F 000 INITIAL COMMENTS

Surveyor: 29354
An off-site complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/6/20 through 4/7/20. An on-site follow-up to the above 4/6/20 through 4/7/20 complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities was conducted on 11/9/20. Areas surveyed included accidents and neglect. Good Samaritan Society Canton was found not in compliance with the following requirements: F600, F610, and F842.

A COVID-19 Focused Infection Control Survey was conducted by the South Dakota Department of Health Licensure and Certification Office on 11/9/20. Good Samaritan Society Canton was found not in compliance with 42 CFR Part 483.80 infection control regulation: F860.

Good Samaritan Society Canton was found in compliance with 42 CFR Part 483.10 resident rights and 42 CFR Part 483.80 Infection control regulations: F550, F562, F563, F563, F862, F886, and F866.

Good Samaritan Society Canton was found in compliance with 42 CFR Part 483.73 related to E-0024(b)(6).

Total residents: 33
Free from Abuse and Neglect CFR(s): 483.12(a)(1)

§483.12 Freedom from Abuse, Neglect, and Exploitation

1. For resident #1 the care plan was updated to reflect total lift transfers assist of 2 on 3-24-2020 related to fall that day. The Facility is not able to go back and correct the event of 3-24-2020. The facility must ensure the staff know that a nurse must be called immediately when a resident is found on the floor, when a resident is...

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

TITLE Administrator

(xd) DATE 12-4-2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
F 600  Continued From page 1
The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident’s medical symptoms.

§483.12(a) The facility must-

§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
This REQUIREMENT is not met as evidenced by:
Surveyor: 29354
Surveyor: 35237
Based on record review, interview, job description review, and policy review, the provider failed to ensure resident safety for one of the sampled resident (1) who had a fracture identified on 3/24/20 from a previous off-site complaint health survey done on 4/6/20 through 4/7/20 after being assisted with a mechanical lift by two of two certified nursing assistants (CNA) (C and D). Findings include:

1. Review of the provider’s 3/24/20 South Dakota Department of Health (SD DOH) Online Self Reporting form for resident 1’s 3/24/20 event revealed:
   * The director of nursing (DON) had completed the form on 3/24/20.
   * The event occurred on 3/24/20 at 7:00 a.m., and it was considered a suspicion/allegation of abuse/neglect due to physical harm/injury.
   * The form indicated the resident was capable of providing an explanation of the event.

lowered to the floor, or fallen from a mechanical lift. The nurse will assess the resident, supervise the transfer from the floor and ensure resident safety. Staff will be educated regarding fall management and process by 5-1-2020. Falls committee was educated about the root cause analysis (RCA) on 4-16-20 for investigation phase after a fall occurs with major injury. Falls committee completed a root cause analysis (RCA) on 4-16-2020.
2. For all other potential residents that may be involved in abuse and neglect related to falls with major injury; The facility staff will continue to do sit-stand-walk UDA upon admission, quarterly, annually and with significant changes to identify appropriate mechanical lift for that resident.
Staff completing the sit-stand-walk UDA will immediately update the care plan after completion of this UDA. Staff will notify charge nurse immediately after the resident is safe on the floor to have nurse assess resident as fall policy and procedure states. Nursing staff will be re-educated about proper policy and procedure after a fall has occurred by 5-7-2020.
3. Facility staff will monitor for compliance with annual training
**Summary Statement of Deficiency**

- "CNA reports to nurse when transferring resident using the sit to stand [mechanical lift] resident's arms gave way/slipped causing him to slip and he was then lowered to the floor. CNA also stated resident did not hit his head during incident. Resident states 'my arms slipped.' Asked resident upon return from ER [emergency room] visit about how he hurt his shoulder. Resident stated 'What do you mean, I didn't get hurt.' Unable to remember/explain incident today. Resident was assessed for injuries, VS [vital signs] and ROM [range of motion] done. VS are WNL [within normal limits]. Resident c/o [complained of] severe pain to his right upper arm up to his right shoulder area. He is not letting nurse do ROM to that area. Other ROM to rest of his body is WNL. Notified Physician on call-[name], NP [nurse practitioner] and she ordered to have resident seen in the ER today. Family, [administrator name] and [DON name] notified."

- "The conclusion summary statement of the facility investigation was:"

- "During investigation it was noted staff was using sit to stand properly and following care plan. Staff member has been certified with proper lift use within the past 12 months. Staff stated that during transfer he was fine in the lift and then suddenly his arms gave out and he started to slip and staff lowered to the floor to prevent further injury. Last evaluation of transfer appropriateness was done by a nurse on 1/20/20 and sit to stand was appropriate at that time. No documentation noted that resident/staff had concerns with safety with transfers since assessment."

- "Intervention: Sent to ER and scapula of staff about falls through computer education via eLearning annually. Facility staff utilizing lifts will complete the safe resident handling validations annually and with new employees. Staff will continue to complete the mechanical lift audit for proper functioning of lifts monthly. Staff will continue to take lifts out of service the moment the mechanical lift was known to not be working properly. Falls committee was educated on RCA on 4-16-20. Falls committee completed a RCA on 4-16-20 for resident #1. Coach counseling will be provided to nurse aide C, D and Nurse E about this incident and placed in their employee files by 5-1-2020.

4. Safety committee or designee will do audits that the RCA has been completed after each fall with major injury and audit that the nurse assessed resident prior to transferring off of the floor per policy and procedure after a fall occurs for 6 months and give report to QAPI committee after completion. Facility clinical educator will audit compliance with annual falls training and safe resident handling validations annually and with new employees and will give audits to AAPI committee for 6 months.

5. See above for dates of completion on above changes.

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**Facility: Good Samaritan Society Canton**

**Date:** 11/09/2020

**Address:**

1022 North Dakota Avenue
Canton, SD 57013

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**ID Tag:**

- (x4) ID Prefix: F 600
- (x5) Completion Date: 

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F 600  Continued From page 3
fracture/dislocation. Care plan updated with Total lift with assist of 2 with transfers. Staff on floor currently notified verbally as well."
-"Emailed proof of Facility investigation notes - ER documentation - Care plan - Resident lift assessment completed in January 2020 - Last lift competency completed for aide involved."
""No" was selected for if abuse/neglect allegation was substantiated due to lift was used properly.
*Action taken by facility was: 
-"Care plan reviewed/revised."
-"Personnel education."
*There was no mention of: 
-How the resident had been gotten up from the floor and sent to the ER.
-If there were any concerns found with the mechanical lift that was used.
-What personnel education was given.
-If any other personnel were involved in the event.

