, the facility must ensure
that residents receive treatment and care in
accordance with professional standards of
practice, the comprehensive person-centered
care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced
by:

Surveyor: 32356
Based on observation, interview, record review,
and policy review, the provider failed to ensure

ID PREFIX TAG
F 684

For resident 11, the care plan was
reviewed and updated on 6/29/18
to reflect a repositioning program ensuring
that the resident is repositioned every 2
hours and laid down after breakfast and
dinner. POC has been updated to reflect
this change; CNA's will be required to
document on this item accordingly.

The care plan for resident 43 could not
be updated as the resident has passed
away.

For all other potentially affected (dependent)
residents, the need for a personalized
repositioning program was identified
through a review of their Braden Score.
Continued From page 13
appropriate repositioning had occurred for two of nine sampled residents (11 and 43) who were at high risk for skin breakdown and were dependent upon the staff to assist them with all activities of daily living (ADL). Findings include:

1. Random observations on 6/11/18 from 2:35 p.m. through 5:50 p.m. of resident 43 revealed:
   *He had appeared:
   - Very thin, weak, and frail with his bones easily identified through the skin.
   - To be able to move his arms minimally, but no spontaneous movement of his legs was observed.
   *He had been laying:
   - In his bed resting and was positioned on his back.
   - On top of an air mattress overlay.
   *His heels had been resting directly on the air mattress overlay without any devices used to prevent pressure from occurring.
   *His head was supported with two pillows and had caused his chin to rest on his chest.
   *He had responded with short yes/no answers and closed his eyes frequently.
   - His facial expressions remained flat.
   - His voice was weak, wet, and raspy.
   *At 3:50 p.m. certified nursing assistants (CNA) A and B assisted the resident with personal care.
   - He had refused to get out of bed and preferred to have his supper in bed.
   - After the CNAs had proceeded to assist him with positioning:
     -- They pulled him up further in bed, left him on his back, and had not placed any type of device underneath his heels to relieve pressure from occurring.
   *The CNAs had not attempted to reposition the resident off of his back nor did they ask if he

Those care plans were updated as indicated.

Education was provided to all nurses and CNAs on 6/26/18 by the DNS and Staff Development Coordinator to include a review of organizational policy and procedure on Mobility Support & Repositioning, skin breakdown prevention, repositioning every 2 hours, and the use of the Braden Score.

the DNS/QAPI Coordinator/Designee will complete audits weekly for 4 weeks on resident 11, and 5 random residents to ensure that they have a personalized repositioning program in place as indicated by their Braden Score. Audits will be completed as follows: weekly for 4 weeks, monthly for 2 months, quarterly for 3 quarters.

The audit will be immediately submitted to the QAPI Coordinator upon completion, for review of any deficiencies. All audit results will be submitted and reviewed by the QAPI Committee for further recommendations in order to identify root causes for resolution. Initialed M.I., 7-12-18
**GOOD SAMARITAN SOCIETY CANISTOTA**

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| F 684 | Continued From page 14 preferred another position.  *From 4:20 p.m. through 5:50 p.m. he had remained positioned on his back and feet resting directly on the bed.  
Random observations on 6/12/18 from 7:55 a.m. through 5:30 p.m. of resident 43 revealed:  *At 7:55 a.m. the resident had been laying in bed on his back with feet/heels directly on the air mattress.  *At 8:24 a.m. CNA C had assisted the resident with personal care.  
-He remained in his bed and preferred to have his breakfast in bed.  *She had:  
-Assisted the resident with positioning in his bed.  
-Left him on his back and had not placed any type of device to off-load his feet/heels from the air mattress.  
-Not attempted to reposition him off of his back nor did she ask him if he preferred another position.  
*From 8:57 a.m. through 11:45 a.m. he remained positioned on his back with his feet/heels directly on the air mattress.  
-Unidentified staff had been observed assisting him with meals and personal care during that time-frame.  
*From 1:00 p.m. through 5:30 p.m. he remained in the same position as observed above.  
Interview on 6/12/18 at 9:10 a.m. with resident 43 revealed:  *Occasionally the staff would have positioned him on his left or right side and off-loaded his feet/heels but not all the time.  
*He stated "I can move myself around some too."  
*He had been capable of making slight movements with his knees but was not strong. | | | |
| F 684 | | | |

**STREET ADDRESS, CITY, STATE, ZIP CODE**

700 WEST MAIN ST
CANISTOTA, SD 57012
Continued From page 15

Interview on 6/12/18 at 9:15 a.m. with CNA C regarding resident 43 revealed:
*He was:
-Dependent upon the staff to assist him with all ADL including bed mobility.
-At risk for skin breakdown.
*She would have checked on him, changed his incontinent brief, and repositioned him every two hours according to the provider's protocol.

