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 _____	06/29/2021

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 Surveyor: 29354 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 6/27/21 through 6/29/21. Good Samaritan Society Canton was found not in compliance with the following requirements: F690, F867, and F880.	F 000	1. Resident 30's EMR was updated to allow charting on catheter cares. 2. 3 additional residents with catheters had the potential to be affected. Their charts were audited on 6/28/21 by DNS and found catheter care was appropriately documented. On 7/15/21, CNAs were educated on how to properly provide and document catheter care for residents with indwelling catheters. Staff who were not educated on that date watched video education or participated in a Zoom Call for education. 3. Education was provided to MDS nurse by DNS on 7/21/21 regarding ensuring interventions for catheter care are properly entered in the EMR to allow for documentation. 4. To monitor compliance, Infection Preventionist or designee will audit care plans and documentation records for 3 residents with catheters to ensure catheter cares are properly documented and observe 2 CNAs performing catheter care. Audits will be completed weekly x4, then monthly x2. Infection Preventionist or designee will report findings to QAPI committee monthly. QAPI committee will determine on going interventions and monitoring. 5) Substantial compliance will be achieved by 7/28/2021.	7/26/21
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690		

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

Justin Jones, LNHA 7/23/2021

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 690	Continued From page 1 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, interview, record review, and policy review, the provider failed to ensure one of two sampled residents (30) with an indwelling catheter had received ongoing catheter care. Findings include: 1. Observation and interview on 6/27/21 at 3:30 p.m. with resident 30 revealed: *She had: -An indwelling Foley catheter due to urinary retention. -Used a catheter almost two years after a hospitalization for a severe infection. -Been treated for a urinary tract infection (UTI) in March of this year. *When the surveyor asked her for permission to observe catheter care the following morning she stated: -She normally got up for the day around 9:00 a.m. -She had not received catheter care when the staff came to do her personal care. -The staff had not offered to complete the catheter care and she had not wanted to bother them, because they were busy doing other things. -Even when she was at the hospital the hospital (she had a cystoscopy done in November 2020 for blood in her urine) staff had asked if she received catheter care. She had told them she had not.	F 690		

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F 690	Continued From page 2 -She had her catheter changed monthly and her catheter care was done at that time. Observation and interview on 6/28/21 at 9:30 a.m. of certified nursing assistant (CNA) I completing catheter care on resident 30 revealed: *CNA I performed catheter care with good technique. *She thought catheter care was to have been completed twice daily. Interview on 6/28/21 at 5:15 p.m. with resident 30 regarding the catheter care she had received at 9:30 a.m. when questioned whether that was something she had received routinely she confirmed: *She had not been receiving that or any other catheter care except for the monthly catheter changes. *CNA I had completed the catheter care with good technique. Review of resident 30's medical record revealed: *A 5/4/21 annual Minimum Data Set (MDS) assessment indicated her Brief Interview for Mental Status (BIMS) examination score was 15 indicating her mental status was cognitively intact. *She had a urine culture done with positive results of infection on 3/31/21. *Her revised 5/17/21 catheter care plan revealed "CNA to clean catheter." *The monthly CNA task documentation area for CNA documentation of resident care tasks had no area to remind staff to complete catheter care or document that the care had been completed. *The December 2020 through June 27, 2021 treatment administration records had no documentation to indicate catheter care had been completed.	F 690		

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F 690	Continued From page 3 Interview on 6/29/21 at 1:45 p.m. with the director of nursing services (DNS) regarding resident 30's concern about the lack of catheter care revealed: *Resident 30 had reported to her on two occasions of not having catheter care done in the past, even though the DNS had completed catheter care for her when she had helped out with resident care. -There was no documentation of the catheter care she had provided. *She confirmed resident 30's cognition was intact. *She had discussed infection control issues with the nursing staff monthly the last two months since she began working at the facility. -There was no specific documentation to indicate catheter care had been a topic. *She: -Thought catheter care was part of CNA competencies. --Had not provided copies of those competencies when this writer had requested them at the above time of the interview. *Confirmed there was no documentation to indicate the catheter care had been completed. Review of the provider's May 2021 Catheter: Care, Insertion and Removal, Drainage Bags, Irrigation, Specimen policy about indwelling catheters revealed catheter care was to have been done with morning and bedtime cares and as needed.	F 690		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and	F 867		

