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

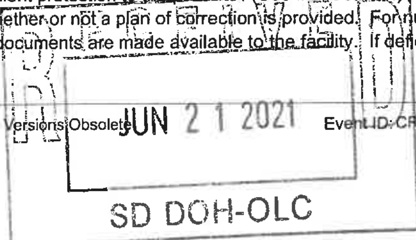
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435134	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 05/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST MARTIN VILLAGE	4825 JERICHO WAY RAPID CITY, SD 57702

(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: 40788 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 5/25/21 through 5/27/21. Good Samaritan Society St. Martin Village was found not in compliance with the following requirements: F550, F565, F692, F700, F755, F758, F812, F880, and F909.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen	F 550	One resident was affected as all other blinds were and continue to be operational. A blind is on order and because of Covid there is a shortage from the manufacturer and it is currently on back order. A blind was installed in the room from another location in the building that is not affecting any resident's privacy. The blind is operational and continues to be operational for the resident and in all other resident rooms and locations. When the other blind is received it will be installed on the window that does not affect any resident privacy; however, the resident privacy blind was corrected and is operational. Maintenance director or his designee will audit blinds to ensure operational effectiveness of all blinds on a rotating basis. The audit will consist of 10 blinds per week being audited for 3 weeks, 10 blinds per every other week x 3, and 10 blinds per month for 3 months. The maintenance director or his designee will report to the QAPI committee on a monthly basis the results of the audits of the functional blind operations. The QAPI committee will review the audit and if make any recommendations for improvement.	5/28/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kyle Richards	Senior Director	6/17/21

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 550	Continued From page 1 or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Surveyor: 40788 Based on observation, interview, review of the maintenance request sheet, and policy review, the provider failed to ensure privacy for one of one sampled resident (53) whose window blind had been broken. Findings include: 1. Observation and interview on 5/25/21 at 3:15 p.m. with resident 53 in his room revealed: *He was lying on top of his bed. *He was able to see out the double window next to his bed across a parking lot to the assisted living center. *One horizontal blind was attached at the top of each window. -The left side blind had been pulled up at an angle towards the top of the window. *Resident 5 stated that blind had been broken for about a month. -"That was too long." *He said he needed staff to help him with some of his personal cares. -Those cares sometimes occurred at his bedside.	F 550	Monitoring results will be reported by maintenance person to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	

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F 550	Continued From page 2 Interview on 5/26/21 at 9:22 a.m. with certified nurse aide (CNA) I regarding resident 53 revealed she: *Helped him get dressed and out of bed that morning. -Had a second staff person hold up a sheet in front of his window while she cared for him because the left blind was broken and unable to be lowered. -Stated this was her usual process. *Had not thought other caregivers had consistently protected that resident's privacy during personal cares in that same manner or other manner since that blind had been broken. *Thought the blind had been broken for a few weeks and a new blind was ordered. Interview on 5/26/21 at 4:40 p.m. with environmental services supervisor H revealed he: *Was aware resident 53's room blind was broken and a replacement had been ordered. *Had not considered installing a temporary window covering until the replacement had arrived. *Agreed the resident's right to privacy had been compromised. Review of the maintenance request sheet revealed: *Staff had reported resident 53's blind was broken on 5/10/21. -"He's [resident 53] upset." *Environmental services had responded on that same date that a replacement blind was ordered. *Staff reported resident 53's blind was still broken on 5/23/21. -Environmental services had responded on 5/25/21 that a replacement blind was ordered.	F 550		

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F 550	Continued From page 3 Review of the 10/6/20 Resident Dignity policy revealed: *Policy: -"The location will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect and in full recognition of his or her individuality."	F 550		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups.	F 565	All residents have the potential to be affected by this deficiency Manager education was completed for all managers at St Martin Serenity Place on the Grievances, Suggestions or Concerns policy and how to fill out Concern forms completely. This education included a complete description of what happened leading up to and during the time of the incidents or concerns, actual or contributing factors that led up to the event, recommendations to resolve the incident, an analysis of the concern or incident, and the resolution and report back to the person making the concern or grievance. A new form has been created to allow for more details and information on a concern or grievance and what immediate actions were taken. Education for staff was conducted on this new form. On 5/28/21 the call light company was contacted in order to be able to retrieve call light reports form the call light system.	6/17/21

