DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435101	A. BUILDING _____ B. WING _____	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY CANTON	1022 NORTH DAKOTA AVENUE CANTON, SD 57013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 11/29/22 through 12/1/22. Good Samaritan Society Canton was found not in compliance with the following requirements: F692 and F880.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the nutritional status was monitored for one of one sampled resident (19) who had a significant weight loss. Findings include:	F 692	Resident 19s weights have stabilized with interventions described in findings. Registered Dietician (RD) reviewed R19s nutritional status on 12/11/22 and will continue to monitor monthly. Any resident who experiences a weight loss has the potential to be affected. By 12/30/22, Certified Dietary Manager (CDM) will review all residents and ensure any who are experiencing significant weight loss are referred to registered dietician, and the provider and family are notified. To ensure deficient practice will not recur, by 1/12/2023, CDM will initiate bi-weekly Nutrition at Risk meetings with Nursing and Social Services, to monitor resident nutritional status and determine appropriate interventions. RD will attend at least once per month. CDM will also receive education from Food and Nutrition Consultant on how to correctly complete the Mini-Nutritional Assessment.	1/12/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Justin Jones | TITLE: Administrator | (X6) DATE: 1/4/2023

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

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F 692	Continued From page 1 1. Observation on 11/29/22 at 11:20 a.m. of resident 19 sitting in a wheelchair at a table in the dining room revealed he: *Appeared thin. *Was eating a nutritional supplement. Review of resident 19's medical record revealed: *An admission date on 5/6/22. *His diagnoses included: chronic obstructive pulmonary disease, depression, hypertension, chronic heart failure, dementia, and muscle weakness. *His Abilify (medication used to treat depression) had been tapered starting 9/9/22 and discontinued at the beginning of October 2022. *On 09/15/2022, he weighed 130 pounds (lbs). *On 10/17/2022, he weighed 118.5 lbs. -An 8.85 percent weight loss. *On 10/31/22, he weighed 117.5 lbs. *A Mini-Nutritional Assessment (used to identify geriatric patients who are malnourished or at risk of malnutrition) had been completed on: -8/9/22, his score was 11 out of 14 indicating he was at risk of malnutrition. -11/11/22, his score was 8 indicating he was at risk of malnutrition. --The question for weight loss in the last 3 months was answered incorrectly. --If answered correctly his score would have been 6 indicating he was malnourished. *His 10/25/22 physician progress note stated: "Appetite is fair and weight is stable." *No documentation his physician had been notified of weight loss until 11/3/22. *On 11/3/22 when the facility had notified the physician of the weight loss and his refusal to get up out of bed, he wrote new orders to restart the Abilify and increased his house nutritional	F 692	To monitor performance and ensure ongoing compliance Administrator or designee will conduct audit by review of meeting minutes and resident medical record to ensure CDM is routinely reviewing residents weights; that family, provider, and RD are notified with weight loss identified; meeting is attended by RD monthly; minutes identify recommended interventions and those interventions are followed-up on as appropriate within 72 hours. Audits will occur every 2 weeks x 4 and then monthly x 2. Administrator or designee will report finding to the QAPI committee monthly and the QAPI committee will determine ongoing monitoring and interventions.	

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F 692	Continued From page 2 supplement from two ounces to four ounces four times a day. *On 11/20/22 his physician saw him and wrote new order to increase the house nutritional supplement to six ounces four times a day for weight loss. *No documentation the dietician had been notified of his weight loss prior to the survey date. *No documentation of family notification until his care conference on 11/17/22. Review of resident 19's care plan revealed: *He had a nutritional problem related to his diagnosis and evidenced by his variable intakes and weight loss. *His goals had not been updated since is admission and included: -"Resident will try to maintain weight without triggering a 5% weight loss/gain through the review date. " - " Resident will consume an average greater than 50% of meals through the review date. " *His interventions had not been updated since the weight loss occurred. Interview on 11/30/22 at 4:12 p.m. with dietary manager (DM) C regarding resident 19's weight loss revealed: *She sent the doctor a fax to notify him of resident's weight loss on 11/4/22. *She reviewed weights on residents who are due for a minimum data set (MDS) assessment. *Tried to look at all resident's weights weekly. *The registered dietitian (RD)came monthly and sees the residents who are due for a MDS assessment, recently returned from a hospital stay, had wounds, on dialysis, had weight loss, or any other dietary concerns. *She made the list of resident's that needed seen	F 692		

