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
	435046	A. BUILDING ______ B. WING ______	C 11/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

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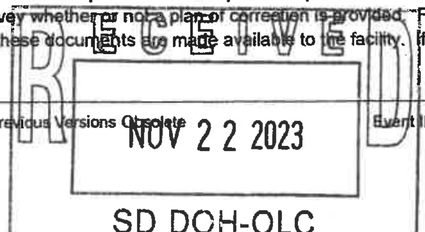
F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 11/6/23 through 11/7/23. Areas surveyed included resident neglect and pressure ulcers. Good Samaritan Society Sioux Falls Center was found not in compliance with the following requirement: F686.	F 000		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on the South Dakota Department of Health (SD DOH) complaint intake information, record review, interview, and policy review, the provider failed to ensure consistent repositioning for one of one sampled resident (1) who was completely dependent on staff for all activities of daily living (ADLs) that included mobility and had a high risk for skin breakdown on admission. Findings include:	F 686	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. Resident no longer resides in this facility.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11-22-2023

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



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F 686	Continued From page 1 1. Review of the SD DOH complaint intake information revealed: *Resident 1 was admitted to the facility on 8/16/23 after an extended stay in an acute care facility due to a cardiac arrest with subsequent anoxic brain injury. *The resident had a large pressure wound to the sacral area. *Her tailbone was visible through the resident's sacral area. *The resident was unable to move or speak. *The resident was unable to perform any ADLs independently and was completely dependent on staff. 2. Review of resident 1's electronic medical record (EMR) revealed: *She was admitted on 8/16/23. *Her age was 41 years. *Her diagnoses included the following: -Anemia. -Atrial fibrillation. -Heart failure. -Orthostatic hypotension. -Seizure disorder. -Anoxic brain damage. -History of cardiac arrest. -Gastrostomy (feeding tube). -Tracheotomy (breathing tube). -Incontinent of bowel and bladder. *The 9/29/23 quarterly Minimum Data Set (MDS) indicated the following: *She was incontinent of bowel and bladder. *She was dependent on staff for all ADLs and mobility. *Her Braden scale score on admission was 10 indicating she was at high risk for skin breakdown.	F 686	DON/Designee will audit repositioning documentation on all current residents with pressure injuries or are at high risk for pressure injuries evidenced by a Braden Score of 12 or less, to determine compliance with documentation of repositioning schedules as care planned. Education to be provided by DNS/designee regarding the importance of charting, review processes of charting, and repositioning. CNAs will check in with charge nurse prior to departing their shift to ensure charting on repositioning is completed. Charge nurse to check CNA charting at the time of check-in to ensure compliance. Comprehensive review of resource packet for repositioning completed with wound nurse. Wound nurse will be registered for the wound nurse certification course by 11/24/23. Wound nurse has been provided additional education through online modules and videos to be completed by 11/24/23. In person training for Wound Nurse to be completed by Restorix Wound Specialist by 11/24/23.	

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F 686	Continued From page 2 3. Review of resident 1's 8/16/23 comprehensive care plan revealed the following: *The resident had ADL self-care deficits related to her anoxic brain injury and was totally dependent on staff for ADLs. -Bed mobility: "Turn from Side to Side: resident is totally dependent on staff for this activity." -Bed mobility: "Lying to Sitting: resident is totally dependent on staff for this activity." -Bed mobility: "Sitting to Lying: resident is totally dependent on staff for this activity." *The resident had bowel and bladder incontinence related to anoxic brain injury and required total assistance with ADLs. -"Resident will remain free from skin breakdown due to incontinence and brief use through the review date." -"Resident uses soaker pads for incontinence due to resident having an air mattress." -"Turn and reposition in bed every two hours." Initiated two days after her admission to the facility on 8/18/23. *A revision date of 10/3/2023 regarding "The resident has an impairment to skin integrity R/T [related to] anoxic brain injury and inability to reposition her E/B [evidenced by] wound sacral area and bil [bilateral] ears." *Interventions included the following: -"Reduce risk of skin impairment. Sling to remain under resident while in the chair." -High risk for skin injury - use extra caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface." -"Keep skin clean and dry." -"Turn and reposition in bed every two hours." -"Weekly skin observation by licensed nurse. Schedule tx [treatment] to ears and sacrum." -Revision date of 11/02/2023: "Resident has an	F 686	To monitor compliance, DON/Designee will audit five repositioning documentation charts from the current list of residents who have either current pressure injuries or are at high risk for pressure injuries evidenced by a Braden score of 12 or less. This will occur weekly x 8 weeks then every other week x 8 weeks. DON or designee will report findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring. Substantial compliance will be achieved on 11/27/23.	11/27/23

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F 686	Continued From page 3	F 686		

air mattress on her bed and a pressure reducing cushion on her chair. Cushion change to high pressure ROHO cushion for pressure relief on 8-22-23."