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F 565	Continued From page 4 §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Surveyor: 40788 Based on observation, interview, review of resident council minutes, review of grievance reports, review of suggestion or concerns reports, review of call light audits, and policy review, the provider failed to thoroughly investigate resident concerns regarding call light wait times for one of one sampled resident (159) and two of two resident council group interviews. Findings include: 1. Observation and interview on 5/25/21 at 4:15 p.m. with resident 159 revealed she: *Had been admitted about one month ago for short term rehabilitation and planned to return home at discharge. *Had waited 29 minutes one time and an hour another time to have her call light answered. *Stated physical therapist (PT) K had been with her at the time of the second incident and reported it. -Resident 159 had not heard what action had been taken as a result of that report and no one had spoken to her to determine if she had further problems with call light response time. Review of the suggestion or concern reports completed between 5/1/21 and 5/27/21 revealed: *Three reports had been completed regarding call light response time. *Investigative action included staff education on	F 565	The company was on site on 6/1/21 in order to be able to retrieve reports on the south unit. The call light system will or has been upgraded in the North unit on or before 6/18/21 with software to review the call light wait times to ensure call lights can be followed up on appropriately. The South unit call light software is functioning and operable for call light wait times in order to follow up on call light wait times appropriately. A review will happen with these forms and call light times during the safety meeting to ensure all areas of the form is completed and followed up on appropriately. The social services director or her designee will conduct audits on a weekly basis on concerns and grievance forms for three weeks, then every other week x 3 times, and finally once a month x 3 times to ensure grievance and concern forms are completed thoroughly and that concerns or grievances are followed up with the person making the concern or grievance. The social services director or her designee will report to the QAPI committee on a monthly basis the audit results of the completion of forms, follow up and resolution to the person making the grievance or concern.	

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F 565	Continued From page 5 one report and call light audits for all three reports. *Investigative action had not included any analysis of the incidents such as: -A description of what happened leading up to and during the time of the incidents. -Actual or contributing factors that had led to the length of the call light response. -Recommendations to decrease the length of call light response. -An analysis of those reports for commonalities such as time of day, day of week, staff who had worked when those reports had been made. *The resolution section of those reports had not been completed and follow-up with the author of those reports had not occurred. *Those reports had been reviewed and signed by administrator A, director of nursing (DON) B, and social services director (SSD) D. Interview on 5/27/21 at 8:15 a.m. with SSD D regarding suggestion or concern reports and call light audits revealed she: *Said sometimes information for the resolution section of that report was included with the investigation section of that form. *Agreed the three reports identified had not been thoroughly investigated. *Said follow-up was not consistently completed with the authors of those reports. -Agreed it was important that author had known the suggestion or concern was acted upon. *Confirmed she had completed two call light audits. -Stated results of the 5/19/21 audit revealed a staff person had acknowledged a call light from the nurses' station for a resident's room at 11:07 a.m. -After five minutes that call light system alerted	F 565	The QAPI committee will review the audit results and if necessary make any recommendation for improvement. Monitoring results will be reported by social services director to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	

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F 565	Continued From page 6 that staff person that call light had not been answered. -Had found that staff person with a certified nurse assistant in a different resident's room. -Documented that call light acknowledged from the nurses' station at 11:07 a.m. was answered after 17 minutes. *Had expected that resident's call light to have been responded to sooner. *Had not interviewed that staff person at the time of the audit to identify what had contributed to that call light response time, but she should have. *Confirmed her audit tool had included a date, time of call light activation, resident room number, and her personal notes. -Those notes had not drawn any conclusions from that observation. Interview on 5/27/21 at 3:00 p.m. with administrator A and DON B regarding the investigation and follow-up process for the suggestion or concern reports revealed: *They acknowledged call light response time had been a concern. *Agreed call light response times referred to in the above reports had not been acceptable. *Agreed the suggestion or concern reports and audit referred to above lacked the ability to determine a root cause for excess call light wait time. -That was a barrier to addressing the problem. Surveyor: 43844 2. Group resident interview on 5/26/21 at 10:05 a.m. through 10:50 a.m. with south unit resident council revealed: *The staff would come into their rooms, turn off the call light, and would say they would come back to help them.	F 565		

