STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435087	A. BUILDING _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY CANISTOTA	700 WEST MAIN ST CANISTOTA, SD 57012

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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 8/7/23 through 8/10/23. Good Samaritan Society Canistota was found not in compliance with the following requirements: F644, F658, F761, and F791.	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 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review the provider failed to ensure one of one resident (23) who had a mental illness had a Preadmission Screening and Resident Review (PASARR) Level II completed timely.	F 644		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Alexis Luke | Administrator | 9/7/23

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 644	Continued From page 1 Review of resident 23's medical record revealed her: *Admission date was 9/15/20. *Diagnosis included bipolar and an 8/25/21 schizoaffective disorder. *7/25/23 Brief Interview of Mental Status was a 15, that score meant she was cognitively intact. *Her care plan included: -She preferred to remain in her room. -She had disruptive behaviors including screaming and cursing at other people. -She had a private room due to the above. -Mental health services were provided to her by a behavioral health agency. Review of resident 23's admission PASARR revealed it: *Was completed on 8/24/20. *Had not included a diagnosis of schizoaffective disorder or any other mental illness diagnosis. Interview on 8/10/23 at 9:42 a.m. with social services G regarding resident PASARRs revealed she: *Had worked in long-term care as a social worker for over 16 years at various facilities. -Was hired by the provider January, 2022 *Was well versed in PASARR requirements. *Would have notified the state PASARR nurse consultant for the following: -When a resident had a new diagnosis of mental illness. -When a resident had a medication change that included an antipsychotic or anti-depressant medication. *Was not aware that resident 23 had a new diagnosis of schizoaffective disorder or who had given the resident that diagnosis. -She did not know who had given resident 23 that	F 644	Preadmission screening and resident review (PASARR) Level II for resident 23 completed 8/14/23. To identify other Residents having the potential for deficient practice, DNS or designee will audit all residents with mental illness to ensure a level II PASARR has been completed and has appropriate medical diagnosis listed on PASARR by 9/19/23. To ensure systemic change, nursing and social services staff will be educated by DNS or designee on PASARR requirements by 9/19/23. To monitor our performance and ensure that solutions are sustained, record review audits for residents with mental illness to ensure a level II PASARR has been completed and has appropriate medical diagnosis will be conducted by DNS or designee weekly x4,bi weekly x4, and monthly x2. The results of these audits will be reviewed and reported at the monthly Quality Committee meeting.	9/19/23

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F 644	Continued From page 2 diagnosis. *Confirmed a new PASARR should have been completed for resident 23 when she received a new diagnosis of schizoaffective disorder on 8/25/21. Interview on 8/10/23 at 9:48 a.m. with administrator A regarding resident PASARR's revealed: *Social services G was responsible for completion of resident PASARR's. *Administrator A had not had training regarding completion of resident PASARR's. *She was not aware a new PASARR should have been completed for resident 23. Review of provider's "Pre-Admission Screening and Resident Review (PASARR)-Rehab/Skilled" revealed: *"Purpose" -*"To ensure that individuals with retardation, serious mental disorder or intellectual disability receive the care and services they need in the most appropriate setting." -"Serious Mental Illness - An individual is considered to have a serious mental disorder if the individual meets the following requirements on diagnosis, level of impairment and duration of illness: --1. Diagnosis: the individual has a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, revised 1987. Mental disorders include: ---a. A schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; or another mental disorder that may lead to a chronic disability..." --"During the Stay ---1. If the resident is diagnosed with a mental	F 644		

