<table>
<thead>
<tr>
<th>F 000</th>
<th>INITIAL COMMENTS</th>
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<tbody>
<tr>
<td>Surveyor: 35121</td>
<td></td>
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<tr>
<td>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/18/19 through 3/20/19. Good Samaritan Society Canton was found not in compliance with the following requirements: F600, F610, F655, F657, and F689.</td>
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<tr>
<td>F 600</td>
<td>Free from Abuse and Neglect</td>
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<tr>
<td>SS=E</td>
<td>CFR(s): 483.12(a)(1)</td>
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<tr>
<td>§483.12 Freedom from Abuse, Neglect, and Exploitation</td>
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<tr>
<td>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident’s medical symptoms.</td>
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<td>§483.12(a) The facility must-</td>
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<td>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Surveyor: 39190</td>
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<td>Based on observation, interview, record review, and policy review, the provider failed to ensure resident safety and interventions were put in place during six resident-to-resident altercations involving one of one sampled resident (7). Findings include:</td>
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<tr>
<td>1. Review of resident 7’s medical record</td>
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Continued From page 1

revealed:
* She had been admitted on 2/13/13.
* She had been discharged to a behavior unit on 3/13/18.
* She had returned to the facility on 3/15/18.
* Her Brief Interview of Mental Status score of 3 indicated she had a severe cognitive
impairment.
* Her diagnosis included: Alzheimer’s disease, anxiety disorder, dementia, major depressive
disorder, and wandering.
* She had six incidents of resident-to-resident altercations on the following dates:
  - 3/5/18.
  - 4/26/18.
  - 5/27/18.
  - 12/1/18.
  - 1/24/19.
  - 3/13/19.

Review of resident 7’s 3/20/19 Medication Review report revealed:
* A physician’s order for:
  - Aricept 10 milligrams (mg); give one tablet daily for dementia. Start date 9/12/18.
  - Aripiprazole 5 mg; give a half tablet one time a day for major depressive disorder. Start date
    3/20/18.
  - Sertraline 100 mg; give one tablet daily in the morning for anxiety related to anxiety disorder.
    Start date 3/20/18.
  - Remeron 15 mg; give one tablet at bedtime for mood related to major depressive disorder. Start
    date 3/20/18.
* Gradual dose reduction for the above medications had been recommended in October 2018 by the
  pharmacist.
* Physician had disagreed related to the severity of her dementia and behavioral issues.

F 600 team. They will work with the physicians, pharmacy and counseling providers to review
effective medications and mood and behavior concern. Resident #7 started on medication 4/24/19
ordered by Clinical Psychologist for episodic hostile behavior.
2. For all other residents that may be involved in abuse and neglect including resident to residents
altercations. The facility staff will continue to separate the residents immediately to ensure they are
safe. The physician and family will be notified of the event. The facility staff will provide on-going
support, seek mental health providers for resident counseling and resource to the resident and
family as needed. The care plan will reflect all updates as the interdisciplinary team
develops a person-centered comprehensive care plan for each resident.
3. INSERVICE: The DNS and Social Services will provide all staff education of GSS policy/
procedure on Abuse and Neglect including resident to resident altercations, the role of each
employee of their responsibility to notify supervisor of alleged abuse, the completion of the
incident report in PCC. The thorough investigation and follow up. This education is scheduled
Continued From page 2

Observation on 3/18/19 at 5:29 p.m. of resident 7 in the dining room revealed:
*She had been sitting at a table where residents required assistance with eating.
*She required cueing with meals.
*She had been grabbing at residents' silverware that were sitting to her left and to her right.
*She had been trying to replace their silverware on the napkins.
*The resident to her right kept telling her "That is not your silverware, don't touch that."
*Certified nursing assistant (CNA) B had to keep reminding her that was not her silverware.
*[Resident name] do not touch that, [resident name] please do not touch those, they are not yours."
*She received her food and began eating.
*She no longer grabbed at the other residents' silverware.
*When she finished her meal she left the table.

Interview on 3/20/19 at 1:40 p.m. with the director of nursing (DON) and the social service designee (SSD) regarding resident 7 revealed:
*She had several resident-to-resident incidents over the last year.
*She exhibited other behaviors such as:
-Urinated in places other than the bathroom.
-Wandered into other residents' rooms.
-Wandered throughout the facility.
*She had been sent to a behavior unit March 2018.
-Medication adjustments and changes had been made so she could return to the facility.
*She continued to have behaviors since returning and despite the interventions.
*Her behaviors were inconsistent and did not follow a pattern or specific resident.

for May 8, 2019. The facility will also reach out to ombudsman and mental health providers for additional training and resources as needed.
4. Audits will be completed by the administrator and/or designee on all incidents involving abuse and neglect including residents to residents altercations. The audit will include a thorough investigation, follow up and the reporting. These audits will be completed by the administrator weekly x 4 weeks and monthly x 4 months. Audit findings will be reported monthly by the administrator to the QAIP committee for further Recommendations.

5. Completion date 5/9/19
**Summary Statement of Deficiencies**

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Continued From page 3

*Many suggestions for interventions had been made to the family.*

- The family would not allow:
  -- Medication increases or adjustments.
  -- They did not want a psychologist involved.
  -- They did not want a counselor to see her.
  -- They had refused any form of help.