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F 565	Continued From page 7 -They would have to wait up to an hour when that occurred. *Group interview on 5/26/21 at 11:00 a.m. through 11:30 a.m. with north unit resident council revealed: *The staff are polite and eager to help. -They have taken a long time to answer a call light. -They have had to wait up to one and one-half hours to get help. Interview on 5/26/21 at 5:11 p.m. with SSD D revealed she: *Had assisted the residents with the resident council meetings. *Had ensured suggestions or concerns were "in my minutes" of the council meeting. *Was aware of the suggestions or concerns regarding call light wait times. Interview on 5/27/21 10:30 a.m. with DON B revealed: *The process for suggestions or concerns was: -The provider had a "concern form" for grievances. -The social worker provided the "concern form" to the appropriate department when a grievance had been filed. -The appropriate department corrected the issue and developed an intervention to prevent further issues. -The "concern form" was then returned to the social worker. *She was unaware of what the social worker does regarding the form when it had been returned. Review of resident council meeting minutes from 1/19/21 through 5/12/21 for the north and south units revealed:	F 565		

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F 565	Continued From page 8 *There had been four meetings where residents had voiced call light concerns: -Long wait times, up to one and one half hours. -Not being answered. -Not assisting when answering. Review of providers May 2021 "Concern tracking log" revealed: *Call light time concerns dated 5/13/21, 5/15/21, and 5/19/21 had an outcome/resolution of, "Staff education, call light audits". Review of the revised 11/5/20 Grievance, Suggestions or Concerns policy revealed: *Purpose: -"To document concerns, investigative findings, and plans of correction. -To develop a systematic approach in resolving grievances as a tool to ensure continuous quality of care." *Procedure: -"6. An investigation must be completed for all grievances." -"7. The grievance official will issue a written grievance decision to the individuals filing the concerns and to the administrator. The written grievance decision must include the date the grievance was received, a summary statements of the resident's grievance, the steps taken to investigate the grievance, a summary of pertinent findings or conclusions regarding the resident's concern(s), a statements as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued." Review of provider's 9/28/20 Resident Groups-Rehab/Skilled policy revealed:	F 565		

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F 565	Continued From page 9 *"7. All grievances discussed at the group meeting will be written in the minutes and filed on the Suggestion or Concern form (GSS #213). The procedure for handling the grievance will be followed." *"8. Each department will respond to the resident group recommendations, concerns and grievances as requested and as appropriate, with plan of correction submitted to the administrator for final disposition."	F 565		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on interview, record review, and policy	F 692	All residents have the potential to be affected by this deficiency Quality of life committee will review all registered dietician orders and make recommendations and changes to all care plans and orders for residents.The certified dietary manager and clinical care coordinators will be responsible for following up on any recommendations made by the registered dietician. Education was provided to the certified dietary manager and clinical care coordinator on the responsibility to follow up on registered dietician recommendations. Care plans will be updated as needed from the recommendations for the residents. Audits will be conducted to ensure orders and recommendations are reviewed and implemented by the certified dietary manager and clinical care coordinator.	6/17/21