Review of resident 1's medical records submitted by the provider with the above report revealed:
*His current care plan indicated: 
-He had been admitted in June 2017.
-His diagnoses and health condition included: 
--Parkinson's disease, history of a stroke, peripheral vascular disease, arthritis, severe cognitive impairment, hearing loss, insomnia, behaviors, and a left foot nodule, and skin lesions.
-Transfers had been revised on 3/24/20 to be completed with the total mechanical lift and two staff.
--Previously it had been to use the sit-to-stand mechanical lift with one staff person since 7/23/19.
-He had falls on 7/23/19, 7/26/19, and on 3/24/20.
*The 3/24/20 ER visit notes, x-ray, and computed tomography scan results included:

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<td>-He was seen for a fall with arm pain and diagnosed with a closed, displaced fracture of the right scapula.</td>
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<td>-The physician's orders included to use ice every three to four hours and hydrocodone medication as needed for pain.</td>
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<td>*The 3/24/20 incident report included:</td>
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<td>-The nursing and resident description were the same as the brief explanation in the above SD DOH Online Self Report.</td>
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<td>-&quot;No apparent unsafe condition&quot; was marked for predisposing environment factors.</td>
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<td>--Options that could have been marked included if equipment/assistive devices were involved.</td>
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<td>-The only predisposing physiological factors marked were impaired memory and confused.</td>
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<td>--Options that could have been marked included if the resident had a recent illness or recent changes in medications.</td>
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<td>-The only predisposing situation factor marked was &quot;Other (specify in Other information)&quot;.</td>
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<td>--Options that could have been marked included if a mechanical lift or equipment was used.</td>
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<td>-Other information was: &quot;Resident's arms gave way/slipped when using sit to stand while transferring resident.&quot;</td>
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<td>-There were no witnesses identified or listed.</td>
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<td>-The form indicated the physician, resident's family, DON, and administrator were all notified on 3/24/20.</td>
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<td>*A 1/20/20 Sit-Stand-Walk Data Collection Tool indicated he would be transferred using the sit-to-stand mechanical lift with assistance of one staff person.</td>
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<td>-That had been completed by Minimum Data Set (MDS) assessment coordinator nurse F.</td>
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<td>*CNA C's Safe Resident Handling Equipment Competency Validation Checklist had been completed on 7/1/19.</td>
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Phone interview and entrance conference review on 4/6/20 at 11:15 a.m. with administrator A and DON B revealed:

*They confirmed they had reported resident 1's 3/24/20 fall that had resulted in a scapula fracture to the SD DOH on the day of the fall.

*That one report had been the initial and final report combined.

*The surveyors requested access to the resident's medical record, to interview the staff involved with that event, and for several other documents relevant to the investigation including:

-Manufacturer's recommendations for the mechanical lift used in the incident on 3/24/20 with resident 1.

-If CNA C had any prior disciplines or re-education and where she received her certification.

-Who usually completed the transfer tool that was completed on 1/20/20.

-Resident 1's restorative sheets from 3/1/20 through 3/24/20, if there were any therapist notes from 3/1/20 through 3/24/20, medication and treatment administration records from 3/1/20 through 3/24/20, physicians' orders from 1/1/20 through 3/31/20, and nursing progress notes from 3/1/20 through 3/31/20.

-If resident 1 had any other falls in the past six months, if so to include the incident reports and/or any investigations.

-If any other residents had falls from any mechanical lifts in the past six months.

-Preventative maintenance plan: include documentation on when and how often mechanical lifts were checked for safety, and specifically the mechanical lift used in the incident on 3/24/20 with resident 1.

-Documentation and sign-in sheet for all staff who
GOOD SAMARITAN SOCIETY CANTON

F 600
Continued From page 6
operate a mechanical lift and include education material used and competencies completed.
- Policies and procedures: mechanical lift (specific to the one used in the 3/24/20 incident), accident prevention, and falls.
- Quality assurance performance improvement projects (QAPI) being monitored for past six months.

Phone interview on 4/6/20 at 2:00 p.m. with MDS coordinator nurse F regarding resident 1's falls and assessments revealed:
* She had been working at the facility less than a year and completed the residents' MDS assessments.
* When asked about mechanical lift assessments for the residents she indicated she was not responsible and "usually therapy drives that."
* She confirmed she had completed the 1/20/20 Sit-Stand-Walk Data Collection Tool that indicated the resident should have been transferred using a sit-to-stand lift with one staff person for assistance.
* The Sit-Stand-Walk Data Collection Tool was done quarterly, on admission or re-admission, and with significant changes for all residents.
* She stated it was "just a tool" that was done by the nurse.
* If there was a concern they would refer to therapy.
* She stated there was a safe handling program, and therapy was involved.
* Assessments should have been completed to ensure safe transfers.
* She was unsure if resident 1 had seen therapy recently.
* He was on a restorative nursing program for active ROM and transfers.
* She worked as a floor nurse also and watched...
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<td>F 600</td>
<td>Continued From page 7 resident transfers to do the data tools. *She confirmed resident 1 had a history of a stroke and was at risk for falls. -She was not aware of him having an affected side or weakness related to that. -She felt he was able to use both of his arms/hands to hold onto the lift and was able to bear weight on both of his legs. *She was not aware of: -His cognition changing throughout the day or if he had an change in condition prior to the 3/24/20 incident. -Him ever letting go of the lift prior to that fall or having any issues prior to that fall. -What occurred with his previous falls in July 2019. *She indicated she did not assist with incident investigations. On 4/6/20 at 2:56 p.m. an email was sent to administrator A requesting further information regarding resident 1’s falls in July 2019; policies related to abuse, neglect, investigations; and the safe handling program. Review of resident 1’s electronic medical record (EMR) revealed: *Sit-Stand-Walk Data Collection Tools had been done by nurses on the following dates: -4/24/19 quarterly: indicated for transfers to use a stand aid, if unsuccessful use sit-to-stand lift with one staff person assist. -7/18/19 quarterly: same as April. -7/23/19 change in condition: changed transfers to using the sit-to-stand lift with one staff person assist. -10/17/19 quarterly: same as July. -1/20/20 quarterly: same as July. *His interdisciplinary and nursing progress notes</td>
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F 600

Included:

- On 7/23/19 at 4:25 p.m.: he fell when he let go of the stand aid while being assisted by staff.
- The intervention was: "Resident is to use the sit-to-stand with all further transfers. CP [care plan] updated."
- On 7/26/19 at 12:15 p.m.: he had another fall when staff were using the stand aid to assist him with a transfer.
- The intervention was personnel education on proper lift to use.
- On 3/4/20: new orders to start on quetiapine 25 milligrams (mg) twice daily for Parkinson's dementia with behaviors.
- He started the medication that evening.
- On 3/14/20: he was sleepy and hard to wake up for lunch.
- On 3/15/20: he yelled out many times but his eyes were closed and he was resting in a recliner sleeping during lunch.
- On 3/16/20: he was yelling out during the night with eyes closed.
- On 3/18/20:
  - At 9:55 a.m.: "Resident temp [temperature] earlier this am was 100.2. His O2 sats [oxygen saturation] are 89% RA [room air]. LS [lung sounds] are diminished. No coughing noted ...."
  - At 11:53 a.m.: quetiapine was discontinued due to excessive sleepiness and no improvement in moods.
  - A weight change note indicated he had a slight weight loss which was due to having flu like symptoms.
- On 3/19/20:
  - At 1:18 p.m.: he was more alert and no longer had a temperature.
  - At 3:15 p.m.: the physician saw him on rounds with no new orders indicated.
  - There were no notes from 3/22/20 at 1:20 p.m.
F 600

