STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435101	A. BUILDING ______ B. WING ______	12/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 12/19/2023 through 12/21/23. Good Samaritan Society Canton was found not in compliance with the following requirements: F806, F812, and F880. On 12/19/23 at 5:39 p.m., immediate jeopardy was identified related to the proper disinfection of one of one community shared glucometers at F880. The survey team exited the building at 5:45 p.m. On 12/20/23 at 9:41 a.m., administrator A provided a final plan for removal of the immediate jeopardy and the removal plan was accepted with agreed-upon changes made by the provider. On 12/20/23 at 12:57 p.m., the survey team reviewed the provider's documentation for the removal plan of the immediate jeopardy. The removal plan was accepted and the immediacy was removed. The resident census was 52.	F 000		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice;	F 806		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Scott Larson
TITLE: Administrator
(X6) DATE: 1/18/2024

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 806	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the provider failed to offer one of one sampled resident (45) a meal alternative when the resident expressed that she did not like what had been served. Findings include: 1. Observation on 12/19/23 at 11:10 a.m. in the dining room revealed the menu for lunch was cheesy tuna casserole, cucumber salad, bread, and apple crisp. Observation on 12/19/23 at 11:44 a.m. in the dining room revealed that a staff member was wheeling a cart of room trays out of the dining room. 2. Observation and interview on 12/19/23 from about 2:15 p.m. to 3:15 p.m. with resident 45 in her room revealed: *She was on airborne precautions due to her diagnosis of COVID-19 and was isolated in her room. *There was a Styrofoam plate on her overbed table. There was tuna casserole and green beans on her plate. She had not touched those food items. *She was "disgusted" by the meal because she "didn't care for" the casserole and the green beans were cold by the time her tray was delivered. *She indicated the cooked vegetables were usually cold by the time it was served. *"No one ever gives me an option. You just get served whatever's on the board." *Since she was in isolation due to her diagnosis, she was not able to go to the menu board posted outside of the dining room to check on the menu.	F 806	1. Resident #45 is currently eating in the main dining room and alternate food choices are being offered if they request or indicate that they do not like what is served. 2. All residents have the potential to be affected. Dietary Supervisor/ designee discussed with residents receiving room trays, to determine if other had concerns related to alternatives being offered. Residents audited reported no concerns regarding room trays or alternatives. 3. Dietary Supervisor and Director of Nursing will re-educate on policy named "Resident Choice Dining - Food and Nutrition" with staff. Policy states procedures for providing options for meals to residents. An assigned nurse or nurse aid will bring food trays to all residents who eat in their rooms. if a resident indicates they want another meal option, the nurse or nurse aide will return tray to dietary and inform dietary staff that resident would like an alternative. Menu slips will be given to residents, who are receiving meal trays in their rooms, which will indicate two options that resident may choose from for the meal being served at that time. The two options on the slip will include the main menu item and the alternative option for the day. The resident will will choose his or her option and the slip will be returned to the kitchen to fulfill the residents request. 4. Dietary Supervisor, or designee will audit two resident receiving room trays for breakfast, lunch and supper every day for two weeks, then two residents for two meals every day for two weeks, then two residents for one	January 20, 2024

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F 806	Continued From page 2 *She indicated the staff usually would deliver "The Daily Chronicle" that had the menu printed on it, but she had not received one for that day. *At around 2:30 p.m., certified nurse aide (CNA) F entered the resident's room and gave her a fresh cup of ice water. *Resident 45 informed CNA F that she did not care for the casserole or the beans. -CNA F did not ask the resident if she wanted anything else to eat. CNA F did not offer any alternative meal options. -CNA F said that they would pick up her lunch meal tray when supper was delivered. She left the plate of food sitting on the resident's overbed table. Interview on 12/19/23 at 4:06 p.m. with CNA F about the above observation revealed: *If a resident was not eating their meal, the nurse should have been notified. *She confirmed she had not yet notified a nurse about resident 45 not eating lunch. *She indicated she "should have asked [the resident] if she wanted something else [to eat]." *She could not explain why she left the plate of food in the resident's room. *At times, she would have also spoken to her coworkers in the dietary department to see if there were any food preferences for that resident. *She confirmed she had spoken with a dietary employee to inform them that resident 45 had not eaten her lunch, that she was not happy with the menu option, and that she had not received "The Daily Chronicle" for 12/19/23. *She explained that there was no set alternative meal menu. If a resident did not like what was served on the main menu, staff were to ask the resident what else they wanted. -Usually, the alternatives were an egg salad	F 806	meal for next four weeks. This audit will indicate if resident requested a meal alternative and the action taken by staff. Audits will be reported to the QAPI committee for review and revision as warranted.	