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F 692	Continued From page 10 review, the provider failed to ensure the registered dietician (RD) recommendations had been followed for two of two sampled residents (17 and 54). Findings include: 1. Review of resident 54's medical record revealed: *His admission date was 4/16/21 and he had weighed 145.8 pounds. *On 5/25/21 his weight was 137.3 pounds which was a 5.83% weight loss. *RD note from 5/11/2021 at 10:57 a.m.: -"DIET: Heart healthy, regular texture, thin fluids. -INTAKES: mostly 51-100% with many at 76-100%; fluids 240-480+ ml /meal. -SKIN: on 5/10/21 noted left buttock unstageable [pressure injury] per wound assessment and on 5/8/21 upper buttock and bilateral heels noted as getting smaller on wound assessment. -MNA [Mini Nutritional Assessment score] 6 on admit noted malnourished. -Dx [diagnosis] has included mild PCM [protein-calorie malnutrition], anemia, HTN [hypertension]. -Receives FeSO4 [iron sulfate], KCl [potassium]. - A. Resident at nutrition risk r/t [related to] dx, skin and pressure areas noted, variable intakes, MNA score and wt [weight] loss from admit and current wt near low end of IBWR [ideal body weight]. GOAL: avoid wt loss below 135 lbs [pounds] with gradual gain to about 145-148 lbs. -P. 1. Nursing please provide recommendations to MD [medical doctor]: diet change from Heart Healthy, regular texture, thin fluids to NAS [no added salt], regular texture, thin fluids. - 2. Nursing please note to MD for: Rec [recommendation]: 3 oz [ounce] 2.0 Kcal [kilocalorie] tid [three times a day] with med pass	F 692	Audits will be conducted every week for 3 weeks, every other week x 3 times, and every month x 3 times to ensure the recommendations are followed up on properly. The certified dietary manager or her designee will report to the QAPI committee on a monthly basis the audit results for the follow up and resolution to the recommendations made by the registered dietician. The QAPI committee will review the audit results and if necessary make any recommendation for improvement.The results will be reported by certified dietary manager director to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	

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F 692	Continued From page 11 between meals. - 3. CDM [certified dietary manager] please continue recommendation: complete Food and Nutrition data and check if resident drinks milk or consumes other dairy along with meats and eggs for protein. -4. CDM please continue recommendation to check with resident for 8 oz Ensure plus tid at meals, if accepted by resident and include in care plan. Please note to RD if resident does not accept supplement. -5. Cont [continue] wt and meal intake monitors. -6. RD follow up as needed." *There was no follow up note on the recommendations from the RD. *There were no orders for dietary supplements in his record. *His diet order had not been changed. *There was no documentation the medical doctor had been contacted about the RD recommendations. *The Food and Nutrition data assessment was 38 days over due. 2. Interview on 5/25/21 at 5:34 p.m. with resident 17 revealed she: *Had lost 92 pounds. *Stated no one had talked with her about the weight loss. *Was not concerned about her weight loss. *Stated she needed to loose some weight, but now she was comfortable and thought she should probably stop loosing weight. *Does not take a supplement. Review of resident 17's medical record revealed: *RD note from 5/11/2021 at 10:32 a.m.: *"A. Nutritional status appears stable and adequate at this time evidenced by wt [weight]	F 692		

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F 692	Continued From page 12 within about 5 lbs [pounds] the past 8 months, no food intake issues noted and skin area is healing. Is noted that current wt is down slightly and will request current wt. Resident is at potential nutrition risk r/t [related to] pressure area noted. P. 1. Nursing please request to MD for diet change From: CCHO [consistent carbohydrate] diet, Regular texture, Regular fluid consistency, for diet 2gm [gram] sodium TO: Regular diet, regular texture, thin fluids r/t resident making own dietary choices and A1c [a test to measure the average blood sugar over the past 3 months] in excellent range and wt is stable. 2. Cont. [continued] recommendation: CDM [certified dietary manager] please visit with resident if she may accept milk or cottage cheese or yogurt 1-2 x/day [times a day] to assist with protein intakes and note in care plan or progress note. If not drinking milk, please check if she may accept 4 oz [ounce] Ensure plus tid [three times a day] at meals until healed. 3. Nursing please obtain current wt. 4. RD follow up as needed." *Diet order had not been changed. *Ensure had not been ordered. *No progress notes indicating a medical doctor had been notified about the recommendations. 3. Interview on 5/27/21 at 11:24 a.m. and 3:29 p.m. with director of nursing B revealed: *It was up to clinical coordinator C to work with the nurses to ensure there had been follow-up on RD recommendations. *Agreed the RD recommendations had not been followed-up on. Interview on 5/27/21 at 11:27 a.m. and at 3:04 p.m. with Clinical Coordinator C regarding RD	F 692		