Review of resident 43's medical record revealed:
*An admission date of 3/1/18.
*His diagnoses included: failure to thrive, cachexia with abnormal weight loss, chronic obstructive pulmonary disease (COPD), and sepsis.
*His life expectancy was limited, and he had been receiving end-of-life care from Hospice.
*He was dependent upon the staff to assist him with all ADL.
-That had included bed mobility and transfers.
*He had:
-A Brief Interview Mental Status (BIMS) score of fifteen indicating he had good memory recall.
-Been capable of making his needs known.
-Been admitted with a small reddened area to his coccyx.
--That reddened area had been healed as of 3/25/18.
*His Braden Scale for Predicting Pressure ulcers score on 6/1/18 was a sixteen.
-That score had indicated he was at mild risk for skin breakdown.

Review of resident 43's 3/16/18 comprehensive care plan revealed:
*A focus area: "The resident has potential for..."
**GOOD SAMARITAN SOCIETY CANISTOTA**

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| F 684  | Continued From page 16 pressure ulcer development R/T [related to] dehydration, immobility, incontinence, poor nutrition."
*Interventions for that focus area: "Assist to reposition at least every 2-3 hours."
*No documentation to support:
- The resident was resistive to repositioning and would have occasionally refused to be moved off of his bottom/back.
- If his feet/heels should have been off-loaded to ensure relief from pressure on the air mattress had occurred.

Interview on 6/12/18 at 3:59 p.m. with licensed practical nurse (LPN) D and registered nurse (RN) E regarding resident 43 revealed they:
* Had confirmed the resident had:
  - Been admitted with an area of concern on his coccyx.
  - Been at risk for skin breakdown and was dependent upon the staff to ensure his ADL and mobility needs had been met.
  - A history of refusing to be repositioned off of his back/bottom.
* Agreed:
  - There was no documentation in his medical record to support those refusals.
  - The staff should have attempted or offered to reposition him side-to-side.
  - His feet/heels should have been off-loaded to relieve any type of pressure from the air mattress.

Interview on 6/12/18 at 4:10 p.m. with the assistant director of nursing (ADON) and Minimum Data Set (MDS) coordinator regarding resident 43 confirmed and supported the interview above with LPN D and RN E.

Observation on 6/13/18 at 7:35 a.m. of resident
F 684  Continued From page 17
43 revealed he remained in the same position as observed on 6/11/18 and 6/12/18.

2. Random observations on 6/12/18 from 7:50 a.m. through 12:15 p.m. of resident 11 revealed:
   *At 7:50 a.m. he had been:
   - Sitting in a geriatric [geri]-chair at a dining room table waiting for his breakfast.
   - Unable to make any spontaneous body movements without assistance.
   *From 8:50 a.m. through 11:00 a.m. he:
   - Continued to sit in the geri-chair.
   - Had been taken to the living room area to watch television.
   *From 11:15 a.m. through 12:15 a.m. he:
   - Continued to sit in the geri-chair.
   - Had been taken to the dining room for dinner.
   * Had required staff assistance to help him eat his meal.

Review of resident 11's medical record revealed:
*An admission date of 11/28/14.
*His diagnoses included: dementia without behavioral disturbance, drug induced subacute dyskinesia, and mental disorders due to known physiological condition.
*He was dependent upon the staff to assist him with all ADL.
*That had included bed mobility and transfers.
*His Braden Scale for Predicting Pressure ulcers score on 4/10/18 was a fourteen.
*That score had indicated he was at moderate risk for skin breakdown.

Interview on 6/13/18 at 11:00 a.m. with the ADON/MDS coordinator regarding resident 11 revealed:
*She confirmed the above medical record review, and he was dependent upon the staff to assist
F 684 Continued From page 18

him with all ADL.

*He was to have been repositioned every two hours.

*That repositioning should have included checking and changing his incontinent brief.

*He was at risk for skin breakdown and had been dependent upon the staff to ensure his mobility and repositioning needs were met.

3. Interview on 6/13/18 at 3:10 p.m. with the director of nursing regarding the above observations of residents 11 and 43 revealed he:

*Confirmed the medical record reviews for both of the residents.

*Confirmed they were dependent upon the staff to ensure their repositioning and mobility needs had been met.

*Would have expected the staff to follow the provider’s protocol for repositioning them every two hours to ensure no skin breakdown could have occurred.

*Confirmed and supported the above interviews with LPN D, RN E, and the ADON.

Review of the provider’s October 2017 Mobility Support and Positioning policy revealed:

*Purpose: “To position those residents unable to position/reposition independently in a manner which prevents formation of contractures, provides comfort and maintains skin integrity.”

*“Developing an individualized repositioning schedule is recommended based [on] an evaluation of risk factors and on observation of the resident’s skin over a period of time.”

*“Individual pressure points are observed for redness or discomfort (tissue tolerance) after repositioning has been done.”