Through the fall note on 3/24/20 at 10:35 a.m. that stated:

- "CNA reports to nurse when transferring resident using the sit to stand resident's arms gave way/slipped causing him to slip and he was then lowered to the floor. CNA also stated resident did not hit his head during. Resident states 'my arms slipped' Resident was assessed for injuries, VS and ROM done. VS are WNL. Resident is c/o severe pain to his right upper arm up to his right shoulder area. He is not letting nurse do ROM to that area. Other ROM to rest of his body is WNL. Notified Physician on call- [name] and she ordered to have resident seen in the ER today. Family, [administrator] and [name] DON."

-- The above was the same note as the brief description on the 3/24/20 SD DOH online report and in the 3/24/20 incident report.

-- There was no indication of what time the actual fall occurred, where he was at the time of the fall, if any concerns were identified with the mechanical lift or transfer, if he bumped anything during the fall, how he had been gotten up off the floor, or the timeline of the events that occurred during and after the incident.

- On 3/24/20:
  -- At 10:38 a.m.: resident left to the ER per provider transport.
  -- At 11:34 a.m.: the consultant pharmacist note of "...resident to hosp er [hospital ER] today. Shoulder, arm pain. 3/19 MD [medical doctor] rounded, no med changes. Tried Seroquel [quetiapine] 3/4-3/18 for dementia with behaviors, discontinued, too sleepy. No recommendations."
  -- At 1:03 p.m.: "Received phone call at 1255pm from [name] and they report resident does have a fractured right scapula. He will be returning with a sling and new orders."
  -- At 1:11 p.m.: the resident's son was notified.
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| Continued From page 10: | --At 2:24 p.m.: he returned from the ER with new orders for ice, hydrocodone as needed for pain, and could apply sling for comfort. *In the above interdisciplinary notes there was evidence supporting he had:  
- Recent medication changes.  
- Experienced a change in condition with his sleepiness, weight loss, and flu like symptoms.  
- A history of falls related to staff transferring him with lifts or equipment.  
-- The above items were not listed as predisposing factors on his incident report or the SD DOH report.  

Phone interview on 4/7/20 at 10:00 a.m. with CNA C regarding resident 1's incident on 3/24/20 revealed:  
*She was assisting him with morning care in his room that day.  
- He seemed to be his usual self.  
*She had his upper body dressed and was planning to dress his lower half while he was standing in the sit-to-stand mechanical lift, and then she would move him from his bed to his recliner using the lift.  
*She got him situated and hooked up to the lift according to her usual process.  
- She had not used the leg strap, because he normally had not had an issue with moving his legs.  
*She indicated sometimes she used the leg strap and sometimes she did not depending on the resident.  
*Usually he stood up in the lift appropriately and used both hands to hang onto the handles.  
*She stated that morning while he was standing up in the lift all of a sudden his legs went up in the air, his arms went up, and he started slipping down. |
### Good Samaritan Society Canton

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- *She indicated he did not fall out of the lift, but she had to lower him down with the lift and then all the way to the floor.*
- *She had not seen him hit or bump anything when he was lowered to the floor.*
- *While she was lowering him down to the floor CNA D came into the room.*
- *CNA C had not called anyone for help yet, and she was unsure why CNA D had come into the room at that time.*
- *She indicated CNA D helped her with the resident when she noticed what was happening.*
- *CNA C stated she had called the nurse on the walkie-talkie, but the nurse was busy at the time, so the CNAs just got him up into his recliner.*
- *She stated they used the total mechanical lift to get him up off the floor since he seemed very uncomfortable.*
- *After the resident was up in his recliner the nurse came in to check on him and stated "his arm was not right."*
- *They assisted with getting his vital signs while the nurse called the physician.*
- *The staff then used the total mechanical lift to get him into his wheelchair, and facility staff took him to the ER.*
- *She indicated the resident appeared to be in pain when he was lowered to the floor and when he was on the floor.*
- *When asked why they got the resident up off the floor and into the recliner without the nurse coming in to check him out first she stated because the nurse was busy.*
- *Normal practice if a resident fell or incident occurred was for the nurse to assess them first before moving them.*
- *She indicated there was an emergency call light they could have put on when there was an incident or a resident was on the floor.*
**NAME OF PROVIDER OR SUPPLIER**

GOOD SAMARITAN SOCIETY CANTON

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

1022 NORTH DAKOTA AVENUE
CANTON, SD 57013

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| F 600         | Continued From page 12
*They had not used that.  
*The decision to get him up into the recliner was made by the CNAs.  
*She was not sure if they had told the nurse he was in pain or not when they initially called her.  
*She stated he just seemed very uncomfortable and restless and wanted off the floor, so they did that.  
*She had not indicated she had been educated further on what occurred with the resident's incident or his safety. 

On 4/7/20 at 9:30 a.m. an email request was made to administrator A for further evidence related to resident 1's investigation for the 3/24/20 incident. At 10:00 a.m. that information was received and revealed: 
*It was signed by the DON, administrator, and social services designee on 3/24/20.  
*There was no evidence of CNA D having been involved at all.  
*There was no mention of how the resident was gotten up off the floor.  
*There were missing details to ensure a complete and thorough investigation had been done to rule out abuse or neglect and ensure the resident's safety. 

On 4/7/20 at 10:23 a.m. an email request was made to administrator A to set-up an interview time for CNA D to speak with the surveyors. 