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F 867	Continued From page 4 assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on interview, document review, and policy review, the provider failed to ensure an effective quality assurance and performance improvement (QAPI) had consistently been implemented to identify, track, and trend infection control concerns for residents and staff had been identified by a lack of documentation for infection control monitoring for tracking or trending of infections by the infection control preventionist for the first quarter of 2021. Findings include: 1. Interview on 6/29/21 at 10:30 a.m. with QAPI coordinator N regarding the QAPI program revealed: *The expectation had been for the QAPI committee to meet monthly or at a minimum quarterly to discuss identified concerns. *She took over as QAPI coordinator in January 2021. *Each facility department was to have reported quarterly on QAPI findings to the QAPI committee. Review at the above time with QAPI coordinator N of the QAPI committee minutes from 1/1/2021 through 6/29/21 of QAPI information brought to the meetings revealed she: *Was unable to find documentation of infection control statistics/tracking and trending of resident and staff infections. -Had attended QAPI meetings from January 2021 through June 2021.	F 867	1. No residents were identified as being affected by the deficient practice. 2. All residents had the potential to be affected by the deficient practice. 3. A new Infection Preventionist was hired on 6/6/2021. On 7/22/2021 Infection Preventionist and DON received education from Infection Prevention Consultant on the tracking and trending responsibilities of the Infection Preventionist. Infection Preventionist will consistently document and provide to the QAPI committeereports for infection control monitoring for the tracking and trending of infections. On 7/26/21 Medical Director was educated on the need for documented representation on quarterly QAPI meetings. 4. To monitor compliance for IP, DNS or designee will audit Infection Preventionist reports to the QAPI committee to ensure they identify, trend, and track, resident and staff infection control concerns. To monitor compliance for Medical Director attending quartley QAPI, Administrator or designee will audit quarterly attendance of medical director. Both audits will be completed monthly x3 and quarterly x1. QAPI committee will determine on going interventions and monitoring. 5) Substantial compliance will be achieved by 7/28/2021.	7/28/21

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F 867	Continued From page 5 *Stated no infection control statistics had been added to the QAPI meetings for discussion at any of those meetings. *Her expectation was for infection control statistics to have been shared and discussed as part of QAPI. Interview on 6/29/21 at 1:25 p.m. with QAPI coordinator N regarding the missing Infection control statistics information confirmed: *The missing information could not be located, because there was no information or documentation to be found. *The current QAPI team were making good faith attempts to correct identified concerns. *She had not stated how long they had been making good faith attempts. Review of the provider's 2021 QAPI plan revealed: *The QAPI committee was to have ensured an effective QAPI program was in place and the program was adequately resource with time, personnel, training, equipment and financial resources. *The executive leadership was to have supported improvement work by ensuring the provider had a well-defined adequately resource QAPI program to address facility specific issues. *The provider's QAPI committee was to have met at least quarterly and as needed to address identified quality concerns. *The provider's administrator: -Was the leader of the QAPI committee with assistance of the QAPI coordinator. -Was responsible for the QAPI committee's effective operation. *The medical director was included as a member of the QAPI committee.	F 867		