Review of the provider’s Braden Scale for
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<tbody>
<tr>
<td>684</td>
<td>Continued From page 19</td>
<td>F 684</td>
<td>Predicating Pressure Sore Risk assessment form revealed: *Mild risk (score of 15 to 18) intervention guide: *Frequent turning (e.g., q [every] 2 hours). *Pressure-reduction support surfaces if bed- or chair-bound. *Protect heels.&quot; *Moderate risk (score of 13 to 14) intervention guide: &quot;Frequent turning with a planned schedule.&quot;</td>
<td>F 689</td>
<td>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</td>
<td>For residents 7 &amp; 14, the IDT applied the Elopement Screening and Monitoring Process flow sheet on each resident. Resident 14 was found to not be an elopement risk and the care plan was adjusted to reflect this finding. Resident 7 was found to be an elopement risk and at need for a Wanderguard. Resident 7's care plan was reviewed and updated to reflect this finding as were orders.</td>
<td>7-9-18</td>
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<td>689</td>
<td>SS=E</td>
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<td>§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 39190 Based on observation, interview, record review and policy review, the provider failed to ensure appropriate assessments to prevent accidents and hazards were completed for: *Two of three residents (7 and 14) at risk for elopement. *One of three residents (43) who smoked. *One of three residents (43) who were observed with side rails on their bed. Findings include: 1. Review of resident 7's medical record revealed他: *Was admitted on 12/27/17.</td>
<td>Initialed M.I.</td>
<td>7/12/18</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

[X1] PROVIDER/SUPPLIER/CLA

IDENTIFICATION NUMBER:

435067

[X2] MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

[X3] DATE SURVEY COMPLETED

06/13/2018

**NAME OF PROVIDER OR SUPPLIER**

GOOD SAMARITAN SOCIETY CANISTOTA

**STREET ADDRESS, CITY, STATE, ZIP CODE**

700 WEST MAIN ST

CANISTOTA, SD 57012

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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<tr>
<td>F 689</td>
<td></td>
<td><strong>Education will be provided at an all-staff in-service on 7/9/18 by the DNS/Social Service Designee/Staff Development Coordinator to include a review of organizational policy and procedure for elopement, physical devise and restraint assessments, as well as tobacco assessments.</strong>&lt;br&gt;<strong>Also to be reviewed includes the process for reviewing new admits, and when to re-assess a resident using the Elopement Screening and Monitoring Process Flow sheet.</strong>&lt;br&gt;<strong>The DNS/QAPI Coordinator/Designee will complete audits weekly for 4 weeks, monthly for 2 months, and quarterly for 3 quarters to ensure compliance. Audits will include 5 random residents to ensure that an elopement screening was completed upon admission.</strong>&lt;br&gt;<strong>Audits will be completed on 5 random residents to ensure that all to ensure assessments pertaining to physical devices and restraints, and tobacco use have been completed according to policy/procedure.</strong></td>
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Continued From page 20

"Had diagnoses of: vascular dementia with behavioral disturbances, chronic obstructive pulmonary disease, edema, major depressive disorder, anxiety disorder, restlessness, and agitation.

*Had a Wander Guard due to exit seeking behaviors.

*Had a Brief Interview of Mental Status (BIMS) score of ninety-nine meaning his cognitive status was incomplete or could not be done.

Review of resident 7's undated care plan revealed he:

*Had impaired thought process related to dementia.

*Had an adjustment issue related to admission as evidence by his confusion to place and desire to return home to his farm.

*Had behavior symptoms related to vascular dementia as evidenced by elopement attempts.  
- Would be safe in his environment as evidenced by not eloping.
- Would not leave facility unattended.

Review of resident 7's mood and behavior progress notes from 5/12/18 to 6/4/18 revealed:

*He exhibited exit seeking behavior eleven times.
- There were multiple accounts per event.
- That had occurred throughout the day and evening.

*Every time the nurses had documented "Resident frequently exit seeking this shift."

Interview on 6/13/18 at 1:48 p.m. with the director of nursing revealed there was no assessment completed for elopement risk. There was no system for determining if a resident needed a Wander Guard or was at risk for elopement.

Surveyor: 32355
The audit will be immediately submitted to the QAPI Coordinator upon completion, for review of any deficiencies. All audit results will be submitted and reviewed by the QAPI Committee for further recommendations in order to identify root causes for resolution. Initiated M.I., 7/12/18.