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F 692	Continued From page 13 recommendations revealed: *She agreed the recommendations for residents 17 and 54 had not been followed up on. *The RD would have sent an email with names of residents she had recommendations for. -That email goes to the DON, clinical coordinators, CDM, and the QAPI (quality assurance and performance improvement) coordinator. -"No one owns the responsibility of following up on the recommendations." -Recommendations should be followed up on during the quality of life meetings held on Tuesdays, but do not always get done. --She thought a meeting in May 2021 had been canceled. --She had not attended all of those meetings. Interview 5/27/21 at 3:17 p.m. with CDM E regarding: *Resident 54, she had: -Offered Ensure with meals. --Not documented the intake of the Ensure so did not know if resident 54 was drinking the supplement. -Not completed the Food and Nutrition data assessment requested by the RD. -Been aware he did not like milk -Known he would eat meat and eggs but told her he just does not have much of an appetite. *Resident 17 she had: -Attempted to give resident 17 Ensure, but the resident had refused to drink it because she did not want to gain any weight. -Not documented the refusal of the Ensure. 4. Review of the provider's 5/10/21 Interventions for Nutritional Risk of Residents- Food and Nutrition policy revealed it had not addressed:	F 692		

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F 692	Continued From page 14 *Who would have been responsible to follow-up on RD recommendations. *What the process was for follow-up on RD recommendations.	F 692		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on observation, interview, and policy review, the provider failed to ensure safety assessments were routinely completed and documented for ten of fifteen sampled residents (7, 9, 28, 32, 45, 46, 48, 53, 159, and 209) who had quarter length side rails on their beds.	F 700	All residents have the potential to be affected by this deficiency Director of Nursing audited all residents for the need and use of positioning bars.The nursing side rail assessment UDA will be done on whether the positioning bars are needed at least twice per year. The new admissions checklist will also be updated to include the assessment UDA to verify if the resident is needing the position bar. If the positioning bar is not needed it has been taken off of all residents bed not needing positioning bars. Audits will be conducted by the director of nursing or her designee to ensure the nursing side rail assessment UDA is done appropriately and that side rails are taken off if not needed. Audits will be conducted every week for 3 weeks, every other week x 3 times, and every month x 3 times to ensure the positioning bars are needed and the side rails have been taken of if needed.The director of nursing or her designee will report to the QAPI committee on a monthly basis the audit results for the UDAs and the positioning bars for appropriate use.	6/16/21

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F 700	Continued From page 15 Findings include: 1. Observations on 5/25/21 between 1:30 p.m. and 6:00 p.m. of sampled resident rooms revealed residents 7, 9, 28, 32, 45, 46, 48, 53, 159, and 209 had quarter length side rails on one or both sides of their beds. Surveyor: 41895 Interview on 5/26/21 at 4:29 p.m. with clinical coordinator C revealed: *Side rail assessments were not completed on any residents who had side rails. *She knew they probably should have been completed but those assessments had not been implemented. *She did not think the side rails would have been care planned either. Surveyor: 40788 Interview on 5/27/21 at 10:00 with director of nursing B regarding side rails revealed she: *Said side rails had been installed "in case a resident could use them." *Confirmed no initial or routine assessment had been completed to determine or validate if a resident had the ability to use those side rails to reposition themselves or help them get in and out of bed. *Confirmed no initial or routine assessment had been completed to determine the continued safety for side rail use. -Had not known that was needed. Review of the 5/27/21 revised Bed Safety and Side Rail Entrapment Resources Packet policy page 5 revealed: *Before a side rail was used a physical device and restraint assessment was expected to be	F 700	The results will be reported by certified dietary director to the QAPI committee and if necessary make any recommendation for improvement. It will be continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	