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F 867	Continued From page 6 *Each service line was responsible for tracking individual performance and report data to the QAPI committee. *Action plans were to have been presented to the QAPI committee for monitoring and to ensure improvement was sustained. Review of the administrator's April 2021 job description revealed the administrator was responsible for: *The overall leadership and management including meeting established goals and outcomes, ensuring regulatory and organization compliance, and directing and coordinating work, financial and operational stability, and demonstrating leadership. *Ensuring a QAPI program was in place. *Assigning responsibility to individuals for the daily management of QAPI. *Ensuring the leadership of monthly QAPI committee meetings. *Sponsoring performance improvement projects (PIPs) and reviews. *Providing access to information needed to support QAPI. *Provides equipment and supplies to support QAPI efforts. Review of the provider's May 2020 medical director job description revealed the medical director was identified as a leader and was to be responsible to collaborate with the provider's executive leadership, administration, and department leadership to develop and coordinate overall strategy for the reduction of healthcare associated infections. Review of the provider's December 2020 Associate Quality Strategist job description	F 867		

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F 867	Continued From page 7 provided after a request for the QAPI coordinator job description revealed: *The associate quality strategist: -Role was responsibility for maintaining knowledge of current quality measures within value based programs and contracts. -Was to have the ability to collect and organize detailed information and review, analyze, and validate data reports. -Was to be willing to seek out new information and embrace new responsibilities and change. *Each service line was responsible for tracking individual performance and report data to the QAPI committee. *Action plans were to have been presented to the QAPI committee for monitoring and to ensure improvement was sustained. Refer to F880, findings A1, 2a, 2b, and 3.	F 867		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		

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F 880	Continued From page 8 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 identified under the facility's IPCP and the corrective actions taken by the facility.	F 880	Corrective Action: 1. Time cannot be turned back to a time prior to the identification of *lack of infection control and prevention tracking and trending. *lack of follow through for facility policies for employee health and TB screening. *lack of appropriate hand hygiene and glove use during task of providing resident personal care. Ensure identified infection control nurse receives necessary education and resources to complete assigned tasks and includes conducting meetings for discussion and review of infection control and prevention plan and procedures. Provider has previously been cited for F880. Administrator, DON, and Infection control nurse were provided education/re-education by corporate Lead Infection Preventionist on 7/22/21. The administrator and DON in consultation with the medical director and infection control nurse and whomever else identified will review, revise, create as necessary policies and procedures about: *Appropriate implementation and maintenance of infection control and prevention tracking and trending. *Appropriate implementation and follow through for facility policies for employee health and TB screening. *Appropriate hand hygiene and glove use during resident personal care. *Necessary infection control and prevention plan that includes effective compliance. All staff who provided above care and services to residents will be educated/re-educated by 7/28/21 by Director of Nursing. Identification of Others: 2. ALL residents including those indicated have the potential to be affected if staff do not adhere to: *A formulated plan for tracking and trending infection control. *A formulated plan for employee health and TB screening. *Appropriate hand hygiene and glove use during resident personal care. ALL staff completing the care and/or assigned tasks have potential to be affected including those indicated. Policy education/re-education about roles and responsibilities for the above identified assigned task(s) will be provided by 7/28/21 by DNS System Changes: 3. Root cause analysis conducted answered the 5 Whys : We learned from the 5 whys that this was something that fell through the cracks during transition. Administrator, DON, infection control nurse, 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. All staff, including those indicated, should be aware of infection control nurse's task(s) of tracking and trending infection control and prevention throughout the facility so they may be aware of what may contribute to negative outcome. Administrator contacted the South Dakota Quality Improvement Organization (QIN) on 7/22/21 and discussed resources they provide as well as conducted a 5 fishbone and 5 why analysis. They provided us with quality improvement tools to ensure continued compliance In The future. Monitoring: 4. Administrator, DON, infection control nurse, and whomever else determined will conduct auditing and monitoring for areas identified. Monitoring of determined approaches to ensure effective infection control and prevention include at a minimum weekly for 4 weeks, administrator, DON, and/or infection prevention nurse making observations across all shifts to ensure staff compliance with: *Necessary infection control and prevention plan that includes compliance in the above identified areas. *Any other areas identified thru 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 infection control person to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director. 5. Substantial compliance will be achieved by 7/28/2021	7/26/21