*Did not have family cooperation.*

*In February 2019 the ombudsman had been contacted for assistance.*

*He had not yet made it to the facility.*

*A family care conference had been scheduled for Thursday 3/28/19, they were hoping the ombudsman would attend.*

*Family had refused to attend care conferences in the past.*

*The daughter worked at the facility.*

*After discussions with the family the DON and SSD were shunned by the family member during work hours.*

*They were fearful for the resident's safety and the safety of all the residents.*

Interview on 3/20/19 at 4:20 p.m. with licensed practical nurse A regarding resident 7 revealed:

*She was confused and wandered.*

*Most of the time she had been sweet and easy to get along with.*

*Had to redirect her in the dining room on occasion.*

*She liked to tidy up.*

*Would try to clear the table before residents were done eating.*

*On occasion direct care staff would report she spit or kicked at them during care.*

*She had not been aggressive with her.*

Interview on 3/20/19 at 4:35 p.m. with CNA B regarding resident 7 revealed she:
F 600 Continued From page 4

*Had gotten angry about things.
*Would talk calmly to her and then she could be redirected.
*Would ram her walker into the CNA during redirection.
*I would just calmly ask her to move in a direction and guide her.
*She would start moving in that direction.
*No more anger or trying to hit me with the walker."
*If she was not ready to do something, she left her and went back later.
*If she was not ready for bed, I would go in her room and lay out her pajamas.
*Leave the room and when I would come back later she would be trying to get her pajamas on.
*I would assist her with getting her pajamas on and she would go to bed."
*She would try to clean up after meals.
*Some staff let her help to keep her from getting upset.
*She enjoyed folding towels and napkins.
*She seemed to do better when the same group of staff cared for her.
*She would just get upset/angry at times.
*Not sure of the reason.
*Did not last for a long period of time.
*She redirected easily.

Interview on 3/20/19 at 4:44 p.m. with the activity director regarding resident 7 revealed:
*She was possessive and did not like her things being touched.
*It did not seem to be a certain resident or time of day that caused the behaviors.
*Behaviors were instant and impulsive.
*Did not last more than a few minutes.
*Did not seem to harbor feelings.
*She was angry and had her outburst that was
Continued From page 5

F 600

usually physical.
-Then she would go about her day.
-"Would not try to hit or be mean to the resident she just had the altercation with later in the day."
-"Or even minutes later after the incident."
*Easily redirected.
*Had never been aggressive or mean to her.

Review of resident 7's following incident reports revealed:

a. On 3/5/18 at 1:30 p.m. she had an incident with resident 31 during an activity.
*She had not wanted resident 31 to touch the napkins she had been folding.
-She hit resident 31 with a closed fist.
*The two ladies had been separated.
*Resident 31 was taken to the nurse to be evaluated.
*Incident had been reported to the charge nurse.
*No injury had been noted to either resident.
*Activity staff were to keep the residents separated to prevent future similar incidents.

b. On 4/26/18 at 6:15 p.m. an incident with an unidentified resident's husband.
*She had been in another resident's room holding that resident's blanket.
-The resident and her husband entered the room.
-The husband hollered at the her to put the blanket down and leave the room.
*She approached him and kicked him in the shin.
-He attempted to close the door to separate them when staff approached.
*She left the resident's room without saying a word and walked toward the dining hall.
*She was to be watched and redirected when found entering other residents' rooms.
-Care team was to discuss incident with the psychologist during her visit on 5/3/18.
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<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>F 600</td>
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<td>c.</td>
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<td>On 9/27/18 at 8:30 a.m. an incident where she had been hit by another resident.</td>
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<td>*She had been at the table in the dining room.</td>
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<td></td>
<td>*She grabbed the unidentified resident's silverware.</td>
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<td>*&quot;He took his fist and hit down on her hand.&quot;</td>
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<td>*Incident had been witnessed by staff.</td>
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<td>*The unidentified resident had been removed from the table.</td>
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<td>*He had been asked to eat in his room.</td>
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<td>*He had been informed that kind of behavior was not appropriate.</td>
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<td>*He had been given options to sit at a different table.</td>
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<td>d.</td>
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<td>On 12/1/18 at 11:00 a.m. an incident with resident 31 in the hall.</td>
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<td>*Resident 31 had been standing in a doorway visiting with the dietary manager.</td>
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<td>*Resident 7 approached trying to enter the office.</td>
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<td></td>
<td>*Resident 31 grabbed resident 7's walker to keep her from coming in.</td>
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<td></td>
<td>*Resident 7 hit her with an opened hand on the left arm.</td>
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<td>*Resident 31 then hit resident 7 with an opened hand to the right arm.</td>
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<td>*The two residents were able to hit each other open handed approximately three to four times before staff were able to separate them.</td>
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<td></td>
<td>*No apparent injuries to either resident.</td>
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<td>e.</td>
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<td>On 1/24/19 at 7:00 p.m. an incident with an unidentified resident during Bingo.</td>
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<td>*She had swatted open handed at the unidentified resident when the bucket on the table was moved.</td>
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<td>*The unidentified resident stated she moved the bucket, and resident 7 was letting her know she</td>
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**SUMMARY STATEMENT OF DEFICIENCIES**

- No apparent injury to either resident.
- More closely during activities.
- Intervene as soon as possible.

f. On 3/13/19 at 3:00 p.m. an incident with resident 40 before church services.
- Resident 40 had been greeting residents before church by the doorway.
- Resident 7 came to the doorway and would not move.
- Resident 40 asked her to move out of the doorway nicely, and she would not move.
- The second time he asked her to move she turned toward him.
- With a closed fist she hit him in the upper arm while swaying and cussing at him.
- The incident had been witnessed by the activity manager but it had not been reported to the charge nurse.
- Resident 40 stated that he had not been hurt.