Review of resident 14's medical record from 1/1/18 through 6/12/18 revealed:
*An admission date of 3/7/13.
*A BIMS score of four indicating he had poor memory recall.
*His diagnoses included: antisocial personality disorder, epilepsy, intracranial injury, schizoaffective disorder, major depression, and dementia without behavioral disturbance.
*No documentation to support exit seeking behaviors and elopement episodes from the facility had occurred.
*On 1/10/18 the quality of life (QOL) committee had reviewed his medical record and documented the use of a roam alert.
*On 1/25/18 a faxed document had been sent to the physician requesting his Roam Alert to be discontinued due to no exit seeking behaviors documented since 8/3/14.
*The physician had signed the faxed document and supported the discontinuation of the Roam Alert.
*No documentation to support:
  * An elopement assessment or review had been
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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| F 689 | Continued From page 22 completed.  
- The staff had been checking his RoamAlert daily to ensure it was in place and working properly.  
Review of resident 14's 1/25/18 comprehensive care plan revealed:  
*Focus area: “The resident has potential for elopement /t related to] cognitive impairment, history of elopement.”  
-That focus area had been initiated on 8/5/15 and supported his last elopement was on 8/3/15.  
*Goal for the focus area: “Resident will not leave facility unattended.”  
-That goal had been initiated on 6/5/15 and revised on 1/25/18. The same date the physician had discontinued the roam alert.  
*Interventions for the focus area:  
-”Offer to take resident for a walk outdoors.  
-Provide diversionary activity: table games, tv [television], music.  
-Resident needs 1:1 [one-on-one] supervision while outdoors.”  
--Those interventions had been initiated on 8/5/18.  
--The initiated and revision dates remained unchanged.  
Interview on 6/13/18 at 9:35 a.m. with the director of nursing (DON) regarding resident 14 revealed:  
*The resident had not exhibited any exit seeking behaviors for approximately two years.  
*He would have expected the care plan to have been updated to support the resident was no longer an elopement risk.  
*He stated: “He only eloped once and never again.”  
*The provider had a flow sheet they used to determine if the resident was an elopement risk or not. |
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<td>F 689</td>
<td>Continued From page 23 - There was not a formal assessment that should have been completed routinely with comprehensive and quarterly assessments to support an elopement risk. *He agreed there should have been: - Documentation to support why the resident was no longer an elopement risk and how that was determined. - A system put in place for determining if a resident was at risk of elopement or not. *He stated &quot;We have an elopement flow sheet that we are to use for elopements. There is no other form or assessment tool we use to reassess them routinely.&quot;</td>
<td>F 689</td>
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Interview on 6/13/18 at 11:15 a.m. with the assistant director of nursing (ADON) and Minimum Data Set (MDS) assessment coordinator regarding resident 14 confirmed and supported the above interview with the DON.

Review of the provider's April 2016 Elopement policy revealed:
*Purpose:
   * "To assess and identify residents at risk for elopement.
   * To clearly define the mechanisms and procedures for monitoring and managing residents at risk for elopement.
   * To provide a system of documentation for the prevention of, and in the event of, elopement."

* An Elopement screening and monitoring process flowchart were to be used when determining if the resident was at risk for elopement.

3. Observation on 6/11/18 at 2:35 p.m. of resident 43 revealed:
   * He had appeared:
     * Very thin, weak, and frail with his bones easily
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| F 689  | Continued From page 24: identified through the skin. To be able to move his arms minimally, but no spontaneous movement of his legs was observed. *He had been laying in his bed resting. *Attached to both sides of his bed had been one-quarter sized side rails. Observation on 6/11/18 at 3:50 p.m. of certified nursing assistants (CNA) A and B with resident 43 revealed: *They had assisted the resident with personal care. *They had to move the resident from side-to-side to assist him with personal care. *The resident had been able to use the side rails to help the CNAs turn him from side-to-side. Review of resident 43's medical record revealed: *An admission date of 3/1/18. *His diagnoses included: failure to thrive, cachexia with abnormal weight loss, chronic obstructive pulmonary disease (COPD), and sepsis. *His life expectancy was limited, and he had been receiving end-of-life care from Hospice. *No documentation to support: -The resident used side rails to assist the staff with mobility. -A physical device and restraint assessment had been completed for the safe and proper use of those side rails. Review of resident 43's 3/12/18 comprehensive care plan revealed: *He had been dependent on the staff to assist him with all activities of daily living. -That had included bed mobility and transfers. *No documentation to support he had:
**GOOD SAMARITAN SOCIETY CANISTOTA**

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<td>F 689</td>
<td>Continued From page 25 -Sides rails attached to his bed. -Used side rails to assist the staff with bed mobility.</td>
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Interview on 6/13/18 at 11:00 a.m. with the ADON/MDS assessment coordinator regarding resident 43 revealed:
- She would have expected:
  - A side rail assessment to have been completed on the resident to support the proper and safe use of the side rails.
  - The care plan to have supported the use of those side rails.

Interview on 6/13/18 at 3:05 p.m. with the DON regarding resident 43 confirmed and supported the interview with the ADON/MDS assessment coordinator.

4. Random observations on 6/11/18 from 2:35 p.m. through 5:10 p.m. on 6/12/18 from 7:50 a.m. through 5:03 p.m., and on 6/13/18 from 8:05 a.m. through 2:15 p.m. of resident 43 revealed he had remained in his bed the entire time.

Interview on 6/11/18 at 3:45 p.m. with CNA A regarding resident 43 revealed:
- The only time he would have got out of bed was when his family came to visit on the weekends.
- She stated:
  - "He will get out of bed when his family is here."
  - "He goes outside and smokes with them."
- She confirmed he smoked cigarettes but only when his family came on the weekends.