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F 880	Continued From page 9 §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: Surveyor: 41088 Surveyor: 32332 A. Based on interview, document review, policy review, and infection control preventionist (ICP) and director of nursing services (DNS) job descriptions, the provider failed to ensure a consistent infection prevention and control program had been in place for staff and residents for: *Evaluating and tracking infection control trends and practices. *Conducting infection control meetings. *Reporting statistical information to the quality assurance performance improvement (QAPI) program to assist with establishing goals and objectives for infection control. *Five of five newly hired sampled employees (A, B, C, D, and E) had a health evaluation completed by a healthcare professional within fourteen days of being hired. *Five of five newly hired sampled employees (A, B, C, D, and E) had completed the two-step method for the Mantoux tuberculin (TB) skin test or TB screenings within fourteen days of being hired. Findings include:	F 880		

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F 880	Continued From page 10 1. Interview on 6/29/21 at 1:30 p.m. with the director of nursing services (DNS) A and registered nurse (RN) J regarding the infection control program revealed: *The provider had many staffing changes over the past year with multiple changes in the nurses' responsible for infection prevention and control. *Licensed practical nurse (LPN) L was certified as an ICP and had been in that role until October 2020. -She was now working as a night nurse and sometimes helped out with infection control. *From November 2020 through February 2021 the previous DNS RN J had taken over the job of infection control. *In February 2021 an interim DNS N took over the responsibility of infection control until May 2021. *RN K: -Accepted the position of ICP four weeks ago. -Was not yet certified as ICP. -Had not been trained. -Was not going to begin the job until she became certified. Continued interview with DNS A and RN J regarding the requested infection control program documentation for the last year revealed RN J provided the following information: *A graph indicating the monthly antimicrobial rate form June 2020 through May 2021. *A graph indicating the monthly infection rate from June 2020 through May 2021. *A Monthly Infection Summary from 6/22/20 through 8/7/20. That summary contained: -Residents' names. -Start date. -Date symptoms resolved had been identified for twelve of seventeen residents.	F 880		

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F 880	Continued From page 11 -Type of infection. -The current status of the infection. -The antimicrobial used had been identified for six of seventeen residents. -Infection source. -Surveillance criteria met or not met. *A Monthly Antimicrobial Summary from 6/22/20 through 7/24/20. That summary contained: -Residents' names. -The name and antimicrobial class of the medication used to treat the infections. -The start date and end date of the medication therapy. -The route the medication was given. -The infection type had been identified for one of fifteen residents. RN J was asked to provide the monthly infection and antimicrobial summaries that related to the above graphs, any further tracking, trending, and other statistical information identified, infection control meeting minutes and education provided related to infection control. RN J had not provided any further infection control documentation for review. On 6/29/21 at 3:30 p.m. RN J stated: *There was no further infection control documentation because it had been given to the QAPI committee. *The infection control documentation had not been retained by the infection control nurse. *Infection control meetings were not held separately, because they were just part of the QAPI program. Interview on 6/29/21 at 3:35 p.m. with DNS A regarding the infection control program revealed: *Her expectation was for the infection control	F 880		

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 _____	06/29/2021

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 880	Continued From page 12 preventionist to maintain documentation of: -Evaluating and tracking infection control trends and practices. -Monthly infection and antimicrobial summaries and other statistical information. -Education provided to staff regarding current infection control concerns. -Infection control meeting minutes. -Any infection control statistical information that had been provided to QAPI. Surveyor: 41088 2a. Review of the following employee personnel records revealed the following hire dates: *Employee A: 4/26/21 *Employee B: 5/26/21 *Employee C: 3/1/21 *Employee D: 4/23/21 *Employee E: 5/11/21 *There was no documentation in the above employee personnel files that a health evaluation had been completed, reviewed and signed by a health care professional to determine the employees were free of communicable diseases. Interview on 6/29/21 at 2:30 p.m. with administrator H revealed: *He confirmed there was no documentation in employee A, B, C, D, or E's personnel files that a health evaluation had been completed within fourteen days of being hired to determine they were free of communicable diseases. *He was aware that it should have been done and stated it had been missed. Surveyor: 41088 2b. Review of the following employee personnel records revealed the following hire dates: *Employee A: 4/26/21	F 880		