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F 806	Continued From page 3	F 806		

sandwich, a bowl of soup, cold cereal, toast, or whatever the resident requested.

3. Interview on 12/20/23 at 3:47 p.m. with social services coordinator J and activities director K about menu alternatives revealed:
*There usually was a second option for the vegetable.
*If a resident did not like the main entrée, they had the option to choose a sandwich, soup, or cold cereal.
*The dietary staff were "pretty accommodating" and tried to make a food item that a resident would ask for, within reason.
*"If it's feasible, the kitchen will make whatever they [the residents] want."

4. Review of resident 45's meal intake records for 12/19/23 revealed that CNA I had charted that the resident ate "75 - 100%" of her lunch.

Interview on 12/21/23 at 12:58 p.m. with dietary supervisor D about the meal intake records revealed:
*If the resident ate their meal in the dining room, the dietary staff were responsible for recording the resident's meal intake.
*Nursing staff were responsible for recording the resident's meal intake if the resident ate their meal in their room.
*She expected the nursing staff to check on the residents during and after their meals if they ate in their room.

Interview on 12/21/23 at 1:22 p.m. with CNA I regarding resident meal intake records revealed:
*The CNAs were responsible for recording the percentage of the meal intake if the resident ate their meal in their room.

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F 806	Continued From page 4	F 806		

*When asked about how she would chart the percent meal intake for a resident who only ate the dessert and the bread but did not touch the main entrée or the vegetable, she indicated she would have charted that as "0 - 25%."
*She was not sure why she charted resident 45's meal intake for lunch on 12/19/23 as "75 - 100%."
*She said at times, if she was on the computer charting, she would ask another CNA what the resident's meal intake was for a certain meal and would rely on their answer.
-She indicated she should not have done that, and she should have charted the meal intake based on her observation.

Interview on 12/21/23 at 1:57 p.m. with director of nursing services B about the above observations revealed:
*If a resident was not eating their meal, it was her expectation that staff should have asked that resident if they would have liked something else to eat.
*She also expected the staff to inform the nurse if a resident was not eating so the nurse could assess the resident to figure out why they were not eating.
*She stated that CNA F should have offered a meal alternative or a snack to resident 45 and that the CNA should have taken the plate of food away rather than leave it in the resident's room.
*It was her expectation for staff to chart meal intake based on what they saw rather than relying on another staff member's account.

5. A request was made on 12/21/23 at noon for the alternative menu policy, the menu for the food that was always available, the policy for documenting resident meal intake, and any policy or procedure for what the staff were expected to

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F 806	Continued From page 5 have done when they noticed a resident was not eating some or all of their meal. The requested items were not provided by the end of the survey on 12/21/23 at 4:00 p.m.	F 806		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the kitchen ceiling was free from peeling paint and the following kitchen equipment was free from frayed and broken parts, rust, dust buildup, particleboard breakdown, grime, and food particle buildup: *One of two convection ovens. *One of one dishwasher. *One of one door leading to the dishwasher room.	F 812	1. No specific residents identified. 2. All residents have the potential to be affected 3. Administrator will contact vendor to replace convection oven. Dietary Supervisor, or designee, will clean the wooden cabinet by January 12, 2024. Dietary Supervisor added the cleaning of all cabinets to the monthly cleaning checklist. Wooden cabinets from the dish room will be removed and replaced with stainless steel cabinets on wheels and completed by January 20, 2024. Dietary Supervisor, or designee cleaned all steel tables in the dietary department. dietary Supervisor added cleaning of steel table legs to the monthly cleaning list. Dietary Supervisor, or designee, cleaned shelving on table across from the three compartment sink and will install new contact paper to the shelf. Cleaning of all shelves added to the monthly cleaning checklist. Dietary Supervisor, or designee, cleaned the dishwasher door build up. Dietary Supervisor added cleaning of dishwasher door to monthly cleaning checklist. Administrator contacted contractors to scrape and de-grease the ceiling on Jan. 5, 2024 and awaiting contractor availability, anticipated completion is February 2, 2024. Once ceiling is scraped and de-greased, Administrator has a contracted painter and will have kitchen dish room, entire kitchen ceiling, and dish wash room interior	January 20, 2024