4. Review of resident 1's 8/16/2023 Braden Scale for Predicting Pressure Sore Risk Admission revealed:
*The score was 10 indicating the resident was at high risk for skin breakdown.
*The intervention guide for a high risk score included the following:
-"Frequent Turning with a Planned Schedule.
-Supplement with Small Shifts in Position.
-Manage Moisture.
-Manage Friction and Shear."

5. Review of resident 1's 8/16/23 Nursing Admit Data Collection form revealed:
*Skin Integrity:
-Color was normal.
-Temperature was warm.
-Moisture condition was moist.
-Turgor was normal.
-The resident had abrasions to the right great medial toe.
-The sacrum was slightly reddened and blancheable (able to return to normal color when pinched).
-There was no history of a previous healed pressure ulcer.
-The resident had a potential for pressure ulcer development.
-There was paralysis of upper and lower extremities and the resident was unable to move any extremity.

6. Interview on 11/6/23 at 10:35 a.m. with occupational therapist (OT) D regarding resident

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F 686	Continued From page 4 1 revealed she: *Had conducted pressure mapping (evaluation of the skin for pressure between the individual's body and the surface of the bed or chair) of the resident's wheelchair on 9/15/23. *Had conducted pressure mapping of the residents bed on 9/21/23. *Thought the pressure wound on the residents sacrum was from extended periods of time without being repositioned. 7. Interview and record review on 11/6/23 at 10:50 a.m. with registered nurse (RN) wound nurse C regarding resident 1's wounds revealed: *She had started as the wound nurse approximately a year ago. *Her training had consisted of online courses in wound care. *The wound on resident 1's sacral area first presented as a deep purple and discolored like a deep tissue injury (is a form of a pressure ulcer or pressure sore. Pressure ulcers are localized areas of tissue damage of necrosis that develop because of the pressure of a bony prominence). *The resident had no pressure ulcers on admission. *Pressure mapping was completed by occupational therapy (OT). *She had been completing wound measurements weekly and documented those findings in the EMR. *She had never received a job description of her role and responsibilities as the wound nurse. *On 9/12/23 the sacral wound measured 5 centimeters (cm) by (X) 4 cm and had no depth to the wound. *On 9/26/23 the sacral wound had two opened areas a distal area that measured 2 cm X 1.5 cm and a proximal wound that measured 1.5 cm X	F 686		

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F 686	Continued From page 5 1.0 cm. *On 9/26/23 the proximal wound to the sacrum measured 1.5 cm X 2 cm with no depth. and the distal wound measured 2 cm X 2 cm. *On 10/3/23 The sacral wound was worsening and measured 5 cm X 3 cm with a denuded (removal of the skin) area measuring 1.5 cm X 1.5 cm X 0.5 cm. That was when the Triad paste was increased to twice daily. *On 10/9/23 the sacral wound measured 6 cm X 3 cm X 0.3 cm. A new specialty air mattress was applied. *On 10/16/23 the sacral wound measured 4 cm X 3 cm X 1 cm. *On 10/23/23 the wound measured 5 cm X 3 cm X 1 cm. *On 10/30/23 the wound measured 6 cm X 4 cm X 2 cm. 8. Interview on 11/6/23 at 2:15 p.m. with administrator A regarding resident 1 revealed: *He had started his employment about a year and a half ago. *The wound process was revamped adding a wound nurse to evaluate, monitor, and document on resident wounds. *Education reminders were given to staff frequently. *There was a weekly resident council meeting for residents to voice any concerns they had with the care that was provided. 9. Interview on 11/6/23 at 3:00 p.m. with director of nursing (DON) B regarding resident 1 revealed: *She provided daily huddles for staff at alternating times to include all staff. *If staff could not attend a huddle information from the huddle was available for staff to read. *She had provided frequent education of the	F 686		