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F 644	Continued From page 3 disorder while in the location, the social worker will contact the designated state agency for a Level II screening.	F 644		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure: *Treatment and documentation had been completed for one of one sampled resident (37) according to the provider's polcy who had skin tears. *Two scheduled nebulized medications ordered by the physician for one of one sampled resident (37) were not obtained from the pharmacy according to the provider's policy. Findings include: 1. Observation and interview on 8/8/23 at 4:08 p.m. with resident 37 revealed: *He was seated in his wheelchair in his room. *Had an approximate three-inch skin tear to his right forearm. *Had a small pencil eraser size open area above his right elbow. *Both areas had a small amount of blood present. *The skin tear on his right forearm had skin rolled back to the edges of the wound. *Resident 37 was unable to explain when or how he had received the skin tear.	F 658	Resident 37's skin tear is healed and nebulizer tx medications have been obtained from the pharmacy and are available as of 8/30/23 No revisions have been made to skin or medication ordering policy. RN's and LPNS will be educated by DNS or designee on provider's current skin policy and medication ordering policy by 9/19/23.To identify other residents having the portential For deficient practice DNS or designee will audit residents with Neb tx to ensure medication was obtained from pharmacy by 9/19/23. DNS or designee will audit residents with current skin issues To assure tx's and documentation is in place. To monitor performance to ensure that solutions are sustained, audits for adherence to skin assessment pressure ulcer prevention and documentation requirements and local pharmacy ordering policy will be conducted by DNS or designee weekly x4. bi-weekly x4, and monthly x2. The results of these audits will be reviewed and reported at the monthly Quality Committee Meeting.	9/19/23

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F 658	Continued From page 4 Interview and observation on 8/8/23 at 4:30 p.m. and again at 5:00 p.m. with registered nurse (RN) C revealed she: *Was not aware of resident 37's skin tear or when he had acquired the skin tear. *Cleansed the areas and applied a non-stick dressing over the skin tear and wrapped Kerlix around his arm. Review of resident 37's medical record by RN C indicated the skin tear had occurred a few days ago when he was repositioned in bed. Observations of resident 37 on 8/9/23 at 8:00 a.m., 10:30 a.m., 2:00 p.m., and 3:30 p.m. revealed he had a non stick dressing applied to his right forearm with tape. *The tape was not completely attached to his skin at multiple points on the dressing. *The dressing appeared to be soiled with the resident's own body fluids. Observation of resident 37 on 8/10/23 at 9:00 a.m. revealed there was no dressing on his right forearm skin tear. The area had a dried blood scab that had sealed it. Review of resident 37's interdisciplinary progress notes revealed on: *7/14/23 at 11:58 a.m. "Resident noted to have redness to groin/peri area, skin tear to left arm distal to deltoid, skin tear to left forearm. Admitted with both wounds covered with protective dressing from the hospital." *7/18/23 at 5:03 p.m. "Mepilex dressings came off to left elbow and left upper arm with bath. Dried skin tear to left upper arm. Skin tear above left elbow open and unable to approximate edges. 4 X 4 to wound and wrapped with Kerlix."	F 658		

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F 658	Continued From page 5 *8/1/23 at 5:40 p.m. "Family also had questions about skin tear on resident's arm and Charge Nurse stated that resident had rubbed it on the bed linens, causing friction and tearing the skin, when staff were changing and turning him earlier this morning. Family did inform writer that resident does not like his arms wrapped or does not like to have band aids on. Informed them that this was on for his protection and to make sure skin tear stays clean." Review of resident 37's medical record revealed: *His 7/14/23 Nursing Admit Data Collection assessment revealed there was no documentation regarding his skin tears to his left forearm and elbow. *There was no further interdisciplinary progress notes in regards to the skin tears to his left forearm and left elbow after 7/18/23. *There was no documentation on resident 37's July 2023 Medication/Treatment Administration Record (MAR/TAR) regarding the left forearm and elbow skin tears. *There was no documentation that resident 37's physician had been notified or that a treatment had been requested for the left forearm and elbow skin tears. *The skin tear noted on 8/1/23 had not indicated where it was located. *Resident 37's family had not been notified when the skin tear occurred. *The 8/1/23 interdisciplinary progress note was the only documentation in regards to more skin tears. *There was no documentation on resident 37's August MAR/TAR record for the skin tears identified on 8/1/23. *A skin observation assessment had been completed on 8/6/23 and a right elbow and right	F 658		

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F 658	Continued From page 6 forearm skin tear was documented as covered with a dressing that was clean, dry, and intact. *There was no documentation in the interdisciplinary notes by RN C after she had observed and placed a dressing on resident 37's right forearm skin tear on 8/8/23. Interview on 8/10/23 at 10:04 a.m. with RN D and RN E revealed: *When a resident was admitted with any type of wound it should have been measured with a description of the wound documented in the medical record, and a physician's order for treatment should have been obtained. *The wound should have been assessed daily or weekly depending on the wound type until it was healed. *They agreed resident 37 should have had weekly skin observations completed and documented. *They were not aware of his left of right forearm skin tears. Review of the provider's Skin Assessment Pressure Ulcer Prevention and Documentation Requirements - Rehab/Skilled revised on 4/26/23 revealed: *"All residents will have a comprehensive skin inspection done by the licensed nurse on admission/readmission to identify any skin issues present including, but not limited to, pressure ulcers, and the results will be documented in the legal medical record." *"Assessment and Documentation of Bruises/Contusions/Skin Tears/Abrasions included: -If a bruise, contusion, abrasion or skin tear is observed on a resident this should be reported to the nurse immediately.	F 658		