Phone interview on 4/7/20 at 10:30 a.m. with licensed practical nurse (LPN) E regarding resident 1 revealed:  
*She had been working the day shift on 3/24/20 and was assigned the resident's unit that day.  
*There was another nurse working in the building also at the time of the incident.
Continued From page 13

*She stated she found out about the incident when CNA D came to her and reported the resident had slipped from the sit-to-stand lift and was lowered to the floor.
-CNA D told her in-person not over the walkie talkie.
*When she found out about the incident she went in to check on the resident, and he was already in his recliner.
*She stated no one had contacted her prior to moving him from the floor to the recliner.
-She had not instructed them to get him up off the floor.
-Usually staff got the nurse to assess the resident first prior to moving them.
--She was unsure why they had not reported it to her right away, so she could assess him and possibly prevent further injury.
*When she got to his room she completed an assessment including vital signs and ROM.
-She had not done neurological checks, because she was told he had not hit his head.
*During her assessment she noted something was wrong with his shoulder, and he had pain in his right arm.
*She then sent a fax and called the clinic, and the practitioner indicated he should be sent to the ER.
*The facility staff took him to the ER in their facility bus.
*She had not seen any of the resident's transfers by the CNAs that day during or following the incident.
-She thought they used a total lift to get him from the recliner back into his wheelchair.
*His cognition varied, and he would not remember or be able to explain what happened that day.
-At the time she assessed him he did complain of
**GOOD SAMARITAN SOCIETY CANTON**

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| F 600 | Continued from page 14 | **right arm pain.**  
*It was policy for the staff to notify the nurse first when an incident occurred prior to moving the resident.  
-There was a risk for further injury to the resident without proper assessment.  
*She had told the CNAs that day they should not have moved him without telling her first, but she was unaware if they had further re-education.  
*She confirmed the documentation in his EMR had not supported:  
-The correct time of the fall or the timeline of events that morning.  
-How the resident had been gotten up from the floor.  
-Details of what had occurred during the incident and following the incident regarding his safety.  

Phone interview on 4/7/20 at 11:00 a.m. with CNA D regarding resident 1's 3/24/20 incident revealed:  
*She had been working in the facility since 2013.  
-She worked primarily day shifts and did resident baths along with working on the floor.  
*On 3/24/20 she was working with giving baths and went to the hallway looking for another staff person to help her with a resident in the bathing room.  
*She went into resident 1's room since she knew a staff member was in there.  
-When she entered resident 1's room she saw him hanging by his arms on the sit-to-stand lift with his knees on the floor.  
-She stated CNA C asked her for help.  
*They lifted him up using his pants to get the hooks undone from under his arms, and then lifted him to his bed.  
-He stated they could not use the lift to move
Continued From page 15

him up or down because of how he was hanging.  
She stated he was not laid down or lowered to the floor other than when he was on his knees when she came into the room.  
She stated he had been incontinent of bowel, so they cleaned him up.  
Then they used the same sit-to-stand lift and moved him to the recliner from his bed.  
After they had him sitting in the recliner she went to tell LPN E.  
She could not tell if he was in pain when they were helping him other than when he was hanging in the lift.  
She was unsure who made the decision to move him from the bed to the recliner, if it was he or CNA C.  
When asked if CNAs normally made the decision of moving a resident after an incident she stated no.  
She confirmed the CNAs had made the call to get him out of the lift, to the bed, and then to the recliner without telling the nurse until afterward.  
She felt they just "reacted."  
Normally if a resident was on the floor the staff would have put the emergency light on and waited until the nurse got there to do the assessment.  
They had not done that.  
She was not in the room when the nurse assessed him and did not help with the other transfer after he was in the recliner.  
The day of the incident only LPN E asked her what happened.  
No one else followed-up with her after that until she was told the surveyors were going to talk to her.  
The staff had walkie-talkies for communication, but she had not had hers with her at the time of that incident.
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| F 600        | Continued From page 16  
*She was unsure if CNA C had hers that day.  
*They could have used the walkie-talkie to contact the nurse.  
*She was not aware if he had any concerns with using the lift prior to that incident.  
-Normally he was transferred using the sit-to-stand lift with one staff person.  
Phone interview on 4/7/20 at 1:30 p.m. with administrator A and DON B regarding the above concerns:  
*For investigations into resident incidents:  
-The immediate discussion/documentation was done by the CNAs and nurses or whoever was working at the time of the event.  
-After that the falls committee reviewed all incidents.  
--The falls committee included the DON, administrator, and social services designee.  
-The full investigations were done by the falls committee members.  
*DON B indicated for investigations she talked to the staff involved.  
*For the 3/24/20 incident with resident 1 she indicated:  
-LPN E did the education with CNA C.  
--DON B had not talked to CNA C about the event at all.  
-She had talked to LPN E and CNA D later that day.  
--Those verbal interactions were not specifically documented in the investigation records.  
*Regarding the 3/24/20 incident for resident 1 DON B stated she was told:  
-CNA C was transferring him with the sit-to-stand lift and during the transfer his arms went out.  
-He was on his knees and still attached to the lift when CNA D came into the room.  
-The CNAs pulled him up with his jeans onto | F 600 | | | |
F 600 Continued From page 17

edge of the bed, and then moved him to his recliner.

-Shortly after that they told the nurse about the incident and she then came in to assess him.

*She confirmed all those details above were not mentioned in the SD DOH report, incident report, EMR, or the investigation notes.

*When asked about completing a thorough investigation into the incident she avoided the question.

-She stated she "was well aware of it happening."

*She confirmed the full details were not documented in the investigation notes.

*When asked about the completeness of the documentation in the EMR she did not answer.

*The surveyors discussed the differences in the staff members' interviews related to the incident.

-The parts that matched were the resident having an incident while in the sit-to-stand lift and the CNAs moving him to the recliner prior to the nurse being notified.

*She was told he was on the edge of the bed, so they moved him right away.

-She was not aware they assisted him with incontinence care prior to using the same lift he had just had an incident with to move him from the bed to the recliner.

*When asked if the CNAs should have moved the resident without talking to the nurse first she did not answer.

*When asked if staff had followed their policy for a resident who fell she stated they moved him right away from the edge of the bed to the recliner and would not answer the question directly.

*She confirmed staff could have used walkie-talkies and/or the emergency light to get a hold of other staff or a nurse when they needed help.

*Administrator A confirmed:
**Good Samaritan Society Canton**

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| F 600         | Continued From page 18  
- He was a part of the falls committee and was aware of the 3/24/20 incident for resident 1.  
- He stated the CNAs made a poor choice of judgement.  
- They “missed some steps here” when he was referring to the investigation and documentation.  
*DON B indicated she was aware staff had used the sit-to-stand lift to move him from the edge of his bed to the recliner which was after he had the incident of slipping down in it.  
- There was no re-education or discipline done for the staff involved.  
*They confirmed the facility had been cited during their last recertification survey in March 2019 for investigations.  
- They felt they had been doing well and still had falls as part of their QAPI process.  
*Administrator A felt the current situation in the nation and world could have impacted how this event was handled and investigated.  
*DON B felt the investigation had been complete, and she was not aware the staff had different versions of what happened during the event.  
- She felt her verbal interactions with them had covered what had occurred.  
*She confirmed CNA D was not listed anywhere as part of the investigation or incident reports.  
- She had not thought she should have mentioned CNA D as a witness or with the investigation.  
*After further discussion she confirmed CNA C, CNA D, and LPN E all should have been questioned through the investigation process as to what had occurred related to the event and the resident’s safety.  
*They had not completed a thorough investigation of the entire event to rule out abuse and neglect and ensure resident safety during transfers using lifts. |
F 600  Continued From page 19
Surveyor 29354
Review of the provider’s July 2017 Falls-Mechanical Lift/Transfers policy revealed:
""Manually lifting a fallen resident from the floor increases the risk of injury to both the resident and the caregiver.
-To ensure safe transfer for a fallen resident, the following steps should take place:
--2. The licensed nurse should evaluate the resident while on floor and determine if the resident has injuries that indicate the resident should not be moved.
--3. Use the total lift to assist an uninjured fallen resident from the floor. Avoid manual lifting."