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F 686	Continued From page 6 importance of thorough charting. *She had completed resident chart reviews for completion of documentation. *She had educated and re-educated staff regarding the proper positioning of residents. *Resident 1 had continuous incontinent liquid stools and before her admission she had a fecal management system while she was in the hospital. That type of system was not possible at the facility. 10. Review of resident 1's 8/16/23 Order Summary Report revealed: *"HOB [head of bed]: Elevate HOB [head of bed] 30 to 45 degrees at all times during feeding and for at least 30 to 40 minutes after the feeding is stopped." *"Heel Lift Boots For heel protection or pressure reduction for patients (residents) with high risk for skin breakdown when in bed." *On 9/13/23 "Mepilex to sacral area. Change every 3 days and PRN loose or soiled one time a day every 3 days for skin breakdown." *Occupational Therapy to evaluate and treat order date was 8/17/23. *"SKIN/WOUND CARE: SKIN BREAKDOWN RISK: 1) Assess bony prominence's. 2) Turn/reposition every 2 hours. 3) Heels up/off bed. 4) Protect skin. Keep clean and dry. 5) Moisture barrier for incontinence. 6) Use lift pad. 7) Speciality bed if indicated or air mattress overlay per facility protocol." *"9/14/23 WOUND CARE: Apply Triad paste to sacral area twice daily for sacral wounds related to PRESSURE-INDUCED DEEP TISSUE DAMAGE OF SACRAL REGION." *"10/26/23 WOUND CARE: Apply Triad paste to sacral area twice daily for sacral wounds related to PRESSURE-INDUCED DEEP TISSUE	F 686		

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F 686	Continued From page 7 DAMAGE of SACRAL REGION" 11. Review of resident 1's August 2023 through October 2023 Turn and reposition in bed every two hours documentation revealed: *There was extensive periods where no documentation for repositioning was found for the following dates and times: -8/18/23 at 5:14 p.m. until 8/19/23 at 5:11 a.m. that was a 12 hour period of time. -8/19/23 at 2:01 p.m. until 8/19/23 at 11:09 a.m. that was a 9 hour period of time. -8/23/23 at 3:19 p.m. until 8/23/23 at 10:02 p.m. that was a 9 hours period of time. -8/25/23 at 6:01 a.m. until 8/25/23 at 4:28 p.m. that was a 10.5 hour period of time. -8/26/23 at 8:02 p.m. until 8/27/23 at 5:27 a.m. that was a 9.5 hour period of time. -8/27/23 at 10:06 a.m. until 8/27/23 at 7:50 p.m. that was a 9 hours period of time. -8/28/23 at 3:52 p.m. until 8/29/23 at 12:22 a.m. that was an 8 hour period of time. -8/30/23 at 9:30 p.m. until 8/31/23 at 12:30 p.m. that was a 15 hour period time. *There were multiple lapses in August for every two hour repositioning that went from 3 hours to 15 hour periods of time with no documentation of repositioning resident 1. -9/10/23 at 11:25 a.m. through 9/11/23 at 10:22 a.m. that was a 10 hour period of time. -9/14/23 at 2:00 p.m. through 9/14/23 at 11:01 p.m. that was a 9 hour period of time. -9/19/23 at 1:33 p.m. through 9/20/23 at 12:30 a.m. that was an 11 hour period of time. -9/28/23 at 1:21 p.m. through 9//28/23 at 9:32 p.m. that was an 8 hour period of time. -9/29/23 at 9:22 p.m. through 9/30/23 at 12:32 p.m. that was a 15 hour period of time. *There were multiple lapses in September for	F 686		