Review of the providers October 2018 Abuse and Neglect policy revealed:
- The purpose of the policy was to ensure that residents are not subjected to abuse by anyone, including but not limited to other residents.
- To ensure that all identified incidents of alleged or suspected abuse/neglect are promptly investigated and reported.
- To prevent future injuries.
- To intervene in any situation in order to protect residents.
- Remove any individual from the location if necessary for the protection of residents or employees, including but not limited to employees, visitors, contractors, or family members.
- The abuse/neglect policies and procedures...
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**X1 PROVIDER/SUPERVISOR/CLLA**
IDENTIFICATION NUMBER: 435101

**X2 MULTIPLE CONSTRUCTION**
A. BUILDING
B. WING

**X3 DATE SURVEY COMPLETED**
03/20/2019

**NAME OF PROVIDER OR SUPPLIER**
GOOD SAMARITAN SOCIETY CANTON

**STREET ADDRESS, CITY, STATE, ZIP CODE**
1222 NORTH DAKOTA AVENUE
CANTON, SD 57013

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>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</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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</thead>
<tbody>
<tr>
<td>F 600</td>
<td>Continued From page 8 cannot and do not guarantee that abuse will never occur. -To prevent such occurrences, all reasonable measures within their control will be taken. *If it is an allegation of resident-to-resident abuse, the residents will be separated immediately and both ensured a safe environment. *The physician and family will be notified regarding the facts of the situation. *The social worker and other employees, as appropriate would provide ongoing support and counseling to the resident and family as needed.</td>
<td>F 600</td>
<td>5/9/19</td>
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<tr>
<td>F 610</td>
<td>Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)(4)</td>
<td>F 610</td>
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- §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:
- §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.
- §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.
- §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:
  - Surveyor: 32335
  - Based on record review, interview, and policy review, the provider failed to ensure falls were

1. For resident #16 the care plan was reviewed and updated to reflect active and current interventions. The facility is not able to go back and do a thorough investigation of prior falls. The facility moving forward will complete a thorough investigation of all incidents, including falls by gathering the following information; the date and time the incident was reported, action taken to prevent recurrences of incident if possible, completion of the incident in PCC and the GSS 415 investigation, the GSS 409 fall scene huddle. Documentation will include last time resident was toileted, name of witnesses,
GOOD SAMARITAN SOCIETY CANTON

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<tbody>
<tr>
<td>F 610</td>
<td>Continued From page 9 thoroughly investigated and documented for one of two sampled residents (16) who had multiple falls. Findings include:</td>
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<tr>
<td></td>
<td>1. Review of resident 16's medical record revealed:</td>
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<td>*She was admitted on 9/9/17.</td>
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<td>*Her diagnoses included:</td>
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<td>-Parkinson's disease.</td>
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<td>-Dementia.</td>
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<td>-Contracture of bilateral hands.</td>
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<td>-Major depressive disorder.</td>
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<td>-Syncope.</td>
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<td>-Generalized anxiety disorder.</td>
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<td>*She had fallen on 12/6/18, twice on 12/14/18, 1/10/19, 1/13/19, 2/18/19, 2/17/19, and 3/14/19.</td>
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Review of the above fall investigation reports revealed they were not complete or thorough and had been missing some or all of the following information:

*The date and time the incident was reported.
*Corrective actions to prevent recurrence of that incident.
*Who was to complete the corrective actions that were selected to prevent recurrence of another fall incident.
*The last time toileted.
*Date of the investigation.
*Name of the witness, caregivers, or employees for the last seventy-two hours.
*No results of the investigation were noted.
*Staff action that included:
-The name of the last staff member that had contact with the resident.
-The time between last staff member contact and fall.
*No picture or diagram of the fall scene.
*Medications within the last eight hours.

caregivers or employees that had been in contact or providing care for the resident involved in the incident. Time between last staff member contact and time of incident or fall, use of the fall scene huddle to provide a diagram of the fall scene and medications that may have been administered within the last 8 hours. Summary of results or potential root cause of the fall and interventions taken to prevent a recurrence. Documentation should include statement made by resident and what they were doing prior to their fall.

2. For all other residents, the facility must ensure thorough investigation of all incidents including falls. The investigation will include the completion of GSS 415 and if a fall occurred, GSS 409 fall scene huddle. As part of the investigation the following information will be included; the date and time the incident was reported. Action taken to prevent recurrence of incident if possible. Completion of the incident, in PCC and the GSS 415 investigation, the GSS 409 fall scene huddle. Documentation to include last time resident was toileted, name of witnesses, caregivers or employees that had been in contact or provided care for the resident involved in the incident. Time between last staff member contact...
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<th>ID</th>
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<th>TAG</th>
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<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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| F 610 | Continued From page 10 | -The form was to be completed by the charge nurse by the end of her shift. No comments indicating the potential root cause of the fall and interventions taken to prevent another fall. Resident action indicating what the resident said they were doing before the fall. Missing signatures of the director of nursing services (DNS) and the social services designee. The fall scene huddle worksheet had an area to mark if the care plan was updated. It had not been checked on any of the above reports as an action that had been taken. 
Interview on 3/20/19 at 5:00 p.m. with the DNS revealed she agreed the above investigations had not been thorough or complete. Review of the provider's October 2018 Abuse and Neglect policy revealed: "To ensure that all identified incidents of alleged or suspected abuse/neglect are promptly investigated and reported."
"To ensure that all identified incidents involving injuries of unknown origin are promptly investigated to determine probable cause of unknown origin injuries."
"To ensure that a complete review of existing incidents is documented." |
| F 655 | Baseline Care Plan | CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide and time of incident or fall. Use of the fall scene huddle to provide a diagram of the fall scene and medications that may have been involved within the last 8 hours. Documentation should include comments made by residents and what they were doing prior to their fall. Falls committee will review care plans and update interventions effectiveness as needed. 3. IN-SERVICE TRAINING: The DNS, and or designee will educate all licensed nurses on GSS policy/ procedure on incident reporting, staff witness statements, resident statements if applicable and investigation. The required completion of GSS 415 (investigation) and GSS form 409 (Fall scene huddle worksheet) by 4/30/19. 4. AUDITS: The Administrator, DNS and Social Services will review each incident. The DNS and or Social Services will audit each incident to ensure the fall scene huddle GSS 409 was completed with each fall and the GSS 415 investigation was thoroughly completed with each incident. Audits will include any missing signatures. These audits will be done weekly x 4 weeks and monthly x 4 months. Audit findings will be reported and submitted to the QAPI committee monthly for further recommendations. 5. Date of Completion 5/9/19 |
**F 655** Continued From page 11 effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must:
(i) Be developed within 48 hours of a resident’s admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to:
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan:
(i) Is developed within 48 hours of the resident’s admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident’s medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by:
Surveyor: 35121