Review of the provider’s May 2019 Incident Report policy revealed:
""Purpose:
-To document resident and visitor incidents.
-To conduct an investigation of each resident.
-To gather objective information and identify root causes to prevent similar occurrences from happening in the future."

Review of the provider’s October 2018 Abuse and Neglect policy revealed:
""Purpose:
-To assure that employees are knowledgeable regarding the reporting and investigative process of abuse and neglect allegations in the location.
-To ensure that all identified incidents of alleged or suspected abuse/neglect are promptly investigated and reported.
-To prevent future injuries.
-To ensure that a complete review of existing incidents is documented.
-To identify events, such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse and to determine the
Continued From page 20

direction of the investigation."

Review of the provider's 8/16/16 Certified Nursing Assistant job description revealed:

"**Basic Responsibilities:
-This position will be held accountable for complying with all related laws, regulations, company policies and procedures pertaining to his or her position."

"**Physical/Mental Requirements:
-While performing the duties of this job, the employee will operate/activate/use/prepare/inspect/place/detect/position objects, tools, or controls.
- The employee will frequently communicate/express/observe/assess/detect information relative to this position.
- Must be able to effectively communicate in English, both orally and in writing."

Review of the provider's 8/17/16 Director of Nursing job description revealed:

"**Responsible to lead management and monitoring/auditing of the EMR (electronic medical record) in the location; to include training, documentation, reports/dashboards and retrieval management and monitoring/auditing.
- Assures plan of care and interventions are evaluated for effectiveness on an ongoing basis and adjusted and updated accordingly.
- Assures residents are free of neglect and abuse.
- Maintains thorough and accurate records for each resident."

Review of the provider's 8/16/16 Charge Nurse-LPN job description revealed: "Observes and documents observations and care given to residents."
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| F 600             | Continued From page 21
Review of the provider's undated Administrator job description revealed:

"An Administrator for the Society is responsible for the overall leadership and management of the location, including meeting established goals and outcomes, ensuring regulatory and organization compliance, directing and coordinating work." 

"Manages Communication and Documentation: 
- Ensures documentation and reports are completed as required by regulations and/or policy and procedure."

Interview and document review on 11/9/20 at 1:55 p.m with DON B regarding the above information revealed:

- They had not had any falls from lifts since the 4/7/20 off-site survey.
- They had made changes in their investigation process.
- The charge nurse had done the assessments.
- The certified nursing assistants had been educated on the fall process.
- There was a list of items staff were to do when a resident fell.
- They had completed audits on falls and were found to be compliant.
- They had followed their plan of correction from the 4/7/20 off-site survey.
- The process was ongoing and they were ensuring all pieces were completed.

Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(2) Have evidence that all alleged

1. For resident #1, fall committee completed a root cause analysis (RCA) on 4-16-2020. Coach counseling will be provided to nurse aide C, D and Nurse E about this incident and placed in their employee files by 5-1-2020.
2. For all other potential residents, nursing staff will be educated about proper documentation in risk management to include correct timeline of events that
| F 610 | Continued From page 22 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: 29354 Surveyor: 35237 Based on record review, interview, job description review, and policy review, the provider failed to thoroughly investigate an event for one of one sampled resident (1) who had a fracture identified after being assisted with a mechanical lift to rule out abuse and neglect. Findings include:

1. Review of the provider’s 3/24/20 South Dakota Department of Health (SD DOH) Online Self Reporting form for resident 1's 3/24/20 injury from a mechanical lift event revealed:
   a. The director of nursing (DON) had completed the form on 3/24/20.
   b. The event occurred on 3/24/20 at 7:00 a.m., and it was considered a suspicion/allegation of abuse/neglect due to physical harm/injury.
   c. The form indicated the resident was capable of providing an explanation of the event.
   d. The brief explanation included:
      - "CNA [certified nursing assistant] reports to nurse when transferring resident using the sit to
occurred. How resident got off the floor, fall interventions that were in place, if lift was involved; stating the mechanical lift was working properly, Any education that was provided to staff, include all staff that was part of the fall process, add any health concerns, recent falls and medication changes recently for falls with major injury. The falls committee was educated about root cause analysis (RCA) on 4-16-2020 to prevent future occurrences. Facility staff will provide coach counseling or written documentation for employee files that violated any policy and procedures by the 7th day after identified noncompliance of policy and procedure.
3. Falls committee will complete a root cause analysis (RCA) on every fall with major injury. Falls committee will include on state reportable after filling out the root cause analysis (RCA); Correct timeline of events that occurred, How resident got off the floor, fall interventions that were in place, if lift was involved; stating the mechanical lift was working properly, Any education that was provided to staff, include all staff that was part of the falls process, add any health concerns, recent falls, similar falls and medication
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| F 610             | Continued From page 23 stand resident's arms gave way/slipped causing him to slip and he was then lowered to the floor. CNA also stated resident did not hit his head during incident. Resident states 'my arms slipped.' Asked resident upon return from ER [emergency room] visit about how he hurt his shoulder. Resident stated 'What do you mean, I didn't get hurt.' Unable to remember/explain incident today. Resident was assessed for injuries, VS [vital signs] and ROM [range of motion] done. VS are WNL [within normal limits]. Resident c/o [complained of] severe pain to his right upper arm up to his right shoulder area. He is not letting nurse do ROM to that area. Other ROM to rest of his body is WNL. Notified Physician on call- [name], NP [nurse practitioner] and she ordered to have resident seen in the ER today. Family, [administrator name] and [DON name] notified.  
*The allegation involved CNA C with the section for previous disciplinary actions left blank. 
-She had been hired on 7/1/19.  
*The conclusionary summary statement of the facility investigation was:  
"During investigation it was noted staff was using sit to stand properly and following care plan. Staff member has been certified with proper lift use within the past 12 months. Staff stated that during transfer he was fine in the lift and then suddenly his arms gave out and he started to slip and staff lowered to the floor to prevent further injury. Last evaluation of transfer appropriateness was done by a nurse on 1/20/20 and sit to stand was appropriate at that time. No documentation noted that resident/staff had concerns with safety with transfers since assessment."  
-"Intervention: Sent to ER and scapula fracture/dislocation. Care plan updated with Total lift with assist of 2 with transfers. Staff on floor recently after each fall major injury.  
4. Safety committee or / designee will do audits that the root cause analysis (RCA) had been completed after each fall with major injury for 6 months and give report to QAPI committee after completion.  
5. See above for dates of completion on above changes. |
### F 610

Continued From page 24

- "Emailed proof of Facility investigation notes - ER documentation - Care plan - Resident lift assessment completed in January 2020 - Last lift competency completed for aide involved."
- "No" was selected for if abuse/neglect allegation was substantiated due to lift was used properly.
  - Action taken by facility was:
    - "Care plan reviewed/revised."
    - "Personnel education."
  - There were no mention of:
    - How the resident was gotten up from the floor and sent to ER.
    - If there were any concerns found with the mechanical lift that was used.
    - What personnel education was given.
    - If any other personnel were involved in the event.