Interview on 6/11/18 at 4:00 p.m. with the administrator regarding residents who smoked in the facility revealed there were only two residents in the facility who had smoked cigarettes. One of
Continued From page 26

those residents had to be supervised, and the other resident had been independent with smoking. He had not mentioned resident 43 as a resident who had smoked.

Interview on 6/12/16 at 10:58 a.m. with resident 43 confirmed:
*He remained in bed at all times except for when his family came to visit on the weekends.
*He would have gotten out of the bed to go outside and smoke with them.

Review of resident 43's entire medical record revealed no documentation to support:
*A smoking assessment to support he was a smoker and was capable of smoking without supervision.
*He would have gotten out of his bed on the weekends to go outside and smoke with his family.
*The physician had been aware he smoked.

Review of resident 43's 3/12/16 comprehensive care plan revealed no documentation to support he smoked and the interventions he required from the staff while he was smoking.

Interview on 6/12/16 at 2:15 p.m. with the administrator regarding resident 43 revealed he had not been aware the resident had been smoking. He would have expected a smoking assessment to have been completed and his care plan updated to support that activity.

Interview on 6/12/16 at 3:43 p.m. with licensed practical nurse (LPN) D and registered nurse (RN) E regarding resident 43 confirmed the above interviews with CNAs A and C. They agreed the care plan should have been updated.
**GOOD SAMARITAN SOCIETY CANISTOTA**

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<td>F 689</td>
<td>Continued From page 27 to support he smoked with interventions in place for safety.</td>
<td>F 689</td>
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Interview on 6/13/18 at 8:45 a.m. with the DON regarding resident 43 revealed he was not aware the resident had been smoking on the weekends when his family visited. He would have expected a smoking assessment to have been completed and his care plan updated to support that activity.

Review of the provider's March 2018 Smoke-Free Locations policy revealed:

"*Staff members will designate acceptable outdoor location(s) for resident/client smoking. Such locations must ensure precautions are taken for the resident/client's individual safety, as well as the safety of others in the location.*"

"*Upon admission, all residents/clients who smoke or use tobacco products will be assessed using the Tobacco Use Assessment. Assessments also will be administered if a resident/client has a change in cognitive ability, judgment, manual dexterity, and/or mobility. Care plans are updated as needed."*

Surveyor: 38899

5. Interview on 6/13/18 at 11:30 a.m. with the environmental services director regarding the bed and side rail assessments revealed he:

*Had completed the bed assessments and side rail safety assessments based on the bed company and not the individual resident.*

*Had completed the assessments annually.*

They were last assessed in January 2018.

*Placed the side rails and/or the positioning bars on the beds per direction from the Minimal Data Set (MDS) coordinator.*
Continued From page 28

Surveyor: 32355
6. Continued interview on 6/13/18 at 11:32 a.m. with the environmental services director regarding the bed and side rail assessments revealed he: "Was not aware those assessments should have been individualized and completed with comprehensive and quarterly assessments. "Was aware of the specific guidelines from the Food and Drug Administration (FDA) for the size of the gaps and specific entrapment zones they had required and allowed. He had a copy of those zones and measurement guidelines. "Would not have followed those guidelines to ensure:
- The gap and space between the side rails and mattresses were within those recommended measurements for safety.
- The mattresses were secured to the bed-frames and would not have shifted or slid easily.

Review of the provider's October 2017 Restraints policy and procedures revealed:
*Purpose:
- "To ensure appropriate use and application of restraints.
- To prevent resident from self-injury or injury to others."
- "Physical restraints may include, but are not limited to side rails that the resident cannot remove."
- "If the device, material or equipment is not a restraint, it must be reviewed quarterly and with a significant change in condition in conjunction with the care plan to ensure that it continues to not be a restraint for the resident. This review is suggested to be documented as part of the quarterly note in the care plan review."
- "There should have been documentation to
| F 689 | Continued From page 29 
support permission for use of the physical 
restraints from the resident or representative. 
*The care plan should have been updated to 
include the reason for the restraint, the required 
monitoring, and a measurable goal. 

Review of the provider's May 2017 Bed Safety - 
Including Bed Rails/Side Rails/Assist Bars policy 
revealed: 
*Purpose: 
-"To promote bed safety.
-To reduce entrapment risk by providing 
appropriate resident assessment and use of less 
restrictive alternatives to side rails."
**"Bed rails/side rail usage will occur only when 
medical necessity for bed rails/side rails is 
documented by the medical provider, and when 
the total bed environment (i.e., bed frame, 
mattress, bed rails/side rails and overlays) have 
been inspected and verified to be free of 
entrapment risk."

| F 689 | F 689 |

| F 880 | 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: 

CNA's A, B, and C were educated by the 
Staff Development Coordinator (RN) on 
proper glove use while performing 
personal hygiene and on hand washing 
on 7/3/18. 