1. For #197 their baseline care plan, staff unable to go back and correct. The initial baseline care plan was made accessible at nurse station on 3/20/13 for all staff.
2. For all other residents the facility must develop and implement a baseline care plan for each resident at the time of admission. The initial care plan will be developed within 24 hours of admission, the baseline care plan must include the minimum health care information necessary to properly care for resident, including but not limited to initial goals, focus areas and interventions specific for that resident; based on admission orders, physician orders, dietary orders, therapy services, social services and mood/behaviors and PASARR recommendations if applicable. Baseline care plan will be made available to staff at nurses station after completion.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

436101

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ____________________________
B. WING ____________________________

(X3) DATE SURVEY COMPLETED

03/20/2019

NAME OF PROVIDER OR SUPPLIER

GOOD SAMARITAN SOCIETY CANTON

STREET ADDRESS, CITY, STATE, ZIP CODE

1022 NORTH DAKOTA AVENUE
CANTON, SD 57013

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LIC IDENTIFYING INFORMATION)

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 655 Continued From page 12
Based on observation, record review, interview, and policy review, the provider failed to ensure a baseline care plan was completed and available to staff to meet the needs for one of two newly admitted sampled residents (197). Findings include:

1. Observation and interview on 3/18/19 at 3:37 p.m. with resident 197 revealed he:
   * Had recently been hospitalized for treatment of a blood clot in his right leg.
   * Had dressings on his right leg and right foot.
   * Had blackened toes on that foot.
   -Stated he was told by his physician it was too soon to determine if they would need to be amputated.
   * Had right leg pain that would worsen when that leg was repositioned and when the dressings were changed.
   * Was not able to stand on his own at that time.
   -Too painful to bear weight on his right leg.
   -Had a history of Polio and did not have use of his left leg.

Review of resident 197's medical record revealed he:
   * Was admitted on 3/14/19 after hospitalization for blood clot treatment.
   * Had skin wounds on his right leg and foot that were healing. Those areas were cleaned and covered with gauze dressings two times a day.
   * Took pain medication twice a day and as needed that provided relief.
   * Required the use of a mechanical lift and the assistance of two staff when transferred from one surface area to another.

Review of resident 197's 3/14/19 computerized care plan revealed:

F 655 3. In-service training will include GSS policy procedures on care planning, developing the initial care plan, required information on the initial care plan and the care plan is to be accessible to caregivers.

4. AUDITS: The DNS and/or designee will audit completion of the initial care plan process with every new admission by the end of 48 hours of admission date and will make accessible to all staff at nurses station after completion. The audit will include the required information to be included in the initial care plan and the compliance of completion within 24 hours. Audits will be completed weekly x 4 weeks and monthly x 4 months. Audit findings will be reported to the QAPI committee monthly for further recommendations.
5. Date of Completion.
5/9/19
**F 655** Continued From page 13

"A focus area: "The resident has an ADL self care performance deficit R/T (SPECIFY) E/B (SPECIFY)."

-It was computer generated and had not been changed to be specific for this resident.

*Goal area was blank.

*The following interventions:

- "AMBULATION: non ambulatory.
- "BED MOBILITY: Position Up in Bed: Assist of 1 with left side assist bar."
- "BED MOBILITY: Turn from Side to Side: independent with left side assist bar."
- "BED MOBILITY: Lying to Sitting: assist of 1 with side assist bar."
- "BED MOBILITY: Sitting to Lying: independent with left side assist bar."
- "TRANSFER - Transfer Between Surfaces: total lift (M) with assist of 2."

*No further interventions.

Interview on 3/20/19 at 3:49 p.m. with the director of nursing services (DNS) regarding the initial care plan process revealed:

*The DNS, social services designee (SSD), or a nurse would routinely fill out a paper baseline care plan form on the day of admission or within forty-eight hours.

-That would be kept in a binder at the nurses' station for nursing and certified nurse aide (CNA) reference.

*A care plan was entered into the electronic medical record for the CNAs to use right away.

-Those care plans routinely only included transfer needs and fall prevention.

*A "bio" (summary) on new admissions would be completed and posted in the nurses' station or placed in the CNA communication binder for staff to review prior to resident's admission.