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F 812	Continued From page 6 *One of two particleboard cupboards in the dishwasher room. *All the handles on the cupboards in the dishwasher room. *All the table legs in the kitchen. *The lower shelving on one of three steel tables. *All the doors to the wooden cabinets. *The shelving inside the wooden cabinets. Findings include: 1. Observation on 12/19/23 from 8:35 a.m. to 9:00 a.m. during the initial kitchen walkthrough revealed: *The inner door seal on the top convection oven was frayed and there was exposed metal mesh. *There was a buildup of dust on the ceiling vest above the wooden cabinet. A nickel-sized clump of dust was observed falling off the vent. *That wooden cabinet was stained with what appeared to have been much oil from repeated hands touching the wood. *The shelves inside the wooden cabinet were stained with dried liquid and there were food crumbs. The cabinet contained pitchers, cloths, and other assortments of dishes. *All the steel legs on the tables, the three-compartment sink, and in the dishwasher room were rusted. *The lower shelving on the steel table across from the three-compartment sink was also rusted. There were mixing bowls and sheet pans stored upside down directly on the rusty shelf. *The ceiling paint in the dishwasher room and the food preparation area was peeling in several spots. *The handles on the particleboard cupboards in the dishwasher room were rusted. *The cupboard above the dirty dish area had particleboard exposed. There appeared to have	F 812	door repainted. Anticipated completion for painting is February 23, 2024. Dietary supervisor educated dietary staff on additional tasks added to the cleaning schedule. 4. Dietary Supervisor/desginee will audit kitchen equipment for cleanliness 3x/ week for 4 weeks and then 1x/week for 8 weeks. Audit finding will be taken to QAPI committee for review and revision as warranted.	

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F 812	Continued From page 7	F 812		

been a buildup of moisture. Bits of wood fell off the cabinet when it was touched.
*There was extensive rust on the cupboard hinges, the walls, and the door in the dishwasher room.
*There was a thick buildup of grime and bits of food on the inside portion of the dishwasher doors.
*There were two fans mounted to the walls in the dishwasher room. Both fan grates were rusty and had a buildup of dust.

2. Observation and interview on 12/21/23 at 11:23 a.m. with food service workers (FSW) G and H in the kitchen revealed:
*The above equipment was in the same state.
*To clean the dishwasher, FSW G stated she drained the dishwasher, removed the catch basket, sprayed that out, and sprayed out the inside of the dishwasher with plain water at the end of each shift.
*FSW H stated he de-limed the dishwasher every month.
*They both stated that they never scrubbed the inside or outside of the dishwasher.
*There were several plastic scrub brushes located in the tall particleboard cabinet in the dishwasher room. They indicated they used those brushes to clean the sinks only.
*They were not aware of the buildup of grime on the inside of the dishwasher.

3. Interview on 12/21/23 at 12:58 p.m. with dietary supervisor D about the above observations revealed
*She confirmed neither she nor the other dietary staff scrubbed the inside or outside of the dishwasher.
*The dishwasher company's technician visited

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F 812	Continued From page 8	F 812		

monthly to inspect the dishwasher.
*She confirmed that the dishwasher was de-limed monthly.
*She was not aware of the buildup of grime and food particles in the dishwasher.
*She was aware of the frayed parts on the convection oven, the stained cabinet doors, all the rust, the peeling paint, and the particleboard cabinets falling apart.
*She stated she had been working at the facility for 17 years and it had always been like that.
*An oven repair technician had previously visited the facility to fix the oven. She said that he was not able to fix the oven "because it was too old."
*She had requested new equipment over the past several years, and over the past several administrators, "but it always gets pushed to the side."

4. Interview on 12/21/23 with administrator A about the above observations revealed:
*He was aware of the state of the kitchen equipment.
*They had repainted the ceiling several times before, but the paint continues to peel away due to the moisture and humidity coming from the dishwasher room.
*He planned to compile a list of items in the kitchen that needed to be replaced or fixed so he could fit that into the budget.

5. Review of the past six months of kitchen cleaning checklists revealed that the dishwasher had been de-limed all the months except for November 2023.