Given the potential to affect any / all 
residents, 
to include residents 4, 17, 29, 
and 43, (Initialied M.I., 7/12/18) 
CNA's will follow appropriate 
hand hygiene and glove use per 
organizational policy/procedure. 

| F 880 | CNA's A, B, and C were educated by the 
Staff Development Coordinator (RN) on 
proper glove use while performing 
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on 7/3/18. 

Given the potential to affect any / all 
residents, 
to include residents 4, 17, 29, 
and 43, (Initialied M.I., 7/12/18) 
CNA's will follow appropriate 
hand hygiene and glove use per 
organizational policy/procedure. 

| 7-9-18 | Initialed 
M.I., 7/12/18 |
Education will be provided to all staff by the DNS/Staff Development Coordinator at an all-staff in-service on 7/9/18 to include a review of organizational policy and procedure on infection control, particularly as it pertains to gloved use and hand washing during peri care and personal hygiene care.

The DNS/QAPI Coordinator/Designee will complete audits weekly for 4 weeks, every other week for 3 months, monthly for 4 months and quarterly for 1 quarter.

The audit will be immediately submitted to the QAPI Coordinator upon completion, for review of any deficiencies. All audit results will be submitted and reviewed by the QAPI Committee for further recommendations in order to identify root causes for resolution. Initiated M.I., 7/12/18
<table>
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<tr>
<td>F 880</td>
<td>Continued From page 31 identified under the facility's IPCP and the corrective actions taken by the facility.</td>
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§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:
Surveyor: 26180
Based on observation, interview, and policy review, the provider failed to ensure appropriate hand hygiene processed was maintained during four of nine sampled resident's (4, 17, 28, and 43) personal care. Findings include:

1. Observation on 6/12/18 at 3:40 p.m. certified nursing assistants (CNA) A and B with resident 17 revealed:
   *The EZ stand was used to stand the resident.
   *CNA A:
   -Tore her gloves while she was putting them on, because her hands were still damp after washing them. -Completed perineal care because the resident had been incontinent of urine.
   -With her soiled and torn gloves, she touched his knee, his wheelchair, the back of his chair, his arm and readjusted the lift.
   --She then removed her soiled gloves.

Surveyor: 32355
2a. Observation on 6/11/18 at 3:50 p.m. of CNAs A and B with resident 43 revealed:
*The resident had been laying in his bed resting.
F 880  Continued From page 32

*They had:
- Prepared to provide personal care for him.
- Washed their hands and put on clean gloves.
*With those clean gloves on CNA A:
- Had touched the handle on the closet and got a clean incontinent brief, pulled down the resident's pants, removed his soiled incontinent brief, and opened a package of wet wipes.
- Pulled out several wet wipes from the package.
*With those soiled gloves CNA A:
- Performed personal care for the resident.
- Assisted CNA B with putting on a clean incontinent brief, pulling up his pants, and positioning him in the bed.
*CNA A:
- Had used the same pair of gloves during the entire process.
- Removed her gloves and washed her hands only prior to leaving the room.

3. Observation on 6/11/18 at 4:20 p.m. of CNAs A and B with resident 4 revealed:
*The resident had been in his wheelchair (w/c) and required assistance to go to the bathroom prior to supper.
*They had:
- Prepared to assist the resident with going to the bathroom.
- Washed their hands and put on clean gloves.
*With those clean gloves on they had:
- Gotten a mechanical lift to assist the resident with transferring to a bedside commode.
- Assisted the resident with placement of the sling and attached it to the mechanical lift.
- Placed the resident's legs on the base of the mechanical lift and secured the safety strap around his legs.
*CNA A:
- Used the remote control on the mechanical lift to
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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| F 880 | Continued From page 33 | assist the resident to a standing position.  
- Assisted CNA B with pulling down the resident's pants and checking his incontinent brief.  
- Assisted the resident to sit on the bedside commode.  
- Unhooked the resident from the mechanical lift while he went to the bathroom.  
* Both of the CNAs removed their gloves, washed their hands, and stepped outside of the room to provide privacy for the resident.  
* At 4:30 p.m. they returned to the resident's room to assist him off of the bedside commode.  
* They had washed their hands and put on clean gloves.  
* With those clean gloves on CNA A:  
  - Assisted CNA B with hooking the resident back-up to the mechanical lift to assist him with standing again as observed above.  
  - Opened a package of wet wipes and pulled out several of them.  
* With those soiled gloves on CNA A:  
  - Had used the wet wipes to provide personal care for the resident.  
  - Assisted CNA B with pulling up the resident's incontinent brief, pants, and sitting him back down in the w/c.  
* Both of the CNAs removed their gloves, washed their hands, and left the room.  

4. Observation on 6/11/18 at 5:03 p.m. of CNA A with resident 29 revealed:  
* The resident had been laying down on her bed sleeping.  
* The resident had been incontinent of urine.  
- Her shirt and pants had been wet with urine.  
* CNA A:  
  - Prepared to assist the resident to the bathroom, provide personal care, and change her clothes.  
  - Washed her hands and put on clean gloves.
**GOOD SAMARITAN SOCIETY CANISTOTA**

**F 880**

Continued From page 34

*With those clean gloves CNA A touched multiple unclean surfaces prior to providing personal care for the resident.