*Staff would be educated for resident specific...
**GOOD SAMARITAN SOCIETY CANTON**

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<td>F 655</td>
<td>Continued From page 14</td>
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<tr>
<td></td>
<td><em>She was unable to locate his baseline care plan or his bio/summary at the nurses' station. They were found in the SSD's office.</em></td>
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<td>Review of resident 197's undated paper baseline care plan, bio/summary, and continued interview with the DNS revealed:</td>
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<td><em>The disease/illness management section of his baseline care plan was check marked for post-surgical care, pain, weakness; it had &quot;polio LLE [left lower extremity]&quot; written on it.</em></td>
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<td>*The safety care section of his baseline care plan indicated he:</td>
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<td>- Had problems with ambulation and transfers.</td>
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<td>- Used a brace/splint and a wheelchair.</td>
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<td>- Needed the assistance of two staff with transfers.</td>
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<td>- Was to be encouraged to weight bear on his right leg.</td>
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<td><em>It did not address:</em></td>
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<td>- He had wounds and blackened toes on his right foot,</td>
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<td>- Where his pain was located,</td>
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<td>- Pain management interventions,</td>
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<td>- He was unable to bear weight on either leg,</td>
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<td>- He required a mechanical lift.</td>
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<td><em>His bio/summary stated:</em></td>
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<td>- He had been in the hospital and was treated for right leg deep vein thrombosis.</td>
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<td>- He had pain and weakness in that leg.</td>
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<td>- His left leg had been &quot;nonfunctioning since he was a child due to Polio.&quot;</td>
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<td>- He used a stand aids or slide board for transfers.</td>
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<td>- &quot;Lower leg/feet wounds/keep elevated AMAP [as much as possible].&quot;</td>
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<td><em>It did not address interventions for pain management, wound care, or that he had blackened toes.</em></td>
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</table>
Continued From page 15

*The DNS agreed his baseline care plan and bio/summary were not available for staff reference and did not accurately reflect his needs.

Review of the provider's revised November 2016 Care Plan policy revealed:

**"A 24-hour care plan will be developed upon admission. The location must provide the resident and resident representative with a summary of the 24-hour care plan."**

**"The care plan will emphasize the care and development of the whole person ensuring that the resident will receive appropriate care and services."**

**"It will address the relationship of items or services required and facility responsibility for providing these services."**

Care Plan Timing and Revision

CFR(s): 483.21(b)(2)(i)-(ii)

§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...
Continued From page 16
and their resident representative is determined
not practicable for the development of the
resident's care plan.
(F) Other appropriate staff or professionals in
disciplines as determined by the resident's needs
or as requested by the resident.
(iii) Reviewed and revised by the interdisciplinary
team after each assessment, including both the
comprehensive and quarterly review
assessments.
This REQUIREMENT is not met as evidenced by:
Surveyor: 32335
Surveyor: 40771
Based on interview, record review, and policy
review, the provider failed to update and revise
care plans to meet the resident's current needs
for 3 of 14 sampled residents (6, 16, and 30.)
Findings include:

1. Review of resident 8's medical record revealed
she had three falls from 12/1/18 through 3/7/19.
Her care plan had not been updated with new
interventions and had not reflected all of those
falls. Refer to F689, finding 1.

2. Review of resident 16's medical record
revealed she had eight falls from 12/1/18 through
3/14/19. Her care plan had not been updated with
new interventions since May 2018 and had not
reflected the most current falls. Refer to F689,
finding 2.

Surveyor: 35121
3. Review of resident 30's medical record
revealed she:
* Had a diagnosis of diabetes.

3) IN-SERVICE TRAINING: The
DNS and or designee will provide
education on GSS policy/procedure
for care planning and updating the
care plan to reflect the most current
status of the resident. This
education will be provided to the
nursing staff by 4/30/19 of these
expectations.
4) AUDIT: The Administrator,
Director of Nursing and Social
Services will audit weekly that
interventions were put into place
and review if the interventions were
effective.
Audits will be completed weekly x 4
weeks and monthly x 4 months for
compliance. The audit findings will
be submitted to QAPI committee
monthly for further recommendations.
4a) AUDIT: To achieve sustained
compliance Certified Dietary
Manager and or designee will audit
all nutritional focus areas by 4/30/19.
Upon each new admission the
nutritional focus area will be audited
within 14 days. These audits will be
completed weekly x 4 weeks and
monthly x 4 months and then
reviewed quarterly with MDS review.
Regarding resident #30, facility
updated care plan for altered
metabolism focus area. To achieve
sustained compliance MDS
Coordinator and or designee, upon
each new admission the metabolism
focus area will be audited within 14
days. These audits will continue
Good Samaritan Society Canton

436101

3/20/2019

57013

F 657 Continued From page 17

Received insulin on a scheduled basis and additionally based on blood sugar results prior to meals.

Review of her care plan revealed:

a. "A focus area: "The resident has potential for altered metabolism r/t Diabetes Mellitus."
   "A goal: "Resident will have no complications related to diabetes."
   "An intervention: "Licensed nurse to provide foot & nail care."
   "No further interventions were found regarding diabetes in that area of her care plan.

   "Diabetes was not identified in this focus area."
   "Goals to consume more than 75 percent of meals and to maintain weight."
   "Interventions: "Resident has order for a therapeutic diet."
   "The type of therapeutic diet was not identified."
   "Resident requests NOT to eat breakfast and does NOT want a breakfast tray sent to her room."
   "Invite resident to food-related activities and offer food, beverages of choice to encourage intake."
   ""HS [bedtime] SNACK PASS."
   "No further interventions were found regarding diabetes management in this area of her care plan.

Interview on 3/20/19 at 3:49 p.m. with the director of nursing (DON) regarding resident 30's care plan revealed she:

*Agreed it was not complete and accurate
<table>
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<th>ID</th>
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<tbody>
<tr>
<td>F 657</td>
<td>Continued From page 18 regarding her diabetic needs. &quot;Would have expected it to have included appropriate interventions regarding diabetes.</td>
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</table>

4. Review of the provider's reviewed November 2016 Care Plan Policy revealed:

- "Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial and educational needs."
- "...any problems, needs and concerns identified will be addressed."
- "The care plan will emphasize the care and development of the whole person ensuring that the resident will receive appropriate care and services."
- "It will address the relationship of items or services required and facility responsibility for providing these services."
- "This plan of care will be modified to reflect the care currently required/provided for the resident."

- Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)

- §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: 32335

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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<td>F 657</td>
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<tr>
<td>F 689</td>
<td>SS=E</td>
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<td>1) For resident #8 and #16 the care plan risk for falls has been updated and the care plan interventions have been reviewed and the care plan updated. 2) For all other residents, the care plan will focus on the risk or potential for falls risk and the care plan will be reviewed, updated to reflect each fall incident and interventions to prevent reoccurrence of this incident. 3) IN-SERVICE TRAINING: The DNS and/or designee will provide education on GSS policy/procedure for care planning and updating the</td>
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<td>F 689</td>
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<td>Surveyor: 40771</td>
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<td>Based on observation, interview, record review, and policy review, the provider failed to ensure interventions were implemented and updated for two of two sampled residents (8 and 16) who had multiple falls. Findings include:</td>
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<td>1. Review of resident 8’s medical record revealed:</td>
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<td>* She was admitted on 3/3/14.</td>
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<td></td>
<td>* Her diagnoses included:</td>
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<td></td>
<td>- Alzheimer’s disease.</td>
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<td></td>
<td>- Major depressive disorder.</td>
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<td>- Anxiety.</td>
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<td></td>
<td>- Dementia.</td>
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<td>- Type two diabetes.</td>
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<td>* She had falls on the following dates:</td>
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<td>- 7/12/18. She was found on the floor in front of her roommate’s recliner.</td>
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<td>- 12/2/18. Her roommate had called for help, and she was found on the floor halfway between her bed and the bathroom.</td>
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<td>- 12/15/18. She was found lying on her back on the floor with her head towards the bed.</td>
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<td>- 3/7/19. She tripped over the call light and hit the right side of her head causing a superficial cut.</td>
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<td>She also had a skin tear to her right elbow.</td>
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<td>Review of resident 8’s 10/9/18 annual Minimum Data Set (MDS) assessment revealed:</td>
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<td>* Her Brief Interview for Mental Status (BIMS) score was eight indicating her cognition was moderately impaired.</td>
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<td>* She had wandered one-to-three days during the assessment period.</td>
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<td>- That had worsened from the prior assessment.</td>
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<td>* She required limited assistance of one staff person for bed mobility, dressing, and personal care.</td>
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<td>care plan to reflect the most current status of the resident. This education will be provided to the nursing staff by 4/30/19 of these expectations.</td>
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<td>4) AUDITS: The Administrator, Director of Nursing and Social Services will audit weekly that interventions were put into place and review if the intervention was effective. Audits will be completed weekly x 4 weeks and monthly x 4 months for compliance. The audit findings will be submitted to QAPI committee monthly for further recommendations.</td>
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<td>5. Completion date 5/9/19</td>
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| F 689 | Continued From page 20 hygiene.  
*S She required extensive assistance of one staff person for toilet use.  
*S She required supervision of one staff person for transferring, walking, and eating.  
*S She was occasionally incontinent of bowel and bladder.  
*S She was not receiving any therapies.  
*S She had one fall with no injury since her prior 7/17/18 assessment.  
Review of resident 8's 1/2/19 MDS revealed:  
*S Her BIMS score was five indicating her cognition was severely impaired.  
*S She required limited assistance of one staff person for bed mobility, dressing, toilet use, and personal hygiene.  
*S She had two or more falls with no injury since her prior 10/9/18 assessment.  
*S She had one fall with injury since her prior 10/9/18 assessment.  
Observation and interview on 3/18/19 at 4:21 p.m. with resident 8 revealed:  
*S She was sitting in her room in her rocking chair sleeping.  
*S She woke up when surveyors knocked on the door.  
*S She was pleasant but confused when responding questions.  
-When asked questions she would respond with answers that were not applicable to the question.  
-She said she loved the surveyors when they left the room.  
-She asked the names of the surveyors during the conversation after she had been given the information upon entry into her room.  
Observation on 3/20/19 at 9:08 a.m. of resident 8. |
Continued From page 21

revealed she was sitting in her rocking chair sleeping. Her walker was beside the chair, and the call light was hanging on the drawer handle within reach.

Review of resident 8's 1/7/19 care plan revealed:
*Focus area: "The resident is at risk for falls, actual fall R/T [related to] weakness, hx [history] exit seeking behavior. Falls: 9/6/14, 11/30/17, 12/15/17, 7/12/18, 10/24/18, 12/2/18, and 12/15/18; revised on 1/2/19."

-Interventions included:
  --"Encourage resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility; revised on 4/1/14."
  --Revision date 12/4/18: "Ensure/provide a safe environment: Keep door open to room when unattended; gripper strips in front of bed, gripper socks at HS [bedtime]."

*There was no update to the care plan reflecting the 3/7/19 fall.

Review of resident 8's discontinued care plan interventions between 4/14/2014 through 3/20/19 for falls included the above interventions with minimal changes to the wording.

Her fall risk assessment tools were requested on 3/20/19 at 3:35 p.m. from the social services designee and had not been received by the end of the survey on 3/20/19 at 6:45 p.m.

Interview on 3/20/19 at 10:39 a.m. with licensed practical nurse (LPN) A regarding resident 8 revealed:
*She had days when she was more confused, and those days were when she had falls.
*She forgot to take her walker when getting up to
Continued from page 22

go to the bathroom or leave the room.
*She had days when she was confused and wanted to go home and leave the facility.