A request was made on 12/21/23 at noon for the dishwasher cleaning and maintenance policy and the kitchen cleanliness policy. Dietary supervisor

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F 812	Continued From page 9 D indicated there were no policies that she could locate.	F 812		
F 880 SS=K	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 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;	F 880	1. RN E was re-educated by the DNS on the appropriate disinfecting process for glucometers at the time of the event identified during survey. All other nurses on the floor at the time of the event were re-educated on proper glucometer cleaning and disinfecting practice by the IP nurse. A dedicated Glucose Monitor was issued to resident 31, at the time of the event identified during the survey, who was suspected of having an infectious disease. The resident's glucometer was labeled with resident's name and is to remain in residents room for use only by that resident. Resident 31's care plan was updated. 2. Residents using glucometers and having bloodborne pathogens have potential to be affected. Residents that utilize the glucometer were reviewed by DNS and IP Nurse on 12/19/23 and no other residents were found to have a bloodborne pathogen. 3. At 1811 on 12/19/23, Director of Nursing sent messages to all nurses and medication aides that competency on glucometer cleaning and bloodborne pathogens must be completed before next shift. Training was completed within 24 hours from the IJ tag issuance by IP nurse and DNS. Education included a review of glucometer cleaning and disinfecting	December 21, 2023

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

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F 880	Continued From page 10 (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. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, policy review, and manufacturer's guideline review, the provider failed to clean and disinfect one of one community shared blood glucose meter for four of four sampled residents (15, 31, 45, 46) resulting in a potential increased risk for bloodborne pathogen infections. Findings include:	F 880	policy and procedure, and review of bloodborne pathogen policy. Employees signed both policies indicating the policy was reviewed and understood by the employees (nurses and medication aides). Proper cleaning of equipment is included in the on-boarding process for new staff. Medical Director was notified of the incident on 12/19/23 at 2026. Reviewed root cause analysis with QIO at 1000 on 1/8/24. No additional recommendations were given. Root cause analysis included reviewing current practice and policy. While Nurse E verbalized her cleaning procedure with alcohol wipers, there was confusion in the cleaning and disinfection policy which likely contributed to the incident. 4. QAPI Nurse/Coordinator or desinee will audit three nurses daily for two days, then three times per week for 12 weeks to ensure compliance. Results of audits will be taken to the QAPI committee for review and revision as warranted.	

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F 880	Continued From page 11	F 880		

1. Observation on 12/19/23 at 3:45 p.m. revealed:
*Registered nurse (RN) E completed a blood glucose check for resident 46.
*When RN E was asked what she used to clean and disinfect her blood glucose meter, she stated, "I should have them with me, but I use the alcohol wipes."
*After RN E performed a blood glucose test on resident 46 she cleaned the blood glucose meter with a 70% isopropyl alcohol wipe and placed the blood glucose meter back on the medication cart.

Interview on 12/19/23 at 3:50 p.m. with RN E revealed:
*She stated that eight residents share the blood glucose meter that she used for resident 46.
*There was a blood glucose meter for every wing in the facility.
*RN E was able to provide the manufacturer's cleaning instructions which stated the following:
-The blood glucose meter was to have been cleaned with a lint-free cloth dampened with soapy water or isopropyl alcohol (70-80%).
-The blood glucose meter was to have been disinfected with an EPA-registered disinfectant detergent, germicide wipe, or 1:(to)10 dilution of household bleach solution or 1:10 commercial bleach wipe.

2. Interview on 12/19/23 at 4:00 p.m. with director of nursing (DON) B regarding the blood glucose meter cleaning and disinfecting procedure revealed:
* When questioned regarding the above observation and interview with RN E not disinfecting the blood glucose meter, DON B stated, "Yes she does, I just watched her do it."
*DON B returned to ask RN E how she cleaned

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435101	A. BUILDING ______ B. WING ______	12/21/2023

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 and disinfected the blood glucose meters between residents and RN E stated that she cleaned the meter with the alcohol swab. *When asked when she used the disinfecting wipe, she said "I do that at the end of the shift." *DON B then corrected RN E and stated "No, you do it between every resident." *RN E stated, "I didn't know, sorry," when educated by DON B about using a disinfectant wipe on the blood glucose meter after each resident's use. 3. Observation and interview on 12/19/23 at 4:15 p.m. with medication aide (MA) L revealed that she explained and demonstrated the correct process to clean and disinfect the blood glucose meter after each resident's use. 4. Record review on 12/20/23 of resident 31's electronic medical record revealed that he was admitted on 6/7/22 with a diagnosis of chronic viral hepatitis C. 5. Review of the provider's 9/22/23 Blood Glucose Monitoring Disinfecting and Cleaning-R/S [Rehabilitation/Skilled Care], LTC [Long-term Care] policy revealed: *The policy referred to CMS requirements and best practices, that blood glucose meters should have been cleaned and disinfected after each resident use whether the meter was assigned to a resident or was shared among residents. *The policy referred to the user manual for specific instructions for each meter. 6. Review of the provider's blood glucose meter User Instruction Manual revealed: *There were two options for cleaning and disinfecting the blood glucose meter.	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 ____	12/21/2023