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F 686	Continued From page 8 every two hour repositioning that went from 3 hours to 15 hours periods of time with no documentation of repositioning resident 1. -10/1/23 at 5:45 a.m. through 10/1 12:58 p.m. that was a 7 hours period of time. -10/3/23 at 2:10 p.m. through 10/4/23 at 1:15 a.m. that was an 11 hour period of time. -10/7/23 at 5:06 p.m. through 10/8/23 at 2:55 a.m. that was a 9.5 hour period of time. -10/11/23 at 4:48 a.m. through 10/11/23 1:03 p.m. that was an 8 hour period of time. -10/14/23 at 1:48 a.m. through 10/14/23 at 10:17 a.m. that was an 8.5 hour period of time. -10/17/23 at 1:51 p.m. through 10/17/23 at 11:19 p.m. that was a 9 hour period of time. -10/18/23 at 9:00 p.m. through 10/19/23 at 1:01 p.m. that was a 16 hour period of time. -10/19/23 at 9:22 p.m. through 10/20/23 at 10:43 a.m. that was an 11 hour period of time. -10/28/23 at 9:27 p.m. through 10/29/23 at 12:35 p.m. that was a 15 hour period of time. *There were multiple lapses in October for every two hour repositioning that went from 3 hours to 16 hours periods of time with no documenting of repositioning resident 1. 12. Interview on 11/7/23 at 5:45 a.m. with licensed practical nurse (LPN) E regarding repositioning and care for resident 1 revealed: *She worked for a staffing agency and was on an eleven week assignment. *Worked only one night shift on resident 1's floor. *She would have to suction the resident every hour. *The resident could not be totally repositioned on her sides due to her tracheotomy. *She had a specialty air mattress. *The HOB was elevated at 30 to 45 degrees during her feeding.	F 686		

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F 686	Continued From page 9 *The only reason she had worked the night shift on that floor was a nurse had called in sick for that night. *She felt the CNAs had done a good job. 13. Interview on 11/7/23 at 6:00 a.m. with certified nursing assistant (CNA) F regarding repositioning and care for resident 1 revealed: *She had been employed as a CNA since December 2023. *She worked the night shift. *One to two CNAs work the night shift. *She had a routine to ensure residents were checked and changed every two hours. *The resident had a speciality air mattress. *Staff would use pillows and or wedges to attempt to keep the resident off of her bottom. *Staff were to document the repositioning every two hours. *The resident had frequent loose stools. *Disposable chux pads were placed underneath the resident for the loose stools. *The last time she had observed resident 1's wound it was an open area the size of an egg but she could not give an exact date. *She had put the Triad paste on the sacral wound one time during care. 14. Interview on 11/7/23 at 6:15 a.m. with LPN G regarding repositioning and care for resident 1 revealed she: *Worked for a staffing agency. *Was on a 13 week contract. *Had shadowed another employee for one day prior to working independently. *Had not been shown where to find the policy and procedures for the facility but had worked for another sister facility and felt she knew the policy and procedures.	F 686		

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F 686	Continued From page 10 *Had cared for resident 1 twice when the wound care nurse was assisting her with care because a nurse had called in sick and she was in charge of 13 to 14 residents. *Was responsible for medication and treatment administration for the residents. *Trusted the staff to complete repositioning and care for the residents. *She would monitor the activity on the floor. 15. Interview on 11/7/23 at 6:41 a.m. with director of nursing B revealed: *CNAs were to have been checking in with the charge nurses prior to leaving for the day. *She was going to implement at affidavit that would have to be signed by the CNAs to ensure repositioning and care was completed and documented prior to leaving the shift. *The Braden scale interventions were utilized but liked to individualize the interventions toward the needs of the residents. *A stand-up meeting occurred daily for any significant changes that occurred in the residents. *She has completed extensive education and re-education with all the CNAs regarding thorough and complete documentation. *Her expectation was that CNAs would be held accountable for following through on the implemented interventions that were put in place for residents care. *Due to staffing issues the facility had to utilize agency staff. 16. Interview on 11/7/23 at 7:15 a.m. with administrator A revealed there were no policy and procedures to ensure thorough and complete CNA documentation. 17. Review of the provider's 2/10/23 Pressure	F 686		

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GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 686	Continued From page 11 Ulcer policy revealed: *The purpose of the policy was to have provided appropriate assessment and prevention of pressure ulcer, as well as treatment when necessary. *Based on the resident's comprehensive assessment, prevention and assessment interventions would have been used to ensure that a resident entering the facility without pressure ulcers would not develop a pressure ulcer unless the individual's clinical condition demonstrated that the pressure ulcer was unavoidable. *Residents would receive appropriate assessments and services to promote and maintain skin integrity. If a resident's clinical condition would make the compromise of skin integrity clinically unavoidable, that information would have been documented in the medical record. *The comprehensive care plan was an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that were to have been furnished to attain and maintain the resident's highest practicable physical, mental, and psychosocial well-being. *"The Federal Regulation F686 was the federal regulation regarding pressure sores. It states the following: 1. A resident who enters the facility without a pressure sore does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and 2. A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 686		