### SUMMARY STATEMENT OF DEFICIENCIES

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

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary of Deficiency</th>
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<tbody>
<tr>
<td>F000</td>
<td>INITIAL COMMENTS</td>
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<tr>
<td>F600</td>
<td>Free from Abuse and Neglect</td>
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**§483.12 Freedom from Abuse, Neglect, and Exploitation**

The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

**§483.12(a) The facility must—**

1. **§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;**
2. This REQUIREMENT is not met as evidenced by:

**Surveyor: 29354**

**Surveyor: 35237**

Based on record review, interview, and policy review, the provider failed to ensure resident safety for one of one sampled resident (1) who had a fracture identified after being assisted with a mechanical lift by two of two certified nursing assistants (CNA) (C and D). Findings include:

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

Myron Moore  
Administrator  
4-28-20

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

**(X1) PROVIDER/SUPPLIER/CLLA IDENTIFICATION NUMBER:**

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<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>F 600</td>
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<td>F 600</td>
<td>3. Clinical staff educator will monitor for compliance with annual annual training 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 will be monitored by clinical staff educator. 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; notify maintence and placed by service door. Falls Committee was educated about the RCA on 4-16-2020 by national campus consultant. Falls Committee completed a RCA on 4-16-2020 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 by the DNS. Any one unable to attend will have 1:1 education with DNS by 5-21-2020.</td>
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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 suspicious/allegation of abuse/neglect due to physical harm/injury.
   - The form indicated the resident was capable of providing an explanation of the event.
   - The brief explanation included:
     - "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 could/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."
   - She had been hired on 7/1/19.
   - The conclusion summary statement of facility investigation was:
     - "During investigation it was noted staff was using..."
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<td>F 600</td>
<td>Continued From page 2</td>
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<td>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.&quot;</td>
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<td>- &quot;Intervention: Sent to ER and scapula fracture/dislocation. Care plan updated with Total lift (M) with assist of 2 with transfers. Staff on floor currently notified verbally as well.&quot;</td>
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<td>- &quot;Emailed proof of Facility investigation notes - ER documentation - Care plan - Resident lift assessment completed in January 2020 - Last lift competency completed for aide involved.&quot;</td>
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<td><strong>No</strong> was selected for if abuse/neglect allegation was substantiated due to lift was used properly.</td>
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<td><em>Action taken by facility was:</em></td>
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<td>- &quot;Care plan reviewed/revised.&quot;</td>
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<td>- &quot;Personnel education.&quot;</td>
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<td><em>There was no mention of:</em></td>
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<td>- How the resident was gotten up from the floor and sent to ER.</td>
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<td>- If there were any concerns found with the mechanical lift that was used.</td>
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<td>- What personnel education was given.</td>
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<td>- If any other personnel were involved in the event.</td>
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<td>Review of the other records submitted by the provider with the above report for resident 1 revealed:</td>
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<td><em>His current care plan indicated:</em></td>
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<td>- He had been admitted in June 2017.</td>
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<td>- His diagnoses and health condition included:</td>
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<td>- Parkinson's disease, history of a stroke,</td>
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**F 600** Continued From page 3

Peripheral vascular disease, arthritis, severe cognitive impairment, hearing loss, insomnia, behaviors, and a left foot nodule and skin lesions. 
- For transfers it had been revised on 3/24/20 for those 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:
    - He was seen for a fall with arm pain and diagnosed with a closed, displaced fracture of the right scapula.
    - The physician's orders included to use ice every three to four hours and hydrocodone medication as needed for pain.
  - The 3/24/20 incident report included:
    - The nurse and resident description were the same as the brief explanation in the above SD DOH Online Self Report.
    - "No apparent unsafe condition" was marked for predisposing environment factors.
    - Options that could have been marked included if equipment/assistive devices were involved.
    - The only predisposing physiological factors marked were impaired memory and confused.
    - Options that could have been marked included if the resident had a recent illness or recent changes in medications.
    - The only predisposing situation factor marked was "Other (specify in Other information):"
      - Options that could have been marked included if a mechanical lift or equipment was used.
      - Other information was: "Resident's arms gave way/slipped when using sit to stand while transferring resident."
    - There were no witnesses identified or listed.
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<th>(X5) COMPLETION DATE</th>
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| F 600             | Continued From page 4  
- The form indicated the physician, resident's family, DOH, and administrator were all notified on 3/24/20.  
* 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.  
- That had been completed by Minimum Data Set (MDS) assessment coordinator nurse F.  
* CNA C's Safe Resident Handling Equipment Competency Validation Checklist had been completed on 7/1/19.  
Phone interview and entrance conference on 4/6/20 from 11:15 a.m. through 11:27 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 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 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 | F 600 | | |
Continued From page 5 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, specify the mechanical lift used in the incident on 3/24/20 with resident 1.
- Documentation and sign-in sheet for all staff who 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 from 2:00 p.m. through 2:15 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 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.
* She stated there was a safe handling program, and therapy was involved.
* Assessments should have been completed to
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**Statement of Deficiencies and Plan of Correction**

**Good Samaritan Society Canton**

**Street Address, City, State, Zip Code**

1022 North Dakota Avenue

Canton, SD 57013

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**Summary Statement of Deficiencies**

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

**Provider's Plan of Correction**

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

**Completion Date**

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**F 600** Continued From page 6

- She was unsure if resident 1 had seen therapy recently.
- He was on a restorative nursing program for active ROM and transfers.
- 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 worked as a floor nurse also and watched 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., further information regarding resident 1's falls in July 2019; policies related to abuse, neglect, investigations; and the safe handling program were requested by email from administrator A.