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F 700	Continued From page 16 completed and documented. -That determined whether the side rail was needed and if necessary that it was the least restrictive device available that enabled the residents' bed mobility. *There was no mention of routinely assessing that side rail for continued safety or for its intended purpose. Surveyor: 40788	F 700		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755	All residents have the potential to be affected by this deficiency The Lorazepam was placed in the lock box in the locked medication room which was fastened to shelving unit of the refrigerator to secure it to the refrigerator. The lock box key was placed in the e-kit system in order to track and identify if the lock box key was used and who used it to ensure an accounting of the medication. This ensures it could not be missing for any length of time without knowing it through the electronic e-kit system which is reported to our pharmacy through a report.	6/11/21

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F 755	Continued From page 17 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on observation, interview, and policy review, the provider failed to ensure a controlled medication in the emergency kit was accounted for at shift change. 1. Observation and interview on 5/27/21 at 2:29 p.m. with registered nurse (RN) J in the north wing medication room revealed: *The medication room was kept locked. *A medication refrigerator with a lockbox in it containing a one milliliter (ml) vial of Lorazepam 2 milligrams (mg)/ml . *RN J stated that was part of the emergency kit and it was not accounted for at shift change. *Agreed if someone would take the medication it could be missing for several days before anyone would know. Interview on 5/27/21 at 2:36 p.m. with director of nursing B regarding the above observation and interview revealed: *The lorazepam was part of the emergency kit. *The Lorazepam was not accounted for at shift change. *Agreed the Lorazepam could go missing for several shifts without anyone noticing. Review of the provider's 12/11/20 Medications:	F 755	The director of nursing and our consulting pharmacy will conduct audits to ensure the system is working properly and that the medication is secured. Audits will be conducted once a week for 3 weeks, every other week x 3 times, and once month x 3 months. The director of nursing and pharmacist or her designee will report to the QAPI committee on a monthly basis: the audit results for the securing of the medication in the refrigerator properly according to narcotic storage. The results will be reported by director of nursing to the QAPI committee and if necessary make any recommendation for improvement. It will be continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	

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F 755	Continued From page 18 Controlled policy revealed: *"3. Each time the keys that secure controlled medications change from one nurse/medication aide to another, the oncoming and off-going nurse/medication aide will work together to reconcile all controlled medications, including discontinued controlled medications and document the same."	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive	F 758	All residents have the potential to be affected by this deficiency The clinical coordinator, director of nursing, and our consulting pharmacist reviewed any psychotropic medications for proper duration of the order. If the psychotropic medication is ordered on a PRN basis it will be followed up on with the provider and if necessary discontinued within 14 days or placed on a longer term order by a provider's order.The medical director will be called for any orders that are PRN which have not been discontinued for an appropriate rational by the ordering provider or to have the medication discontinued. The director of nursing or her designee will conduct audits to ensure psychotropic medications are discontinued or if necessary carried over on a longer lasting order by the provider appropriately. Audits will be conducted one a week for 3 weeks, every other week x 3 times, and once month x 3 months.	6/15/21

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F 758	Continued From page 19 psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Surveyor: 40788 Based on record review, interview, and policy review, the provider failed to ensure a physician included in the order a duration of time for an as needed (prn) psychotropic medication for one of one sampled resident (7) who received a prn psychotropic medication. Findings include: 1. Review of resident 7's medical record revealed: *An order written 7/10/20 for ativan 0.5 millligrams (mg) at night. -That order was changed to 0.5 mg every six hours on 7/15/20 then decreased to 0.5mg at night prn on 7/22/20. *A physician progress note dated 4/28/21 listed the resident's current medications and included ativan 0.5 mg at night prn.	F 758	The director of nursing and pharmacist or her designee will report to the QAPI committee on a monthly basis the audit results for the proper ordering, discontinuing and if necessary using a more appropriate order for the psychotropic medications. The results will be reported by director of nursing and pharmacist to the QAPI committee and if necessary make any recommendation for improvement. It will be continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	

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F 758	Continued From page 20	F 758		

-Beside the name of that medication were instructions: "Dispense: 30 tablets. Refill: 11 [times]."