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F 658	Continued From page 7 -The bruise/contusion/ abrasion/skin tear should be monitored weekly and any changes and/or progress toward healing should be documented on the Skin Observation user defined assessment and on the resident's care plan." *Other documentation that should have been completed included: -A progress note for communication with the resident and or family/resident representative. -A facsimile to the physician for wound care treatment. 2. Review of resident 37's August 2023 MAR revealed: *He was to have received budesonide inhalation suspension 0.5 milligram (mg) per 2 milliliters (ml) two times a day for chronic obstructive pulmonary disease (COPD). *Ipratropium-albuterol inhalation solution 0.5-2.5 3 mg per 3 ml four times a daily for COPD. *Documentation for those medications: -On 8/8/23 revealed a 4 (indicating the drug was not available) had been documented for both doses of the budesonide and the bedtime dose of the Ipratropium-albuterol. -On 8/9/23 revealed an 8 (indicating to see the nurse's notes) had been documented for the morning dose of the budesonide and the 8:00 a.m., 12:00 noon, and 6:00 p.m. doses of the Ipratropium-albuterol. Review of an 8/8/23 5:20 p.m. interdisciplinary note communication with the pharmacy documented by RN C revealed: "Resident noted to be out of Duonebs [ipratropium-albuterol] Budesonide Medications were ordered from [drug store] but did not receive them on delivery this evening. Writer called [drug store] at this time. [Pharmacist] from [drug store] states they are	F 658		

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F 658	Continued From page 8 waiting for refill scripts from [physician]." Interview on 8/10/23 at 10:04 a.m. with RN D and RN E revealed: *The director of nursing services (DNS) B provided an education sheet for when medications were not available. All of the nurses were to review it and sign it. *They stated it included information to notify the resident's physician and check the emergency drug kit (E-Kit) to see if the medication would be available. Interview on 8/10/23 at 2:30 p.m. with administrator A and DNS B regarding the documentation of resident 37's skin tears and his missed doses of Ipratropium-albuterol and budesonide nebulizer medications revealed: *They confirmed the documentation of his skin tears, including the assessments, physician notification, and treatments provided had been missed. *Their expectation would have been to follow the skin policy. *The pharmacy had been notified on 8/7/23 of the need to refill the ipratropium-albuterol and budesonide nebulizer medications. *It was not delivered the evening of 8/8/23. That was due to needing his physician to provide a new prescription for those medications. *They confirmed the nurse should have checked to see if the E-Kit had those medications until the pharmacy could deliver them. His physician should have been notified of the missed nebulizer medications in case a substitute could have been used. Review of the provider's revised 8/24/22 Local Pharmacy Medication Ordering - Rehab/Skilled	F 658		

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F 658	Continued From page 9 policy revealed: *The policy was specific to new medication orders. *"If the medication has not arrived in time for the medication pass, used emergency/contingency kit." *"If the medication is not available in the emergency/contingency kit and the pharmacy has not delivered the drug by the scheduled med (medication) pass time, call the pharmacy, and speak to pharmacist to determine why the medication was not delivered. Document details in PCC [Point Click Care-electronic health record]." *"If the medication is not available, notify the ordering physician immediately to determine whether the order should be changed or starting the medication can wait until the medication is available from the pharmacy. Document in the PN [progress notes] - Communicate with Pharmacy or PN - Communication/Visit with Physician as appropriate." *"Note: Remember, if you wait to re-order a medication until you are out, you need to communicate to the pharmacy you are out of the medication."	F 658		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761	RN D verbally educated on appropriate medication storage by DNS or designee on 8/10/23. Influenza Vaccines in medication refrigerator were removed and destroyed on 8/11/23. To ensure systemic change all nurses will be educated on medication storage and disposition by DNS or designee by 9/19/23. To monitor performance to ensure that solutions are sustained, observation audits for adherence to Medication Acquisition Receiving Dispensing and Storage Policy will be completed weekly x4 bi-weekly x4, and monthly x 2. The results of these audits will be reviewed and reported at the monthly Quality Committee Meeting	9/19/23