Further record review and interviews throughout the survey on 4/8/20 from 11:15 a.m. through 6:30 p.m. and on 4/7/20 from 7:30 a.m. through 2:30 p.m. revealed concerns with the provider's investigation into resident 1's incident on 3/24/20 involving staff and a mechanical lift including what occurred in response to it.
  - The resident was cognitively impaired and not able to participate in the investigation.
  - There was missing documentation to support the details surrounding the event and response.
  - CNA D who had been involved in the event had not been identified in the investigation or documentation.
  - There had been no follow-up with staff or re-education when they had not followed the provider's policies regarding notifying the nurse for assessment prior to moving the resident.
  - The concerns identified showed a thorough investigation had not occurred to rule out abuse or neglect.
F 610 Continued From page 25

Refer to F600.

Surveyor 29354
Review of the provider's July 2017
Fails-Mechanical Lift/Transfers policy revealed:
"**Manually lifting a fallen resident from the floor
increases the risk of injury to both the resident
and the caregiver.
- To ensure safe transfer for a fallen resident, the
following steps should take place:
--1. The licensed nurse should evaluate the
resident while on floor and determine if the
resident has injuries that indicate the resident
should not be moved.
--2. Use the total lift to assist an uninjured fallen
resident from the floor. Avoid manual lifting."

Review of the provider's May 2019 Incident
Report policy revealed:
"**Purpose:
- To document resident and visitor incidents.
- To conduct an investigation of each resident.
- To gather objective information and identify root
causes to prevent similar occurrences from
happening in the future."

Review of the provider's October 2018 Abuse and
Neglect policy revealed:
"**Purpose:
- To assure that employees are knowledgeable
regarding the reporting and investigative process
of abuse and neglect allegations in the location.
- To ensure that all identified incidents of alleged
or suspected abuse/neglect are promptly
investigated and reported.
- To prevent future injuries.
- To ensure that a complete review of existing
incidents is documented.
- To identify events, such as suspicious bruising of
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| F 610 | Continued From page 26 residents, occurrences, patterns and trends that may constitute abuse and to determine the direction of the investigation."

Review of the provider's 8/16/16 Certified Nursing Assistant job description revealed:
"**Basic Responsibilities:**
- This position will be held accountable for complying with all related laws, regulations, company policies and procedures pertaining to his or her position."

"**Physical/Mental Requirements:**
- While performing the duties of this job, the employee will operate/activate/use/prepare/inspect/place/detect/position objects, tools, or controls.
- The employee will frequently communicate/express/observe/assess/detect information relative to this position.
- Must be able to effectively communicate in English, both orally and in writing."

Review of the provider's 8/17/16 Director of Nursing job description revealed:
"**Responsible to lead management and monitoring/auditing of the EMR (electronic medical record) in the location; to include training, documentation, reports/dashboards and retrieval management and monitoring/auditing.**
- Assures plan of care and interventions are evaluated for effectiveness on an ongoing basis and adjusted and updated accordingly.
- Assures residents are free of neglect and abuse.
- Maintains thorough and accurate records for each resident."

Review of the provider's 8/16/16 Charge Nurse-LPN (licensed practical nurse) job description revealed: "Observes and documents
NAME OF PROVIDER OR SUPPLIER
GOOD SAMARITAN SOCIETY CANTON

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| F 610             | Continued From page 27 observations and care given to residents."
                   | Review of the provider's undated Administrator job description revealed:
                   | ""An Administrator for the Society is responsible for the overall leadership and management of the location, including meeting established goals and outcomes, ensuring regulatory and organization compliance, directing and coordinating work."" 
                   | ""Manages Communication and Documentation:
                   | -Ensures documentation and reports are completed as required by regulations and/or policy and procedure."
                   | Interview and document review on 11/9/20 at 1:55 p.m. with DON B regarding the above information revealed:
                   | *They had not had any falls from lifts since the 4/7/20 off-site survey.
                   | *They had made changes in their investigation process since that incident.
                   | *Those changes had included:
                   | -The charge nurse had done the assessments.
                   | -The certified nursing assistants had been educated on the fall process.
                   | -There was a list of items staff were to do when a resident fell.
                   | -They had completed audits on falls and were found to be compliant.
                   | *They had followed their plan of correction from the 4/7/20 off-site survey.
                   | *The process was ongoing, and they were ensuring all pieces were completed.
                   | Resident Records - Identifiable Information CFR(§): 483.20(f)(5), 483.70(i)(1)-(5)
                   | §483.20(f)(5) Resident-identifiable information.
                   | (i) A facility may not release information that is 1. For resident #1, falls committee completed a root cause analysis (RCA) on 4-16-2020. Coach counseling will be provided to Nurse E about this incident and placed in their employee file by 5-1-2020.
                   | 12-9-20 |
2. For all other residents; the Falls committee will review EMR documentation and written witness statements to that fall included Correct timeline of events that occurred, How resident got off the floor, fall interventions that were in place, if lift was involved; stating the mechanical was working properly. Any education that was provided to staff, include all staff that was a part of the falls process add any health concerns, recent falls, similar falls and medication changes recently for all falls with major injury.

3. Nursing staff will be educated about proper documentation in risk management to include correct timeline of events that occurred. How resident got off the floor, fall interventions that were in place, if lift was involved; stating the mechanical lift was working properly. Any education that was provided to staff, include all staff; that was a part of the falls process, add any health concerns, recent falls, similar falls and medication changes recently for all falls with major injury by 5-7-2020. Falls committee will complete a root cause analysis (RCA) on every fall with major injury.

4. Safety committee will complete audit to verify a through risk management and root cause
| F 842 | Continued From page 29 record information against loss, destruction, or unauthorized use. |

$483.70(i)(4)$ Medical records must be retained for:
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

$483.70(i)(5)$ The medical record must contain:
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided:
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.