Review of resident 7's medication administration records for prn ativan use revealed she had received prn ativan:
*Three times between 5/1/21 and 5/25/21.
*Nine times in April 2021.
*Seven times in March 2021.

Review of the April 2021 pharmacist's monthly medication regimen (MMR) review report for resident 7 revealed a letter had been sent to her physician after the November 2020 and December 2020 MMR requesting a rationale for the continued use of the prn ativan and a duration of time needed for that medication.

Interview on 5/27/21 at 10:00 a.m. with director of nursing B regarding resident 7's prn ativan order revealed she:
*Expected prn psychotropic medication orders not limited to fourteen days had a documented rationale for continued use and a stop date.
*Confirmed there was no physician documented rationale or stop date for resident 7's prn ativan, but there should have been.
*Reviewed the monthly MMR reports, but expected clinical coordinator F (south unit) to follow-up on new or unresolved pharmacist recommendations.

Interview on 5/27/21 at 10:55 a.m. with clinical coordinator F regarding resident 7's prn ativan order revealed she:
*Was aware that order should not have exceeded fourteen days without a documented rationale and duration of need from the resident's

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F 758	Continued From page 21 physician. *Confirmed she was responsible for reviewing monthly MMR reports and providing needed follow-up. -Had not contacted resident 7's physician or spoke with him during his onsite visits about that ativan order, but she should have. Review of the 11/19/20 Psychotropic Medications policy revealed: *Procedure: -"7. PRN orders for psychotropic drugs are limited to 14 days. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN."	F 758		
F 812 SS=D	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	F 812	All residents have the potential to be affected by this deficiency All staff have been educated on safe food handling including labeling and properly storing food in the refrigerator and freezers. This includes handling glasses and bowls in a safe, proper and sanitary manner. The refrigerator, freezers, ice scoop and container have been cleaned and sanitized using the proper sanitary techniques. All other areas have been thoroughly cleaned by the dietary staff to ensure proper sanitary conditions for each of its locations. There was a cleaning schedule that was implemented for the refrigerator and freezer.	6/16/21

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F 812	Continued From page 22 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Surveyor: 43844 Based on observation, interview, record review, and policy review, the provider failed to ensure: *Items had been dated when opened. *Storage of resident food items was kept separate from the facility food supply. *Dishware and equipment were maintained in sanitary conditions. Findings include: 1. Observation on 5/25/21 at 1:47 p.m. of the kitchen in the south unit revealed: *Two refrigerators each had a pitcher of juice without an open date. *One refrigerator had an open can of ready-to-drink coffee without an open date, name, and was not covered. *The freezer had crumbs of various foods on the bottom shelf. 2. Observation on 5/25/21 during meal service between 4:28 p.m. and 5:58 p.m. of food service employee L revealed, she: *Used two fingers, one on the inside and one on the outside of a glass to pick it up, filled the glass with liquid, and placed the full glass on a residents meal tray. *Picked up a clean bowl with four fingers of one hand on the inside of the bowl, scooped food into the bowl and served it to a resident. 3. Observation on 5/26/21 at 4:10 p.m. of the south unit kitchen revealed: *The walk-in refrigerator had a white substance which was dried on the floor measuring	F 812	The certified dietary manager or her designee will conduct audits on the cleanliness of the kitchen areas including the refrigerators and freezers. She will also conduct audits on food storage to ensure food items are properly labeled and stored according to dietary guidelines. In addition, the dietary manager or her designee will conduct audits on staff to ensure staff are handling dishes properly to maintain proper sanitation. Audits will be conducted one a week for 3 weeks, every other week x 3 times, and once month x 3 months. The dietary manager or her designee will report to the QAPI committee on a monthly basis the audit results for the proper handling dishes, cleanliness of the kitchen area and properly storing and labeling food items. The results will be reported by dietary manager to the QAPI committee and if necessary make any recommendation for improvement. It will be continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	