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F 761	Continued From page 10 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review the provider failed to: *Ensure resident medications were secured for one of two medication carts four out of five times during the observed medication pass in the dining room. *Ensure expired influenza vaccines in one of one medication refridgerator were removed and disposed of and and were not available for resident use. 1. Observation and interview on 8/9/23 8:25 a.m. of registered nurse (RN) D during the medication pass in the resident dining room revealed: *Her medication cart was located in the doorway into the dining room. *She had walked away from the medication cart and into the dining room to give medications to three residents without locking the medication cart. *There were residents and staff walking past the	F 761		

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F 761	Continued From page 11 medication cart that was unlocked while the RN was away from the medication cart. *The unlocked medication cart contained multiple resident medications *RN D agreed that she should have locked the medication cart when she walked away to administer medications to those residents. *She prepared a fourth resident's medications at the medication cart and then walked into the medication room to grab a snack for that resident. -The unlocked medication cart was not in view by the nurse. -There were residents and staff walking past the unlocked medication cart. 2. Observation on 8/9/23 at 8:30 a.m. of the medication room refridgerator revealed there were three boxes in the vaccination fridge containing a total of fifteen influenza vaccines that had expired on 6/30/2023. Interview on 8/10/23 at 1:40 p.m with RN D regarding the expired influenza vaccines revealed: *Pharmacy was to have checked the refridgerator containing those vaccines every month. *She was not aware that those vaccines were expired. Interview on 8/10/23 1:45 p.m. with Director of Nursing Services (DNS) B and staff development coordinator RN F revealed: *The expectation when walking away from a medication cart would have been that the nurse or medication aide would lock the medication cart. *DNS B was not aware if the policy indicated that the pharmacy was to have checked the refridgerator in the medication room for expired	F 761		

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F 761	Continued From page 12 vaccines. *RN D stated the expectation would have been that the nursing staff would have checked the expiration date of the vaccine before administration. Review of the provider's March 2023 Medications: Acquisition Receiving Dispensing and Storage policy revealed: *"POLICY/PROCEDURE" *"5. Medications will be stored in a locked medication cart, drawer or cupboard. Only the person passing medications and the director of nursing services and/or designee will be permitted to have access to the keys to the medication storage areas. *6. The location will routinely check for expired medications and necessary disposal will be done in accordance with state/pharmacy regulations."	F 761		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested,	F 791	Resident 11 is actively receiving dental care. Tooth extraction completed 8/29/23. To identify other residents having the potential for deficient Practice DNS or designee will audit all residents for routine dental Service compliance and any dental concerns by 9/19/23. To ensure systemic change transportation scheduler will tack and offer dental services per Dentist recommendation and document in resident medical record as appropriate. To monitor performance and ensure solutions are sustained resident record review audits for adherence to recommended dental services will be completed by DNS or designee weekly x4, bi-weekly x4 and monthly x2.	9/19/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435087	A. BUILDING _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY CANISTOTA	700 WEST MAIN ST CANISTOTA, SD 57012

(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 791	Continued From page 13 assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review the provider failed to ensure one of one sampled resident (11) received recommended routine dental services to prevent tooth extractions. Interview on 8/7/23 at 5:10 p.m. with resident 11 revealed she: *Was missing a few teeth and her teeth were discolored. *Stated that her tooth hurt and she had an appointment to have it pulled.	F 791		