This REQUIREMENT is not met as evidenced by:
Surveyor: 29354

Surveyor: 35237
Based on interview, record review, and policy review, the provider failed to ensure one of one sampled resident (1) had complete documentation in his medical record related to an incident with a mechanical lift. Findings include:

1. Review of resident 1's medical record revealed incomplete or missing documentation related to the mechanical lift incident with resident 1 that occurred on 3/24/20 and the details surrounding it including:

- Analysis (RCA) was completed including Correct timeline of events that occurred. How resident got off the floor, fall interventions that were in place, if lift was involved; stating the mechanical lift was working properly. Any education that was provided to staff, include all staff that was a part of the falls process add any health concerns, recent falls, similar falls and medication changes recently for all falls with major injury.
5. See above for dates of completion on above changes.
F 842
Continued From page 30

*The time when the incident actually occurred was not mentioned.
-There was documentation at 10:35 a.m. which was an overall summary to cover the fall and notifications.
*There was no mention of how he had been assisted related to the above incident such as how he was gotten up.
*The 10:35 a.m. documentation had not supported:
-When the nursing assessment had occurred following the fall.
-How the resident was doing from the time of the fall until he was sent to the ER.
-When the family, physician, and others were notified and follow-up orders/responses were received.
*The documentation addressed at 10:38 a.m. he was taken to the emergency room by facility staff.

Review of the South Dakota Department of Health 3/24/20 online self-report, the 3/24/20 incident report, and other investigation notes regarding resident 1 revealed:
*The mechanical lift incident with the resident had occurred at 7:00 a.m. on 3/24/20.
*There were missing details to support a complete and thorough investigation had occurred and was documented.

Review of phone interviews during the off-site survey on 4/8/20 from 11:15 a.m. through 6:30 p.m. and on 4/7/20 from 7:30 a.m. through 2:30 p.m. confirmed there was missing documentation regarding the incident with resident 1 and the mechanical lift incident.

Refer to F600 and F610.
**NAME OF PROVIDER OR SUPPLIER**
GOOD SAMARITAN SOCIETY CANTON

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| F 842 | Continued From page 31  
Surveyor 29354  
Review of the provider's May 2019 Incident Report policy revealed:  
"Purpose:
- To document resident and visitor incidents.
- To conduct an investigation of each resident.
- To gather objective information and identify root causes to prevent similar occurrences from happening in the future."

Review of the provider's October 2018 Abuse and Neglect policy revealed:  
"Purpose:
- To assure that employees are knowledgeable regarding the reporting and investigative process of abuse and neglect allegations in the location.
- To ensure that all identified incidents of alleged or suspected abuse/neglect are promptly investigated and reported.
- To prevent future injuries.
- To ensure that a complete review of existing incidents is documented.
- To identify events, such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse and to determine the direction of the investigation."

Interview and document review on 11/9/20 at 1:55 p.m. with DON B regarding the above information revealed:
  * They had made changes in their investigation process.
  * The charge nurse had done the assessments.
  * The certified nursing assistants had been educated on the fall process.
  * They had completed audits on falls and were found to be compliant.
  * They had followed their plan of correction from the 4/7/20 off-site survey. | F 842 | | | |
GOOD SAMARITAN SOCIETY CANTON

NAME OF PROVIDER OR SUPPLIER

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
(X1) PROVIDER/SUPPLIER/Clinical Laboratory Improvement
Identification Number:

435101

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

B. WING

(X3) DATE SURVEY COMPLETED
C

11/09/2020

ID PREFIX TAG

ID PREFIX TAG

(X4) ID PREFIX TAG

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

F 842
Continued From page 32
*The process was ongoing and they were ensuring all pieces were completed.

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:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;

1. For tag F-880, fans were turned off immediately after state education about fans being on spreading the COVID-19 Virus in the hallways. Doors were closed/plastic curtains pulled once noted to be open during the walk through of the facility. On 11/9/20 DNS labeled peroxide bottles, checked that all peroxide bottles were all labeled that were on the floor at this time. DNS checked for availability of hand sanitizers available on hallways: 3 stations on 200 hallway, 1 station on 300 hallway, 1 station on 400 hallway and 2 stations on 500 hallway. (Each station contained 1 labeled peroxide bottle, 1 hand sanitizer and resuable gowns.) Each hallway had disposable containers available to staff on that hallway. Education provided to staff in the building on 11-9-2020 by DNS on above information verbally.

2. For future infection control involving F Tag 880; All staff will be educated about doors/plastic curtains to be closed at all times, peroxide bottles to be labeled properly, stations will be stocked with hand sanitizers, re-useable gowns and peroxide bottle at all times; to be stocked by nursing
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<td>F 880</td>
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<td>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</td>
<td>F 880</td>
<td>staff daily/ as needed. Disposable containers will be brought to the doorway prior to entering room or place gown in plastic bag to take to disposable container to be washed upon exiting COVID room. All staff education will be completed by 12-9-2020. DNS/ADMIN will ensure stations are stocked until all staff have been educated about above information. 3. Nursing staff will ensure that doors/plastic curtains to be closed at all times; to be stocked by nursing staff daily/as needed. Disposable containers will be brought to the doorway prior to entering room or place gown in plastic bag to take to disposable container to be washed upon exiting COVID room; during nursing staff shift.</td>
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**NAME OF PROVIDER OR SUPPLIER**
GOOD SAMARITAN SOCIETY CANTON