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 _____	06/29/2021

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 880	Continued From page 13 *Employee B: 5/26/21 *Employee C: 3/1/21 *Employee D: 4/23/21 *Employee E: 5/11/21 *There was no documentation in the above employee personnel files TB screening had been completed. Interview on 6/29/21 at 2:30 p.m. with administrator H revealed: *He confirmed employee's A, B, C, D, and E had not had a TB screening completed within fourteen days of hire and should have. *His expectation was for the state regulation to be followed for the TB screenings. Surveyor 32332 3. Review of the provider's reviewed/revised December 2019 Infection Prevention and Control Program policy revealed: *The provider would maintain an infection prevention and control program to provide a safe, sanitary and comfortable environment for residents, patients, children, families, visitors and employees and to help prevent the development and transmission of communicable diseases and infections. *The infection preventionist and the QAPI committee would direct the functions of the infection prevention and control program. *The system of identifying, reporting, investigating, and controlling infections and communicable diseases for all residents was to have been tracked where possible on the Infection and Antimicrobial Tracking Tool and reviewed by the QAPI committee who would keep a record of any corrective action taken. *The system of identifying, reporting, investigating, and controlling infections and	F 880		

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 _____	06/29/2021

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 880	Continued From page 14 communicable diseases for all employees, visitors and other individuals providing services would be tracked where possible on a Monthly Report of Infections in location - Employees, children, family and visitors. Review of the provider's reviewed/revised July 2020 Surveillance policy revealed: *Surveillance was to have been done to find, analyze, control, and prevent nosocomial infections. *Surveillance included collection, collation analysis of date and passing of information to those who needed to know and take action. Review of the December 2019 Infection Preventionist policy revealed the following responsibilities of the IP: *Coordination of an annual review of the infection prevention and control program and update as necessary. *Coordination of the antibiotic stewardship program. *Completion of the infection and antimicrobial tracking tool and use the information to report to the QAPI committee. *Become a member of the QAPI committee. *Investigate and report clusters of infections and unusual nosocomial infections and submit a monthly infection summary and Monthly antimicrobial summary and a monthly report of infections to the QAPI committee. *Work to prevent infections and implement improved resident care procedures. *Collect and catalog infection data, review the reports and recommend procedures to control additional cases. *Investigate and assist with employee health activities, including recording employee infection	F 880		

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 _____	06/29/2021

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 880	Continued From page 15 reports and information. *Provide infection control education to new employees and continuing education to all staff. *Continually monitor employee infection control practices. Review of the May 2021 director of nursing services job description revealed the DNS was responsible for: *The overall quality of care provided by the organization's nursing personnel. *Monitoring the compliance with regulations. *The overall responsibility for the day-to-day operations of the facility. *The quality of resident care. *Performing necessary delegation and coordination for clinical, operational, and managerial activities. *Effectively managing and directing the work of individuals and teams. Surveyor: 29354 B. Based on observation, interview, record review, and policy review, the provider failed to ensure one of three observed certified nursing assistant (CNA) (F) had maintained infection control technique during one of two observed sampled residents (40) personal care. Findings include: 1. Observation on 6/27/21 at 3:50 p.m. in resident 40's room with CNAs F and G revealed: *CNAs F and G had on gloves. *CNA F: -Assisted resident 40 to turn to her left side in bed. -Unfastened her wet brief and pulled it down, took a wet wipe from the package, and wiped one time	F 880		