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F 791	Continued From page 14 *Had received Tylenol for the pain. Interview on 8/10/23 at 8:28 a.m. with resident 11 regarding her dental issues revealed she: *Had cream of wheat for breakfast. *Had difficulty chewing solid foods. *Had an upcoming dental appointment to have two teeth pulled on the left side. *Had no help from staff in brushing her teeth and felt she needed more assistance. *Needed to brush her teeth daily. *Had numerous toothbrushes that were kept in her bathroom cupboard, in a yellow plastic basin. Observation on 8/10/23 8:30 a.m. of resident 11's bathroom revealed: *The cupboard contained a yellow plastic basin that had one toothbrush, in the original unopened packaging, that was dated 7/1/23 and in an enclosed toothbrush holder. *On the sink was a battery-operated toothbrush that was dry. *She had no toothpaste. Review of resident 11's medical record revealed: *She was admitted on 7/29/09. *Her 7/24/23 Brief Interview of Mental Status score was a 12, meaning her cognition was moderately impaired. *Her diagnoses included intellectual disabilities, Alzheimer's disease, paranoid schizophrenia, psychotic disturbance, mood disturbance, and anxiety. *Her care plan included: -On 9/9/14 she required supervision and cueing with mouth care and brushing her teeth. -On 7/30/20 she was to have assistance with set up to brush her teeth and was able to rinse and spit,	F 791		

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F 791	Continued From page 15 -On 7/24/23 she had her own teeth. *Her progress notes included: -On 8/4/2022 her teeth were fine, her last dental appointment was on 7/21/22. --The dentist recommended she have her teeth cleaned at the office every three months. ---She preferred every six months. ----There was no documentation to support she had been to the dentist every six months since 7/21/22. -On 06/14/2023 she had a yearly dental appointment scheduled for 7/18/23. -On 7/6/2023: --She had a toothache on the left side of her mouth. --Was missing most of the teeth on the left side and had a very decayed tooth in the front. --A dentist appointment had been made for 7/7/23. -On 8/7/23 she had an appointment at an oral surgery clinic. --She had returned to the facility with an order to take antibiotics for ten days. --She would have dental surgery after she had received medical clearance from her physician. *There was no documented oral care for the last 30 days in her medical record. Interview on 8/10/23 9:22 a.m. with certified nursing assistant (CNA) J revealed: *Her employment started on March 15, 2023. *She was familiar with resident 11's care needs. -Her dental care was provided PRN (as needed). Interview on 8/10/23 at 9:33 a.m. CNA I revealed: *Her employment started in January, 2023. *She was familiar with resident 11's care needs. -The resident occasionally needed assistance in the bathroom and putting on her undergarments.	F 791		

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F 791	Continued From page 16 -The resident was independent in providing her own oral care and would ask staff when she needed toothpaste. Interview on 8/10/23 at 9:40 a.m. social services G regarding dental appointments revealed: *She had been employed with the provider for about two years. *The activity director (AD) H scheduled dental appointments for the residents. -The appointments were yearly and if the resident had complained of dental pain. -Each residents dental information was discussed at each care conference. *AD H would have made six-month appointments if needed. *She had no knowledge of six-month appointment for resident 11. AD H was not available for an interview. Interview on 8/10/23 at 10:01 a.m. and at 11:24 a.m. with administrator A regarding dental appointments revealed: *Dental appointments were made by AD H. *If a resident refused to go to a dental appointment their process would have been the following: -Document in the resident's electronic medical record under the progress notes the reason the resident had refused the dental appointment. -Discussion would have been held regarding the resident's dental status at the next scheduled care conference. -Rescheduling the appointment if the resident would have wanted another appointment. *Resident 11 should have had a dental appointment in January, 2023. *There was no documentation to support resident	F 791		

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F 791	Continued From page 17 11 had refused a six-month appointment. -Her care conferences had not included follow-up to a six-month appointment. *The provider had no dental policy.	F 791		

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

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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 8/7/23 through 8/10/23. Good Samaritan Society Canistota was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Alexis Luke | Administrator | 8/30/23

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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	435087	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/08/2023**

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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 8/8/23. Good Samaritan Society Canistota was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 8/10/23. Please mark an F in the completion date column for K241 and K374 deficiencies identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K321 and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 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.	
K 241 SS=C	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced by: Based on observation and record review, the	K 241		F

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Alexis Luke | Administrator | 8/30/23