Review of resident 1's electronic medical record
**F 600** Continued From page 7

(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 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 25mg 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 sleepy 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..."
**GOOD SAMARITAN SOCIETY CANTON**

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| 435101 | | Continued From page 6

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. through the fall note on 3/24/20 at 10:35 a.m. which 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 clo 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."
--This was the same note as the brief description on the SD DOH online report and in the 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 was gotten up off the floor, or the timeline of the events that occurred during and after the incident.
--On 3/24/20:
**F 600** Continued From page 9

--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.
--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 from 10:00 a.m. through 10:13 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.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<th>(X1) PROVIDER/SUPPLIER/Clinic Identification Number:</th>
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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

**DATE SURVEY COMPLETED**

04/07/2020

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**SUMMARY STATEMENT OF DEFICIENCIES**

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

- F 600 Continued From page 10 according to her usual process.
  - She did not use 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.
  - 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 did not see 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.
F 600 Continued From page 11

*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.
- 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 10:30 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...
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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**GOOD SAMARITAN SOCIETY CANTON**

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

1022 NORTH DAKOTA AVENUE
CANTON, SD 57013

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<tr>
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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 from 10:30 a.m. through 10:45 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.
*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 in 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
F 600 Continued From page 13

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 she did complain of 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 was gotten up from the floor.
  -Full details of what had occurred during the incident and following the incident regarding his safety.

Phone interview on 4/7/20 from 11:00 a.m. through 11:15 a.m. with CNA D regarding resident 1’s 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.

-She stated they could not use the lift to move 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 movement, 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 her 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.
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES**  
**AND PLAN OF CORRECTION**

| X1 PROVIDER/ SUPPLIER/CLEAN IDENTIFICATION NUMBER: | X2 MULTIPLE CONSTRUCTION 
| | A. BUILDING |
| | |
| | B. WING |

| X3 DATE SURVEY COMPLETED |
| C  
| 04/07/2020 |

**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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<th>(X4) ID</th>
<th>PREFIX</th>
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**SUMMARY STATEMENT OF DEFICIENCIES**  
**AND PLAN OF CORRECTION**

| EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LIC IDENTIFYING INFORMATION |
| PROVIDER'S PLAN OF CORRECTION 
**(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)** |

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**F 600** Continued From page 15

- 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 about what happened.
  - No one else had 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.
  - 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 from 1:30 p.m. through 2:15 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.
  * The DON 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.
    -- The DON had not talked to CNA C about the
F 600  Continued From page 16  
- 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 the DON 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 edge of the bed, and then moved him to his recliner.  
  - Shortly after that they told the nurse about the incident who 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 with him incontinence care prior to using the same lift he had just had an incident with to move him from the bed to the recliner.
**continued from page 17**

*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.
*The administrator confirmed:
  - 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.
  - The DON 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 the QAPI process.
  - The administrator felt the current situation in the nation and world could have impacted how this event was handled and investigated.
  - The DON 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
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<td>F 600</td>
<td>Continued From page 18 as part of the investigation or incident reports. She had not thought she should have been mentioned CNA D as a witnesses 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. Surveyor 29354 Review of the provider's July 2017 Falls-Mechanical Lift/Transfers policy revealed: <strong>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.</strong> 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.&quot; Review of the provider's October 2018 Abuse and</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**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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|       | 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."