2. Review of resident 16's medical record revealed:
*She was admitted on 9/6/17.
*Her diagnoses included:
  - Parkinson's disease.
  - Dementia.
  - Contracture of bilateral hands.
  - Major depressive disorder.
  - Syncope.
  - Generalized anxiety disorder.
*She had falls on the following dates:
  - 12/5/18: She was going to the bathroom. The seat alarm went off, and staff arrived in the room and lowered her to the floor.
  - 12/14/18: She was found sitting on the floor in her bathroom. Staff had assisted her to the toilet and left her before she was done.
  - 12/14/18: Staff observed her rise from her recliner. When the alarm went off she attempted to sit back down. She missed the recliner and slid to the floor in front of the recliner. She had a scrape to her right knee.
  - 1/10/19: She was found on the floor of her room. Her wheelchair was on its side; she said she tripped over the pedals. She reported right and left leg pain.
  - 1/13/19: She was found on the floor of her room.
  - 2/16/19: She slid out of her recliner onto the floor.
  - 2/17/19: She was found on the floor in her bathroom.
  - 3/14/19: She was walking in her room and tripped over her wheelchair pedals.

Review of resident 16's 1/22/19 quarterly MDS
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

<table>
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<tr>
<th>Statement of Deficiencies and Plan of Correction</th>
<th>(X1) Provider/Supplier/CLIA Identification Number</th>
<th>(X2) Multiple Construction</th>
<th>(X3) Date Survey Completed</th>
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<td>435101</td>
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**Name of Provider or Supplier**  
GOOD SAMARITAN SOCIETY CANTON  
1022 NORTH DAKOTA AVENUE  
CANTON, SD 57013

**Street Address, City, State, ZIP Code**

<table>
<thead>
<tr>
<th>ID Prefix TAG</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>Provider’s Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
</tr>
</thead>
</table>
| F 689         | Continued From page 23 revealed:  
*She had a BIMS score of thirteen indicating she was cognitively intact.  
*She required extensive assistance of one staff person with dressing, transferring, bathing, and toileting.  
*She required limited assistance of another staff person with personal hygiene, moving on and off the unit, and walking in her room.  
*She was not steady and required assistance with balance during transitions and walking.  
*She was occasionally incontinent of bowel.  
*She used an alarm daily.  
*She did not receive any therapies.  
Review of resident 16’s 1/22/19 quarterly MDS assessment revealed she had two or more falls since the 10/30/18 MDS assessment. There were no changes to the level of assistance she required for activities of daily living.  
Interview and observation on 3/18/19 at 3:34 p.m. with resident 16 revealed:  
*She fell a week and half ago getting something out of her closet.  
*She said she was supposed to ask for help when she wanted to get up.  
*She indicated she had some falls, and they had put a "restriction" on her. It was an alarm that went off when she got up off her chair.  
*She said she had Parkinson’s, and she wanted to do things on her own.  
*She was sitting in her recliner with her feet up.  
*The call light was attached to the arm of the recliner.  
*There was a body pillow on the left side between her and the arm of the chair.  
*While in the room she stated she needed to use the bathroom. | F 689 |
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<th>F 689</th>
<th>Continued From page 24</th>
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| *She was asked if she could turn on the call light to notify staff.  
*She could not find the call light.  
*She was pointed to the call light pad that was attached to the recliner.  
*She indicated that was the call light; she did not push the button.  
*This surveyor physically moved the pad to under her hand and told her she could go ahead and push the button.  
*She said okay but appeared to be confused as to how to push the button, so this surveyor helped her push the button.  
*She waited three minutes for staff to come in and assist her.  
*There was no alarm on the recliner.  

Observation on 3/20/19 at 8:45 a.m. revealed she was sitting in the recliner with her feet up, the call light was on the arm of her chair, and her body pillow was on her bed.

Review of resident 16’s 1/23/19 care plan revealed:

*Focus area: “The resident is at risk for falls/actual fall R/T [related to] Parkinson’s Dx [diagnosis], Gait/balance problems, History of frequent falls, Psychoactive drug use, Unaware of safety need, syncope d/t [due to] orthostatic hypotension, fall 1/1/18, 1/20/18, 1/31/17, 2/1/18, 2/2/18, 5/18/18, 6/19/18, 3/1/18, 3/3/18, 4/12/18, 4/15/18, 4/25/18, 4/29/18, 5/7/18x2, 5/8/18, 5/18/18, 5/19/18, 7/1/18, 7/8/18, 9/4/18, 9/18/18, 10/10/18, 10/25/18, 11/25/18, 12/5/18, 12/14/18, 1/10/19, 1/13/19; revised on 1/23/19.”

Interventions included:

--“COGNITIVE: Encourage participation and plan diversional activities that are of resident’s interest; revised 9/18/17.”
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

(X(1) PROVIDER/SUPPLIER/CLA 
IDENTIFICATION NUMBER: 435101

(X(2) MULTIPLE CONSTRUCTION 
A. BUILDING 
B. WING 

(X(3) DATE SURVEY COMPLETED 

NAME OF PROVIDER OR SUPPLIER 
GOOD SAMARITAN SOCIETY CANTON

STREET ADDRESS, CITY, STATE, ZIP CODE 
1022 NORTH DAKOTA AVENUE 
CANTON, SD 57013

(X(4) ID 
PREFIX 
TAG

F 689 Continued From page 25
--"Remind resident not to bend over to pick up dropped items. Encourage use of grabber or to ask for assistance. Closet shelves height adjusted for resident ease; revised 3/8/18."
--"Encourage resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility such as: RNP; revised 12/6/17."
--"Ensure resident is wearing appropriate footwear: gripper socks or shoes at all times; revised 1/25/18."
--"ENVIRONMENTAL/PERSONAL SAFETY: antiroll back to w/c [wheelchair], toilet resident and provide assistance with ADL’s [activities of daily living] when resident finishes supper. Recheck resident after supper for any further ADL needs, SMART ALARM; revised 5/22/18."