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	F 880		

-Option 1 stated that cleaning and disinfection could have been completed using a commercially available EPA-registered disinfectant or germicide wipe. Two wipes should have been used; one to clean and the second to disinfect.
-Option 2 stated to clean the outside of the meter with a lint-free cloth dampened with soapy water or isopropyl alcohol (70-80%) and to disinfect the meter by diluting 1 milliliter (mL) of household bleach in 9 mL of water to achieve a 1:10 dilution. Commercially available 1:10 bleach wipes were also acceptable for disinfection.

7. IMMEDIATE JEOPARDY
The potential for blood-borne pathogen infections was increased due to RN E not following the provider's policy or the manufacturer's guidelines regarding the process of disinfecting the blood glucose meter after each resident's use.

The blood glucose meter was shared between four residents on the 200-wing including resident 31 who had a diagnosis of chronic viral hepatitis C.

IMMEDIATE JEOPARDY NOTICE
Notice of immediate jeopardy was given verbally and in writing on 12/19/2023 at 5:39 p.m. to administrator A. An immediate removal plan was requested.

IMMEDIATE JEOPARDY REMOVAL PLAN
On 12/20/23 at 9:28 a.m., administrator A provided the survey team with a final written immediate jeopardy removal plan. The removal plan was approved by the survey team on 12/20/2023 at 9:41 a.m. with guidance from the long-term care advisor for the South Dakota Department of Health.

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F 880	Continued From page 14	F 880		

The provider gave the following acceptable immediate jeopardy removal plan on 12/20/2023 at 5:39 a.m.:

"At 6:11pm on 12/19/23. DNS sent messages to all nurses and medication aides that competency on glucometer cleaning must be completed before next shift. Training to be completed by DNS or designee[.]
- review of glucometer cleaning procedure
- education of risk of BBP exposure if not cleaned properly.
- nurse to complete demonstration of cleaning showing wiping all surface of meter.
- verbalize dwell time

IP or designee will audit 3 nurses daily x 2 to ensure compliance. Then weekly x4. Result to QA committee to determine ongoing monitoring and interventions.
IP Nurse educated all nursing staff (nurses and medication aides) on the floor at 6:00 pm.
A dedicated Glucose Monitor machine has been issued to resident (31) that has an infectious disease and labeled with resident name and is not to leave resident room. Care plan has been updated.
All residents that utilize the glucometer were reviewed by DNS and IP Nurse on 12/19/23, and no other residents were found to be at known risk with diagnosis of Viral Hepatitis C.
The medical director, [name of medical director], was notified of the incident on 12/19/23 at 8:26 p.m. Medical director was conferred with on review of case at 9:15 am on 12/20/23 and his recommendation is to not conduct lab test on residents."
The immediate jeopardy was removed on 12/20/2023 at 12:57 p.m. after verification that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435101	A. BUILDING ______ B. WING ______	12/21/2023

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 provider had implemented the removal plan. After the removal of the immediate jeopardy, the scope and severity of the citation level was H.	F 880		

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

PRINTED: 01/05/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435101	A. BUILDING ______ B. WING ______	12/21/2023

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 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 12/19/23 through 12/21/23. Good Samaritan Society Canton was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	1/9/2024

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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OMB NO. 0938-0391

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 01 - MAIN BUILDING 01 B. WING ______	12/19/2023

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 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 12/19/23. Good Samaritan Society Canton was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 1/9/24

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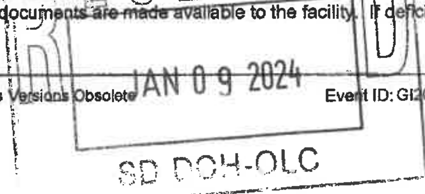

PRINTED: 01/05/2024
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10604	A. BUILDING: ______ B. WING ______	12/21/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 12/19/23 through 12/21/23. Good Samaritan Society Canton was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 12/19/23 through 12/21/23. Good Samaritan Society Canton was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 1/9/24

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