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

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<td>F 880</td>
<td>Continued From page 34 potential for transmission of COVID-19 virus by: *Fans running in three of three resident hallways where COVID-19 residents resided. *Doors not closed and/or plastic curtains not covering doors that had been left opened on COVID-19 positive residents' rooms. * Peroxide bottles not labeled to identify contents. *Hand sanitizer was not readily accessible. *Personal protective equipment (PPE) was not readily available for staff use. *Disposal containers were not readily accessible for soiled linens and garbage. Findings include: 1. Observation and interview on 11/9/20 at 3:45 p.m. with director of nursing (DON) B while touring the facility revealed: *They had a current census of thirty-six residents with three residents in the hospital and thirty-three residents in-house. Of those residents in-house: -Twenty-eight residents were currently in isolation and on transmission based precautions for COVID-19. -Two residents were considered recovered from COVID-19. -Three residents had remained negative for COVID-19. *The most recent positive resident case had just been identified that day. *When the outbreak initially started they had moved residents to the north wing. *She indicated as additional cases kept happening they ended up leaving some of the residents in place and now had COVID-19 positive residents in all areas of the building. -The first resident case had been identified on 10/17/20. *Currently positive residents resided in all areas of the facility and were considered to be in *red</td>
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| F 880         | Continued From page 35 rooms."  
*The three negative residents were in rooms in the center south hallway in "yellow rooms."*  
-They had yellow tape on the door frames signifying their negative COVID-19 status.  
*She indicated they were now planning to move some residents back to their original rooms to even out the workload for the staff since there were positive cases throughout the facility.  
*They had discontinued the dedicated COVID-19 unit due to most of the residents had tested positive for COVID-19.  
*The three negative COVID-19 residents were intermixed with the positive COVID-19 residents.  
*The following room doors had not been closed and had COVID-19 positive residents in them: -203, 204, 212, 501, 506, and 507.  
*Fans in the hallways were on and moving air around in all the resident hallways that housed the twenty-eight COVID-19 positive residents and the three COVID-19 negative residents.  
*DON B was not aware fans had been on and agreed they should not have been.  
*She had heard of not using fans in COVID-19 positive areas due to the risk of further spreading the virus.  
*A spray bottle of an unlabeled disinfectant was located on the south center hallway.  
-DON B indicated that was Peroxide used for disinfecting face shields and should have been used after staff exited a COVID-19 positive resident's room.  
*She confirmed the bottle should have been labeled to identify what it was.  
Observation and interview on 11/9/20 at 3:50 p.m. with DON B in the south hallway revealed:  
*Resident 2 was on a gurney being wheeled back to his room by two unidentified emergency | F 880 | | | |
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| F 880 | Continued From page 36 medical staff.  
*DON B indicated he had been at the emergency room and was returning to the facility.  
-He was COVID-19 positive.  
-He had a surgical mask on and was noted to be coughing while being wheeled to his room.  
*The emergency staff had on full PPE including gown, gloves, respirators, and face shields.  
*Certified nursing assistant (CNA) G was wearing a respirator and face shield already and put on a reusable gown and disposable gloves to enter the room  
-She went into his room to assist the other staff to transfer the resident into bed.  
*When they were finished the two emergency staff removed their disposable gowns and gloves and put them into a disposable container down the hallway.  
-They had not completed hand hygiene until further down the hallway.  
-They left their respirators and face shields on and were not observed disinfecting their face shields.  
-They walked through the area where the COVID-19 negative residents' rooms were as they left the facility.  
*When CNA G exited the room she:  
-Removed her reusable gown, balled it up carrying it half way down the hall to put it into the soiled linen container.  
-Then proceeded farther down the hallway to get hand sanitizer from the medication cart.  
-Was not observed disinfecting her face shield.  
*Outside of the resident room there was no soiled linen container, disinfectant for the face shield, and no hand sanitizer readily available for the staff to use.  
Observation on 11/9/20 at 3:56 p.m. of an |
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| F 880         | Continued From page 37
unidentified staff member revealed they:
* Had come out of a COVID-19 positive resident's room located down the hall with a bag of garbage.
* Had to go most of the way down the hallway to find a garbage container for that garbage.
* Then had to go even further to find hand sanitizer to use.

Interview and observation on 11/9/20 at 4:00 p.m.
CNA G regarding PPE and infection control concerns revealed:
* She agreed:
  - The equipment and supplies needed for proper removal/disposal of PPE, hand hygiene, and disinfection of the face shield were not readily available and should have been.
  - It was important to follow proper infection control practices to prevent further transmission of infections.
* There were two different containers of germicidal wipes on a stand outside the resident's room that were Sanicloth Plus and Sanicloth AF3 wipes.
  - She thought those were effective disinfectants against COVID-19 but was unsure.
  - Those wipes were not the disinfectant they were supposed to use to disinfect the face shields.
* They were supposed to use a peroxide solution on the face shields.
* There was no peroxide solution close to that residents' care area.
* There were several other COVID-19 positive residents also residing on that hallway.

Continued interview on 11/9/20 at 4:05 p.m. with CNA G revealed:
* The opened doors and shower curtains should have been closed because those were COVID-19 positive residents' rooms.
Continued From page 38

*The staff person who had been ensuring supplies were available was currently out due to illness.
-She was unsure who was helping stock supplies while that staff person was out.
*Staff should have had the necessary supplies readily available in order to follow appropriate infection control practices.

Observation and interview on 11/9/20 at 4:15 p.m. with DON B regarding the above concerns revealed:
*Opened doors and shower curtains covering opened room doors should have been closed for the COVID-19 positive residents' rooms to decrease potential transmission of the virus.
*All supplies for appropriate infection control practices should have been readily available for staff to use.
*When staff had to go a distance to get to supplies and/or get rid of soiled supplies it could have caused a potential for transmitting infections or viruses further.
*She agreed it was important to follow proper infection control practices in order to potentially prevent further COVID-19 infections.

Review of the provider's revised 4/14/20 Hand Hygiene and Handwashing policy revealed:
*The purpose was to ensure appropriate hand hygiene technique for clinical use.
**Regular handwashing with soap and warm not hot water is one of the best ways to remove germs, avoid getting sick and prevent the spread of germs to others.
*The guidance on handwashing and glove use for patient (resident) care included.
**Patient care: The goal is to prevent the spread of infection between residents. Handwashing and
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<td>Continued From page 39 changing gloves occurs after care is delivered to prevent the spread of organisms to other residents. Sanitizers are used in patient care areas.&quot; Review of the provider's revised February 2018 Putting on and Taking off Personal Protective Equipment (PPE) Donning and Removing policy revealed: <strong>1.</strong> The Good Samaritan Society location will provide, at no cost to the employee, the following appropriate personal protective equipment for all employees considered at risk for occupational exposure: -a. Gloves, gowns, masks (or shields) -b. Eye protectors -c. Mouthpieces, resuscitation bags, pocket masks or other ventilation devices, if appropriate to the location. -The administrator, director of nursing services, senior living manager, environmental services director, child daycare services director or designee should be responsible for ensuring appropriate PPE is available for all employees.&quot; <strong>3.</strong> It is the location's responsibility to ensure that appropriate personal protective equipment is readily accessible and that employees use it.&quot; <strong>4.</strong> The location is responsible for cleaning, laundering, disposal, repair and replacement of required personal protective equipment.&quot; <strong>5.</strong> Personal protective equipment will be removed before leaving the work area and placed in an appropriately designated area or container for storage, washing, decontamination or disposal. If any garment is penetrated by blood or other potentially infectious materials, it will be removed immediately or as soon as feasible.&quot; <strong>Masks/Eye Protection/Face Shields:</strong> -a. Masks, eye protection and/or face shields</td>
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<td>Continued From page 40 should be worn whenever splashes, spray, spatter or droplets of blood or other potentially infectious materials might occur and contaminate the employee's eyes, nose or mouth. Select masks, eye protection, face shields and combinations of each according to the need anticipated by the task performed. Examples of when to use masks or eye protection could include plunging toilets, emptying fluids, use of hoppers/sprayers, suctioning residents/patients or working where there is risk for blood splashes. -b. This equipment should be discarded after use or placed in an area where it will be washed with soap and water.&quot; <strong>Gowns</strong> -a. Wear a gown, appropriate to the task being performed, to protect skin and prevent soiling or contamination of clothing during procedures and resident/patient care activities when contact with blood, body fluids, secretions or excretions is anticipated. -b. Wear a gown for direct resident/patient contact if the resident/patient has uncontained secretions or excretions. A gown should be selected that is appropriate for the activity. If fluid is likely to be encountered, a long-sleeve impermeable gown is to be used. -c. Remove gown (perform gown removal per any isolation requirements) and perform hand hygiene before leaving the contaminated area.</td>
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