*There was no revision to the care plan when the alarm was discontinued.
*The care plan was not updated with the February or March falls.
*There were no documented fall interventions after May 2018.
*Date of 1/31/17 for a fall is prior to her admission on 9/8/18.

Review of resident 16's discontinued interventions between 9/14/17 through 3/20/19 for falls included the above interventions with minimal changes to the wording.

Review of resident 16's falls tool assessment revealed she was at a medium and high risk for falls. There were thirteen assessments completed since 9/4/18 through this survey date.

Interview on 3/20/19 at 10:48 a.m. with LPN A regarding resident 16 revealed:
*She had an alarm she sat on, but she had
Continued From page 26

started ripping it apart, so it was discontinued.
*She was not happy with the alarm.
*She wanted to be able to do things on her own.
*She was trying to get things in her room, clean her room, and that was when she had fallen.
*She did not like to ask for help, because she wanted to do things on her own.
*She would use the call light sometimes but not always.

3. Interview on 3/20/19 at 2:00 p.m. with the social services designee and the director of nursing services (DNS) revealed:
*There was a limited number of interventions they could select from when creating or updating care plans.
*The options were general, and they had to go in and delete what was written to edit the interventions.
*The interventions they selected were not individualized for each resident.
*They could not identify the interventions that had been attempted since May 2018 for resident 16.

Interview on 3/20/19 at 4:08 p.m. with CNA B regarding residents 8 and 16 revealed:
*Upon start of her shift she would pick up and drop off water to all the residents, so she did a visual check at that time.
*She was unsure of how often residents were to be checked on but believed it was every hour.
*Resident 8 did not use her call light often, and she felt it was due to the resident being confused.
*She checked on resident 8 at least every two hours to see if she needed any assistance.
*Resident 8 was independent when using the bathroom but needed assistance with thoroughness of cleaning her perineal area.
*Resident 16 would use her call light for
F 689 Continued From page 27

bathrooming occasionally.
* Resident 16 would try to get up on her own, because she wanted to do things on her own.
* Resident 16 had an alarm on her chair, but that was discontinued.
* Resident 16 did not like the alarm and started tearing it apart.
* She checked on resident 16 more often than other more independent residents.
* There was no documentation to determine how often residents were being checked on.

Interview on 3/20/19 at 5:12 p.m. with the DNS revealed she:
* Agreed resident 16 was a high fall risk.
* Agreed resident 16 should not be left in the bathroom alone due to her fall risk.
* Agreed interventions were not documented.
* Stated she was aware falls were a problem, and she was working on coming up with ways to decrease the number of falls.
* She currently had no plan in place.

Reviewed of the provider's October 2017 Fall Prevention and Management policy revealed:
* Purpose stated:
  "To promote resident well-being by developing and implementing a fall prevention and management program."
  "To identify risk factors and implement interventions before a fall occurs."
  "To prevent further injury."
* All falls should have been documented on a form GSS#409 to start the investigation.
* Complete a Falls Tool UDA.
* Procedure number 18 stated: "Continue to monitor condition and the effectiveness of the interventions."
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Surveyor: 35121
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 3/18/19 through 3/20/19. Good Samaritan Society Canton was found in compliance.
**GOOD SAMARITAN SOCIETY CANTON**

**K 000 INITIAL COMMENTS**

A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/19/19. Good Samaritan Society Canton 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 upon correction of deficiencies identified at K300 in conjunction with the providers commitment to continued compliance with the fire safety standards.

**K 300 PROTECTION - OTHER CFR(s): NFPA 101**

Protection - Other

List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.

This REQUIREMENT is not met as evidenced by:

Surveyor: 27198

Based on observation, testing, and interview, the provider failed to maintain the fire-resistant rating for one of one randomly observed two-hour building separation wall (at the east end of the east wing before the east lounge addition).

Findings include:

**ABOVE FINDINGS AND CONCLUSIONS ARE DISCLOSEABLE 14 DAYS FOLLOWING THE DATE OF SURVEY OR THE DATE OF THE PLAN OF CORRECTION. IN ACCORDANCE WITH SD RULE 10-25-02, THESE DOCUMENTS ARE MADE AVAILABLE TO THE FACILITY IF DEFICIENCIES ARE NOT CORRECTED BY THE DATE SPECIFIED IN THE PLAN OF CORRECTION. ANY DEFICIENCY IDENTIFIED IN THUS SURVEY IS DISCLOSEABLE 90 DAYS FOLLOWING THE DATE OF SURVEY.**
### K 300

**Continued From page 1**

1. Observation and testing at 11:30 a.m. on 3/19/19 revealed the south leaf of the ninety-minute, cross-corridor doors in the two-hour, fire-rated separation wall between the east lounge addition and the east wing was not latching. That door leaf must latch to maintain the two-hour fire-rating of the wall assembly.

   Interview with the maintenance director at the time of the observation confirmed that finding. He stated he was unaware that condition existed.

   The deficiency could affect 100% of the occupants of the smoke compartments on either side of the fire-barrier.

### K 300

1. Regarding the south leaf on the ninety-minute, cross-corridor door in the two-hour, fire rated separation wall between the east lounge addition and the east wing, the identified latch was repaired 3/20/19 and is now working properly.
2. Regarding all other fire doors in the facility, no other doors were identified as not working properly.
3. Audits: To maintain sustained compliance, Environmental Service Director and or designee will audit all facility fire doors to ensure that they are functioning correctly. Audits will be completed 1 x month for 6 months. Results of audits will be submitted to QAPI committee monthly for review.
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<td>S 000</td>
<td>Compliance/Noncompliance Statement&lt;br&gt;Surveyor: 27198&lt;br&gt;A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44.73, Nursing Facilities, was conducted from 3/18/19 through 3/20/19. Good Samaritan Society Canton was found in compliance.</td>
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