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F 692	Continued From page 3 by the RD each month. *Did not have resident 19 on that list for October. *The provider did not have a meeting to review residents who were at nutritional risk. Continued interview on 12/1/22 at 8:57 a.m. with DM C regarding resident 19 revealed: *He was receiving a magic cup (nutritional supplement) at dinner and supper and Breeze (nutritional supplement) at all three meals. *She stated the additional supplements were started in October 2022 but did not have documentation to show the addition of the supplements. *The consumption of these supplements was not documented. *There was no documentation that anything was done for his weight loss until November 2022. *She agreed her Mini-Nutritional Assessment completed on 11/11/22 was not answered correctly. -She should have answered "Weight loss greater than 3 kg (6.6 pounds." Interview on 12/1/22 at 11:09 a.m. MDS coordinator D regarding resident 19 revealed: *DM C was to monitor residents' weights and let nursing know when a resident was loosing weight. *She noticed resident 19's weight loss when completing his quarterly MDS assessment in November 2022. *She notified DM C and faxed a note his physician. *Resident 19 should have been monitored more closely after his Abilify was stopped. *Provider does have morning meetings to discuss concerns but weights are not part of that meeting.	F 692		

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F 692	Continued From page 4 Interview on 12/1/22 at 11:57 a.m. and at 1:28 p.m. with director of nursing B regarding resident 19 revealed: *She had done doctor rounds on 11/20/22 and had requested his house nutritional supplement be increased. *There had been no documentation the physician had been notified of the weight loss until 11/3/22. *There had been no documentation the RD had been notified of the weight loss prior to 11/30/22. *DM C monitored weights and let her know if a resident had weight loss. Review of the provider's 5/31/22 Identifying Resident With Impaired Nutritional Status and Nutritional Risk policy revealed: *The DM was to review resident weights monthly. *"Residents with newly identified impaired nutritional status or nutritional risk are added to the Nutrition Risk List ... and discussed at the next nutrition risk committee meeting."	F 692		
F 880 SS=D	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:	F 880	**Directed Plan of Correction Good Samaritan Society Canton F880:** **Corrective Action:** 1. For the identification of lack of: *Appropriate procedural technique/storage of gloves for use during IV administration. *Appropriate cleaning and maintenance of multi-resident Use equipment between Residents. **The administrator, DON, and/or designee In consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas.** **Please do read 2567 findings.** All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by **January 12th, 2023**	1/12/2023

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F 880	Continued From page 5 §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; (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. §483.80(a)(4) A system for recording incidents	F 880	**2. Identification of Others:** ALL residents and staff have the Potential to be affected by lack Of: *Appropriate procedural technique/storage of gloves for use during IV administration. *Appropriate cleaning and maintenance of multi-resident use equipment between residents. Policy education/re-education about roles and responsibilities for the above-identified assigned care and services tasks will be provided by **January 12th, 2023 by IP Nurse, DNS or Designee.** **System Changes:** **3.** Root cause analysis conducted answered the 5 Whys: **The facility inconsistently works with IV medications due to the residents needs and treatments at a given time.** **There is an Execution/performance gap with knowing what to do, but not taking the time to slow downand follow appropriate processes and procedures for cleaning equipment.** Administrator, DON, medical director, and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency and documentation. **Administrator** contacted the South Dakota Quality Improvement Organization (QIN) on **December 19, 2022** and include **discussion of techniques on how the educate staff in different ways where they may be able to be more engaged to the topic. We also went through a "5 Why's" Analysis and determined there was an Execution/performance gap with knowing what to do, but not taking the time to slow down and follow appropriate processes and procedures for cleaning equipment.**	