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 _____	06/29/2021

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 880	Continued From page 16 in her front perineum area. -Removed the soiled brief and discarded it into the garbage. -Took another wet wipe from the package and wiped one time over her buttock area. *With the same gloves on, he put a clean brief on her and pulled up her slacks *CNAs F and G: -Assisted her with sitting up in bed. -Attached the mechanical stand lift sling around her and around her feet. *With the same gloves on CNA F touched the control switch on the mechanical lift and guided her to the wheelchair. *CNA F removed those gloves, discarded them into the garbage. tied up the garbage bag, and then went into the bathroom and performed hand hygiene. Review of resident 40's medical record revealed: *She had a diagnosis of dementia and was being treated for a urinary tract infection. *The 6/8/21 Minimum Data Set assessment had been coded she required extensive assistance of one staff member for toilet use, personal hygiene, and was incontinent of bowel and bladder. Interview on 6/29/21 at 10:20 a.m. with DNS A regarding CNA F and hand hygiene during resident 40's personal care revealed her expectations would have been after touching something soiled/dirty to remove gloves and perform hand hygiene, reapply gloves, and continue. CNA F should have removed his gloves and performed hand hygiene. Review of the provider's 4/6/21 Hand Hygiene and Handwashing policy revealed:	F 880		

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 _____	06/29/2021

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 880	Continued From page 17 *The purpose was "to ensure appropriate hand hygiene technique for clinical use." *The goal for patient [resident] care was to "prevent the spread of infection between residents." -"Handwashing and changing gloves occurs after care is delivered to prevent the spread of organisms to other residents. -Sanitizers are used in patient care areas." *During patient [resident] care: -"2. If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based hand rub for routinely cleaning hands." -"c. After having contact with body fluids, wounds or broken skin." -"e. After removing gloves." Review of the provider's 4/16/21 Perineal Care policy and procedure revealed: *Purpose: -"To prevent infection and odors in the perineal area. -To promote good perineal hygiene. -To observe perineal area." *Procedure: -"3. Apply gloves. -4. Fold covers down and remove soiled pad. -5. Remove soiled gloves. Wash hands or use hand sanitizer before touching objects in environment. Re-glove to resume perineal care. -6. If resident is unable to spread legs and flex knees, turn the resident on the side with legs flexed. -7. Wet washcloth, apply a small amount of soap or peri-wash or use a disposable wipe. --For females: —-a. -8. Turn resident (both male and female) on side to wash, rinse and dry anal area.	F 880		

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	435101	A. BUILDING _____ B. WING _____	06/29/2021

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 880	Continued From page 18 –After removing soiled gloves use hand sanitizer or wash wit soap and water to cleanse hands. --Put on clean gloves to put on clean pad and/or clothing."	F 880		

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 _____	06/29/2021

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
E 000	Initial Comments Surveyor: 29354 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 6/27/21 through 6/29/21. Good Samaritan Society Canton was found in compliance.	E 000		

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

Justin Jones, LNHA 7/23/2021

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435101	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/29/2021

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

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K 000	INITIAL COMMENTS Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 6/29/21. Good Samaritan Society Canton was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K211 and in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		7/28/2021
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation, testing, and interview, the provider failed to provide an operable egress door as required at one randomly observed exit door location (600 wing west exit door). Findings include: 1. Observation on 6/29/21 at 2:43 p.m. revealed the west exit door to the 600 wing was unable to be opened. Testing of that door in the direction of	K 211	On 6/30/21 door was fixed so it was able to be opened with less than 50 pounds of force. Starting 6/30/21, all doors will be able to be opened with less than 50 pounds of force. On 7/23/21 education was provided to Maintenance Mechanic by Administrator that all doors need to be able to be opened with less than 50 pounds of force. To ensure continued compliance, audits will be completed monthly x4 Anticipated date of correction is 7/28/21	

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

Justin Jones, LNHA 7/23/2021

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435101	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/29/2021**

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
K 211	Continued From page 1 the path of egress revealed it would not open without applying force greater than fifty pounds in the direction of the path of egress. Interview at the time of the observation with the maintenance assistant confirmed those conditions. He stated he was unaware that door was not able to be opened. Failure to provide working egress doors as required increases the risk of death or injury due to fire. The deficiency affected 100% of the smoke compartment occupants. Ref: 2012 NFPA 101 Section 19.2.2.2.1, 7.2.1.4.5.1(2)	K 211		