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,
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<td>F 600</td>
<td>Continued From page 20 documentation, reports/dashboards and retrieval management and monitoring/auditing. &quot;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.&quot; Review of the provider's 8/16/16 Charge Nurse-LPN job description revealed: &quot;Observes and documents observations and care given to residents.&quot; Review of the provider's undated Administrator job description revealed: &quot;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.&quot; &quot;Manages Communication and Documentation: -Ensures documentation and reports are completed as required by regulations and/or policy and procedure.&quot;</td>
<td>F 600</td>
<td>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 by the DNS. 2. For all other potential residents, 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 5-6-2020 by the DNS. All nursing staff unable to attend will have 1:1 education by the DNS by 5-21-2020. The falls committee was educated about root cause analysis (RCA) on 4-16-2020 to prevent future occurrences by national campus consultant. 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 by the department manager.</td>
<td>5-6-20</td>
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<td>F 610 SS=S</td>
<td>Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</td>
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<td>SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)</td>
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<td>PROVIDER'S PLAN OF CORRECTION (Each corrective action should be cross-referenced to the appropriate deficiency)</td>
<td>COMPLETION DATE</td>
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| F 610         | Continued From page 21  
§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, and policy review, the provider failed to ensure one of one sampled resident (1) who had a fracture identified after being assisted with a mechanical lift had that event thoroughly investigated 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 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.  
   * The brief explanation included:  
     "CNA [certified nursing assistant] 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 incident. Resident states 'my arms slipped.'"  
   Asked resident upon return from ER  
   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 a part of the falls process, add any health concerns, recent falls, similar falls and medication changes recently after each fall with major injury. Safety Committee will audit for compliance and turn audits into QAPI committee.  
4. Safety committee or/designee will do audits that the root cause analysis (RCA) has 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 |
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<td>[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.&quot;</td>
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<td>&quot;The allegation involved CNA C with the section for previous disciplinary actions left blank.</td>
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<td>-She had been hired on 7/1/19.</td>
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<td>&quot;The conclusionary summary statement of the facility investigation was:</td>
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<td>-&quot;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.&quot;</td>
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<td>-&quot;Intervention: Sent to ER and scapula fracture/dislocation. Care plan updated with Total lift (M) with assist of 2 with transfers. Staff on floor currently notified verbally as well.&quot;</td>
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<td>-&quot;Emailed proof of Facility investigation notes - ER documentation - Care plan - Resident lift assessment completed in January 2020 - Last lift competency completed for aide involved.&quot;</td>
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<td>(each corrective action should be cross-referenced to the appropriate deficiency)</td>
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"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 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 4/6/20 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 to rule out abuse or neglect had not occurred.
Refer to F800.

Surveyor 29354
Review of the provider's July 2017
Falls-Mechanical Lift/Transfers policy revealed:
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<td>&quot;Manually lifting a fallen resident from the floor increases the risk of injury to both the resident and the caregiver.</td>
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<td>-To ensure safe transfer for a fallen resident, the following steps should take place:</td>
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<td>--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.</td>
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<td>--3. Use the total lift to assist an uninjured fallen resident from the floor. Avoid manual lifting.&quot;</td>
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<td>Review of the provider's May 2019 Incident Report policy revealed:</td>
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<td>&quot;Purpose:</td>
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<td>-To document resident and visitor incidents.</td>
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<td>-To conduct an investigation of each resident.</td>
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<td>-To gather objective information and identify root causes to prevent similar occurrences from happening in the future.&quot;</td>
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<td>Review of the provider's October 2018 Abuse and Neglect policy revealed:</td>
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<td>&quot;Purpose:</td>
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<td>-To assure that employees are knowledgeable regarding the reporting and investigative process of abuse and neglect allegations in the location.</td>
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<td>-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.&quot;</td>
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<td>Review of the provider's 8/16/16 Certified Nursing</td>
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**Good Samaritan Society Canton**

**Name of Provider or Supplier:**

**Street Address, City, State, Zip Code:**

1022 North Dakota Avenue
Canton, SD 57013

**ID TAG** 435101
Continued From page 25
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 8/17/18 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.
-Asseures residents are free of neglect and abuse.
-Maintains thorough and accurate records for each resident."

Review of the provider's 8/16/18 Charge Nurse-LPN (licensed practical nurse) job description revealed: "Observes and documents observations and care given to residents."

Review of the provider's undated Administrator job description revealed:
**"An Administrator for the Society is responsible
Continued From page 26
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."

Resident Records - Identifiable Information
CFR(s): 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 resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;

1. For resident #1, fall 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 by the DNS.

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 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. Safety Committee will audit for compliance and turn into QAP Committee.

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 5-21-2020 by the DNS. Any staff unable to attend will have 1:1 education by the DNS completed by 5-7-2020. Falls committee will complete a root cause analysis (RCA) on every fall with major injury.
**GOOD SAMARITAN SOCIETY CANTON**

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| F 842 | Continued From page 27  
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.508;  
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.  
§463.70(j)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.  
§463.70(j)(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.  
§463.70(j)(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 |

<table>
<thead>
<tr>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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</table>
| F 842 | 4. Safety committee will complete audit to verify a through risk management and root cause analysis (RCA) was completed including Correct timeline of events that occurred, How resident got off the floor, fail 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. Safety Committee will turn audits into QAPI committee  
5. See above for dates of completion on above changes |
F 842  Continued From page 28

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 an incident that occurred on 3/24/20 and the details surrounding it including:
   *The time when the event actually occurred was not mentioned.
   -There was a note at 10:35 a.m. which was an overall summary to cover the fall and notifications.
   *There was no mention of how he was assisted related to the event such as how he was gotten up.
   *The 10:35 a.m. note 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.
   *At 10:36 a.m. he was taken to the emergency room by facility staff.

Review of the South Dakota Department of Health online self-report, the incident report, and other investigation notes regarding resident 1 revealed:
*The event 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.
Phone interviews during the survey on 4/6/20 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 a concern with documentation.

Refer to F600 and F610.

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."