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F 880	Continued From page 6 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure: *A vital signs machine had been disinfected between use by one of one observed certified nursing assistant (CNA) F for four of four randomly observed residents. *Appropriate glove use by one of one registered nurse (RN) E while administering intravenous (IV) antibiotics to one of one sampled resident (35) receiving IV medication. Findings include: 1. Observation on 11/29/22 at 9:47 a.m. of CNA F using a vital signs machine revealed she had: *Obtained vital signs on four randomly observed residents in rooms 203, 205, and 208. *Not disinfected the vital signs machine between use on those four residents. Interview on 11/30/22 at 1:25 p.m. unlicensed assistive personnel G revealed the vital signs machine was to be disinfected between use with the wipes kept in the basket on the machine. Interview on 12/1/22 at 7:58 a.m. with CNA F regarding the vital signs machine revealed she	F 880	**Monitoring:** 4. Administrator, DON, and/or designee will conduct auditing and monitoring of above identified items 2-3 times weekly over all shifts. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. *Staff compliance in the above identified area. *Any other areas identified through the Root Cause Analysis. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by administrator, DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	

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F 880	Continued From page 7 should have disinfected the machine between uses and had not. Interview on 12/1/22 at 11:51 a.m. with director of nursing B revealed the vital signs machine was to be disinfected between uses. 2. Observation on 12/1/22 at 12:25 p.m. of RN E administering IV medication to resident 35 revealed she had worn gloves she had stored in her shirt pocket. Interview with RN E after the above observation revealed: *Her pockets were probably not clean because that is where she kept her pens. *The gloves she had in her pockets were not clean. Interview on 12/1/22 at 1:31 p.m. with director of nursing B revealed staff should not store gloves in their pockets. 3. A policy for cleaning of re-usable medical equipment and glove use policy was requested on 12/1/22 at 12:40 p.m. the policies provided had not addressed: *When or how to clean the vital signs machine. *How gloves were to be stored.	F 880		

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 11/29/22 through 12/1/22. Good Samaritan Society Canton was found not in compliance with the following requirement: E001.	E 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.	1/12/2023
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements.	E 001	By 1/12/2023, Administrator will revise the Emergency Management Plan to include all required elements. Administrator will educate all-staff on the emergency management plan by 1/12/2023. All residents have the potential to be impacted by deficient practice. To ensure deficient practice will not recur, going forward, Administrator will be responsible for maintaining and updating Emergency Management Plan at least yearly. Administrator will provide education to all staff on the Emergency Management Plan at least yearly. QAPI committee will review Emergency Management plan in April and October and recommend updates as needed. To monitor performance and ensure ongoing compliance QAPI coordinator or designee will audit the Emergency Management plan to ensure it address all areas described in the survey findings. Audits will occur monthly x1 and quarterly x2.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Justin Jones	Administrator	12/22/2022

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E 001	Continued From page 1 The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on interview and record review, the provider failed to maintain an emergency preparedness program, and to update it annually. Findings include: 1. Interview on 12/1/22 at 12:00 p.m. with director of environmental services H and review of provider's emergency preparedness program revealed: *They did not have a complete emergency preparedness program. *They had not: -Addressed patient population. -Addressed collaboration. -Addressed policies and procedures for risk assessment. -Addressed policies and procedures for volunteers. -Addressed tracking of staff and residents. -Addressed procedures for medical documentation. -Addressed methods for sharing information.	E 001		

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E 001	Continued From page 2 -Addressed sharing information on occupancy and needs. -Addressed an integrated health system. -Developed a communication plan that had included names and contact information for emergency officials. Interview on 12/1/22 at 2:15 p.m. with administrator A regarding the emergency preparedness program revealed: He agreed that the information had not been updated and reviewed annually.	E 001		

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GOOD SAMARITAN SOCIETY CANTON	**1022 NORTH DAKOTA AVENUE** **CANTON, SD 57013**

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 11/29/22. Good Samaritan Society Canton was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Justin Jones

TITLE: Administrator

(X6) DATE: 12/22/2022

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

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10604	A. BUILDING: _____ B. WING _____	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY CANTON	1022 N DAKOTA AVENUE CANTON, SD 57013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 11/29/22 to 12/1/22. Good Samaritan Society Canton was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Justin Jones — TITLE: Administrator — (X6) DATE: 12/22/2022