*Those surfaces had been the:
  - Resident's wheeled walker when she had helped to guide the resident into the bathroom.
  - Resident's shoes that had required removing prior to taking off the resident's urine soaked pants and the incontinent brief.
  - Resident's wet and soiled clothes from urine when she had assisted the resident with taking them off.
  - Soiled incontinent brief that had required removing from the resident prior to her sitting on the toilet.
  - Handled on the clothes closet when she had gotten out clean clothes for the resident to wear.
  - Incontinent brief, clothes, and shoes that she had assisted the resident with putting on.
  - Edges on the door of the medicine cabinet when she opened it and got out a tube of perineal wash.
  - Package of wet wipes when she opened them to get out several wipes to use on the resident's peri-care area.

*With those soiled gloves still on CNA A:
  - Provided peri-care for the resident.
  - Moved the resident's w/w closer to her so she could stand-up.
  - Assisted the resident with standing up, and pulled up her incontinent brief and pants.
  - Another unidentified CNA entered the room and assisted the resident down to the dining room.
  - CNA C removed her gloves, washed her hands, and took the soiled clothes and garbage to the soiled room.

b. Observation on 6/12/18 at 8:24 a.m. of CNA C with resident 43 revealed:
**GOOD SAMARITAN SOCIETY CANISTOTA**

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<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
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| F 880         | Continued From page 35  
**The resident had been laying on his bed sleeping.**  
*CNA C:*  
-Prepared to assist the resident with personal and peri-care.  
-Washed her hands and put on clean gloves.  
*With those clean gloves CNA C:*  
-Touched the handle on the clothes closet and got out clean clothes and an incontinent brief.  
-Pulled down the resident's blankets.  
-Removed his soiled incontinent brief.  
-Opened a package of wet wipes and removed several of them.  
*With those soiled gloves that had touched several unclean surfaces CNA C:*  
-Provided perineal care for the resident.  
*After CNA C cleaned the resident's peri-area she had continued to use those soiled gloves for the following:*  
*CNA C:*  
-Assisted the resident with getting dressed.  
-Opened a drawer on the bedside table, got out a tube of deodorant, and put some on the resident.  
-Got a comb out of the drawer and went into the bathroom.  
-Touched the handles on the faucet and turned on the water.  
-Placed the comb under the running water, turned off the faucet, and combed the resident's hair.  
*CNA C then removed her gloves and washed her hands.*  

Interview on 6/13/18 at the time of the above observation with CNA C revealed:  
*She had not realized her process for providing personal and perineal care was not performed in a sanitary manner.*  
*She agreed the process had been unsanitary and had created the potential of*
**Summary Statement of Deficiencies**

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| F 880 | Continued From page 36  
cross-contamination of bacteria to the resident.  
5. Interview on 6/13/18 at 11:25 a.m. with the assistant director of nursing (ADON), Minimum Data Set (MDS) coordinator, and the infection control (IC) nurse confirmed the above care provided by the CNAs had been completed in an unsanitary manner. She would have expected the CNAs to have removed their gloves and washed their hands after performing a task that had soiled their gloves. She agreed the care above had created the potential of cross-contamination of bacteria to be transmitted from one resident to another.  
Interview on 6/13/18 at 3:25 p.m. with the director of nursing regarding the observations of personal and perineal care confirmed and supported the interview with the ADON and IC nurse.  
Review of the provider's December 2005  
Handwashing, Gowns, Gloves, Masks, and Goggles policy revealed:  
"Handwashing is the single most important means of preventing infection and should be a routine practice for all caregivers. Hands of personnel may become a route of transmission if proper handwashing is not practiced."

*Handwashing should occur:*  
- After handling items or residents soiled with body fluids or wastes.  
- Before and after using gloves.  

*Review of the provider's October 2017 Perineal Care policy revealed:*  
*Purpose:*  
- "To prevent infection and odors in the perineal area.  
- To promote good perineal hygiene.*
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| F 880 | Continued From page 37 | -"Perform hand hygiene and put on gloves.  
-If additional supplies are needed during perineal care, remember to remove soiled gloves.  
-Wash hands or use hand sanitizer before touching objects in environment.  
-Re-glove to resume perineal care." | | | | | |
### Summary Statement of Deficiencies

E 000 Initial Comments

Surveyor: 26180

An initial health survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for long term care facilities, was conducted from 6/11/18 to 6/13/18. Good Samaritan Society Canistota was found in compliance.