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 _____	06/29/2021

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 Surveyor: 29354 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 6/27/21 through 6/29/21. Good Samaritan Society Canton was found not in compliance with the following requirements: S210 and S236.	S 000	Starting 7/28/21, DNS, Infection Preventionist, charge nurse or other licensed health professional will evaluate all newly hired personnel for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccination and tuberculin skin tests. On 7/22/21 education was provided to Administrator, Infection Preventionist and DON about this regulation and policy by Lead Infection Preventionist. To ensure continued compliance, DNS or Designee will conduct audits and report to QAPI monthly x4. Anticipated date of correction is 7/28/21.	7/26/21
S 210	44:73:04:06 Employee Health Program The facility shall have an employee health program for the protection of the residents. All personnel shall be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Any personnel absent from duty because of a reportable communicable disease which may endanger the health of residents and fellow employees may not return to duty until they are determined by a physician or physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 41088 Based on record review, interview, and policy review, the provider failed to ensure five of five sampled employees (A, B, C, D, and E) had a health evaluation completed within fourteen days of being hired. Findings revealed:	S 210		

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Justin Jones, LNHA 7/23/2021

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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 _____	06/29/2021

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

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S 210	Continued From page 1 1. Review of the following employee personnel records revealed the following hire dates: *Employee A 4/26/21 *Employee B 5/26/21 *Employee C 3/1/21 *Employee D 4/23/21 *Employee E 5/11/21 *There was no documentation in the above employee personnel files that a health evaluation had been completed, reviewed and signed by a health care professional to determine the employees were free of communicable diseases. Interview on 6/29/21 at 2:30 p.m. with administrator H revealed he: *Confirmed there was no documentation in employee A, B, C, D, or E's personnel files that a health evaluation had been completed within fourteen days of being hired to determine they were free of communicable diseases. *Was aware it should have been done and stated it had been missed. Review of the provider's 6/21 revised General Orientation and Day One New Employee Paperwork Policy revealed: *A medical history questionnaire was to be filled out by the new employee on their first day. *The policy did not include the need for a healthcare professional to complete an examination to verify the employee was free from signs and symptoms of communicable diseases and was signed by a healthcare professional.	S 210		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare	S 236		

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 _____	06/29/2021

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

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S 236	Continued From page 2 workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 41088 Based on record review, interview, and policy review, the provider failed to ensure five of five sampled employees (A, B, C, D, and E) had completed the two-step method for the Mantoux tuberculin (TB) skin test or TB screenings within fourteen days of being hired. Findings include: 1. Review of the following employee personnel records revealed the following hire dates: *Employee A 4/26/21	S 236	Starting 7/28/21, DNS, Infection Preventionist, charge nurse or other licensed health professional will administer a two-step TB test to all new hires within 14 days of hire. On 7/22/21 education was provided to Administrator, Infection Preventionist and DON about this regulation and policy by Lead Infection Preventionist. To ensure continued compliance, audits will be completed monthly x4 Anticipated date of correction is 7/28/21	

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 _____	06/29/2021

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 236	Continued From page 3 *Employee B 5/26/21 *Employee C 3/1/21 *Employee D 4/23/21 *Employee E 5/11/21 *There was no documentation in the above employee files TB screening had been completed. Interview on 6/29/21 at 2:30 p.m. with administrator H revealed: *He confirmed employee's A, B, C, D, and E had not had a TB screening completed within fourteen days of hire and should have. *His expectation was for the state regulation to be followed for the TB screenings. Review of the provider's 7/22/20 Tuberculosis Control Plan and Screening for Employees-Infection Control Policy revealed: "New employees will have a baseline tuberculosis (TB) screening using the tuberculin skin test (TST) two-step method. This involves administering the initial TST to be read in 48 to 72 hours by a nursing professional or physician/practitioner. The second test is administered in one to two weeks and is read 48 to 72 hours after administration by a nursing professional or physician/practitioner."	S 236		