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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K 241	Continued From page 1 provider failed to maintain at least two conforming exits from each floor of the building. One of two floors (basement) did not have two conforming exits. Findings include: 1. Observation on 8/8/23 at 10:30 a.m. revealed there was only one exit provided from the basement boiler room. The only exit was a stair enclosure that discharged into the vestibule on the main level. Review of the previous survey data also identified that condition. The building meets the FSES. Please mark an F in the completion date column to indicate the provider's intent to correct deficiencies identified in K000. That deficiency would affect the maintenance personnel if in the basement during a fire emergency.	K 241		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.	K 321	On 8/16/23 floor/ceiling separation in boiler room was supplied with a fire supressant and penetrations of the one-hour fire-rated boiler room ceiling/laundry area floor was sealed with fire-stop system. All residents have the potential to be affected by the deficient practice. To ensure deficient practice does not recur by 9/19/23,a task will be added to our preventative maintenance schedule for bi-yearly monitoring for floor/ceiling separation and penetrations. Deficient results will be resolved.	9/19/23

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K 321	Continued From page 2 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain a hazardous area (boiler room) in the lower level as required. Findings include: 1. Observation on 8/8/23 at 10:40 a.m. revealed the boiler room was over 100 square feet, had fuel fired equipment and had not maintained the floor/ceiling separation. There was a four-inch open pipe above the water softener which was not supplied with a fire suppressant. 2. Observation on 8/8/23 at 11:00 a.m. revealed the fire sprinkler system installation had two penetrations of the one-hour fire-rated boiler room ceiling/laundry area floor. The pipe penetrations must be sealed with an approved fire-stop system. Interview with the maintenance technician at the above times of the observations confirmed those findings. The deficiencies affected one of numerous	K 321		

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K 321	Continued From page 3 requirements for hazardous rooms.	K 321		
K 374 SS=C	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on measurement and document review, the provider failed to maintain at least thirty-two inches of clear width for two of two smoke barrier doors (100 and 200 wings). Findings include: 1. Measurement on 8/8/23 at 9:30 a.m. revealed the cross-corridor doors to the 100-wing measured thirty-one inches of clear width. Further measurement revealed the cross-corridor doors to the 200-wing adjacent to the nurses' station measured thirty inches of clear width. Review of the previous life safety code survey confirmed those findings. The building meets the FSES. Please mark an F in the completion date column to indicate the provider's intent to correct deficiencies identified	K 374		F

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K 374	Continued From page 4 in K000.	K 374		
K 712 SS=E	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to: Conduct fire drills for a minimum of one per shift per quarter for during the past twelve months. No fire drills were held during the third (overnight) shift during the past twelve months. Findings include: 1. Record review on 8/8/23 at 1:45 p.m. revealed the nursing home had three shifts: First shift: 6:00 a.m. to 2:30 p.m.; Second shift: 2:00 p.m. to 10:30 p.m.; Third shift had various start times, with the earliest beginning at 5:15 p.m. and ending at 6:30 a.m. A total of twelve fire drills were held. Documentation of the date and time of the fire drills for the last twelve months were as follows: *8/31/22: 3:01 p.m. *9/30/22: 10:00 a.m.	K 712	Facility will conduct a fire drill on third shift (overnight) by 9/19/23. All residents have the potential to be affected by the deficient practice. To ensure deficient practice does not recur by 9/19/23, a task will be added to our preventative maintenance schedule for quarterly review of fire drills. Deficient results will be resolved. To monitor our performance to ensure that solutions are sustained, audits of fire drills will be conducted q uarterly x2. The results of these audits will be reviewed and reported at the monthly Quality Committee meeting.	9/19/23

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K 712	Continued From page 5 *10/31/22: 11:20 a.m. *12/12/22: silent (reported as failed system) 10:50 a.m. *12/29/22: 2:30 p.m. *1/31/23: 1:46 p.m. *2/16/23: 4:00 p.m. *3/31/23: 10:00 a.m. *4/28/23: 9:35 a.m. *6/26/23: 2:19 p.m. *6/27/23: 9:50 a.m. *7/31/23: 10:15 a.m. Interview on 8/8/23 at 3:15 p.m. with the administrator and the maintenance technician during the exit interview confirmed those findings. Interview with the maintenance technician during the exit interview revealed he was not aware documentation of staff training during silent drills were necessary. The deficiency had the potential to affect 100% of the building occupants.	K 712		

South Dakota Department of Health

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	10603	A. BUILDING: _____ B. WING _____	08/10/2023

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(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 8/7/23 through 8/10/23. Good Samaritan Society Canistota was found in compliance.	S 000		
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 8/7/23 through 8/10/23. Good Samaritan Society Canistota was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Alexis Luke

TITLE: Administrator

(X6) DATE: 8/30/23