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Mina Iskandir, MPA, LNHA

Administrator

7-6-18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the facility may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patient. A asterisk (*) indicates that the findings stated above are discloseable 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 discloseable 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**

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| K 000 | INITIAL COMMENTS | | Surveyor: 14180  
A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 6/12/18. Good Samaritan Society Canistota 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 (FSES) dated 6/12/19 upon correction of the deficiencies identified below.  
Please mark an F in the completion date column of those deficiencies identified as meeting the FSES to indicate the provider's commitment to continued compliance with the fire safety standards. | K 000 | | | | |
| K 241 | Number of Exits - Story and Compartment CFR(s): NFPA 101 | | Number of Exits - Story and Compartment  
Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment.  
18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4  
This REQUIREMENT is not met as evidenced by:  
Surveyor: 14180  
Based on observation and record review, the provider failed to maintain at least two conforming exits from each floor of the building. One of two | N/A | | F | |

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**LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

Mina Iskandar, MPA, LNHA  
Administrator  
7-3-18

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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 60 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.
K241  Continued From page 1
floors (basement) did not have two conforming exits. Findings include:

1. Observation at 10:00 a.m. on 6/12/18 revealed there was only one exit provided from the basement boiler room. The only exit was a stair enclosure that discharged into the vestibule on the main level. Review of previous survey data also identified that condition.

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.

That deficiency would only affect one or two maintenance personnel if in the basement during a fire emergency.

K374  Subdivision of Building Spaces - Smoke Barrie
      CFR(s): NFPA 101

Subdivision of Building Spaces - Smoke Barrier Doors
2012 EXISTING
Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.
19.3.7.6, 19.3.7.8, 19.3.7.9
This REQUIREMENT is not met as evidenced by:
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| K 374         | Continued From page 2  
Based on measurement and document review, the provider failed to maintain at least thirty-two inches of clear width for two of two smoke barrier doors (100 and 200 wings). Findings include:  
1. Measurement at 9:00 a.m. on 6/12/18 revealed the cross-corridor doors to the 100-wing measured thirty-one inches of clear width. Further measurement revealed the cross-corridor doors to the 200-wing adjacent to the nurses' station measured thirty inches of clear width. Review of the previous life safety code survey confirmed those findings.  
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.  
That deficiency could affect approximately twenty-five residents and staff during a fire emergency. | K 374         |                                                                                                   |                 |
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| S 000 | Compliance/Noncompliance Statement | Surveyor: 29354  
A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 6/11/18 through 6/13/18. Good Samaritan Society Canistota was found not in compliance with the following requirement: S329. | S 326 |  | For UAP A, the Staff Development Coordinator obtained UAP A's original Medication Aide registration showing completion of the SD Board of Nursing approved 20-hour Medication Aid training course completed 12/2015 and this was placed in the personnel file on 6/14/18. | 6-14-18 |
| S 329 | 44:73:08:07 Medication Administration | Medication administration shall comply with §§44:73:08:02 to 44:73:08:05, inclusive, and with the requirements for training in §§20:48:04:01:14 and 20:48:04:01:15 and for supervision in §20:48:04:01:02. The supervising nurse shall provide an orientation to the unlicensed assistive personnel who will administer medications. The orientation shall be specific to the facility and relevant to the residents receiving administered medications.  
 This Administrative Rule of South Dakota is not met as evidenced by:  
Surveyor: 29354  
Based on record review, interview, and clinical skill checklist review, the provider failed to ensure one of one sampled unlicensed assistive personnel (UAP) (A) had received annual medication administration education or competency training. Findings include:  
1. Review of UAP A's personnel record revealed:  
   * A hire date of 9/28/09.  
   * She had received her original UAP certification on 12/31/15.  
   * There was no documentation when she had begun working as a UAP in the facility.  
   * There was no documentation medication administration education or competency training. |  |  |  |  |
Continued From page 1

had been completed.

Interview on 6/12/18 at 3:00 p.m. with the director of nursing (DON) and the assistant DON regarding the above revealed:
*UAP A had started working as a UAP in June 2017.
*They confirmed there was no documentation mediation administration education or competency training had been completed upon being hired.
*The DON thought there had been some type of education provided but was unable to provide documentation.
*They agreed medication administration education or competency training should have been done.

Review of the provider’s October 2017 Medication Administration Clinical Skill Checklist revealed, "Must receive a score of four for each procedure step to prove competency."

S 326 thus, demonstrating competency. This verification of competency will be placed in the personnel file. If the UAP has not received the 20-hour Medication Aide Training Course, the facility will provide this.

The Staff Development Coordinator/designee will provide annual medication administration training and competency evaluation to all UAP’s to ensure training requirements are met.

To ensure sustained correction of this citation, audits of competency will be conducted one time a week for a period of four weeks by the Staff Development Coordinator or appropriate designee.

The audit will be immediately submitted to the QAPI Coordinator upon completion, for review of any deficiencies. All audit results will be submitted and reviewed by the QAPI Committee for further recommendations in order to identify root causes for resolution. Initialed M.I., 7/12/18

Surveyor: 29354
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 6/11/18 through 6/13/18. Good Samaritan Society Canistota was found in compliance.

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