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F 812	Continued From page 23 approximately four feet by two feet. *On top of the ice maker there was a clear container with a scoop inside. -Inside this container was a white residue dried to the bottom. Interview on 5/26/21 at 4:10 p.m. with food service employee L revealed she: *Had been employed for "about two months." *Did not know when or how often the scoop and container was washed. 4. Observation on 5/26/21 at 4:15 p.m. in the north unit kitchenette revealed: *The inside of the refrigerator had dried substance on the floor bottom. *There was fruit, which appeared to be canned prunes, in a clear container without an open date. *In the freezer there was a Sonic malt with an open hole lid. -It was labeled with a resident's name and room number, but no date. -This same freezer had facility food items in it. Observation and interview on 5/27/21 at 8:48 a.m. with food service employee M in north kitchenette revealed: *In the freezer there was a Sonic malt with an open hole lid. -It was labeled with a resident's name and room number, but no date. *Food service employee M stated: -Only facility food was to be stored in the refrigerator. -Residents' personal food should have been dated, covered, and stored separate from facility food. *She confirmed the malt should not have been in the freezer.	F 812		

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F 812	Continued From page 24	F 812		

Interview on 5/27/21 at 10:32 a.m. with dietary manager E revealed:
*Her expectation would be that everything (food) is labeled, dated, and covered and she stated:
-Nursing had put the malt in the freezer.
-The malt should not have been in the freezer.
-They check refrigerators daily but must have missed the malt as it was in the freezer.
-Dietary staff know to date everything and they may have gotten out of the habit during the pandemic as they had been using individual containers.
*Her expectation would be for staff to handle clean dishware without touching the inside of the dish.
*The ice-machine in the kitchen was not used.
-It should not have had ice in it as it should have been unplugged.
-They would not have washed the scoop or container.
-Nursing must have used the ice machine.

Review of providers' dietary cleaning checklist from 3/1/21 through 5/8/21 revealed:
*Daily documentation was completed for food labeled, dated, and put away.
*There was no cleaning schedule for the refrigerators or freezers.

Review of provider's 5/19/20 Safe Handling of Personal Food-Outside Food-Food and Nutrition policy revealed:
*"Personal food is stored separate from the locations food."
-"3. The resident/family:"
--"a. Labels, dates and covers all opened foods that are brought in for the resident."
--"b. Stores food in designated areas only."

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F 812	Continued From page 25 Review of provider's 7/9/20 Food-Supply Storage-Food and Nutrition Services policy revealed: *"Personal food is not considered approved food and is not stored in the food preparation kitchen or location refrigerators and storage areas." -"7. Foods that have been opened or prepared are placed in an enclosed container, dated, labeled and stored properly." -"20. Employee and personal resident food/fluids are not stored in the preparation kitchen cooler/freezer or dry storage." Review of provider's 4/9/21 Hand Hygiene and Handwashing-Rehab/Skilled, Senior Living policy revealed: *"During Service of Meals" -*2.b. Do not touch any food or eating surfaces with bare hands (i.e., fork tines, eating surface of plates, drinking surface of glasses)"	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880	Corrective Action: 1. Time cannot be turned back to a time prior to the identification of *lack of consistent following of CDC recommendations and guidance for mask use and social distancing in activity and communal dining when resident is not vaccinated for COVID-19. *lack of appropriate hand hygiene during provision of resident perineal care task	6/17/21

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F 880	Continued From page 26 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880	Administrator, DON, and infection control nurse were provided education/re-education about the identified areas cited on 6/14/21 by a Good Samaritan Nursing and Clinical Services Consultant. 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 to be in line with CDC and CMS recommendations about: *Mask use and social distancing in activity and communal dining when resident not vaccinated. Do include informed resident choice. *Hand hygiene use during resident perineal care task. *Necessary infection control and prevention plan that includes effective compliance. All staff licensed and unlicensed who provide care and services to residents will be educated/ re-educated by June 15 and 16 by the administrator and DNS. Identification of Others: 2. ALL residents have the potential to be affected if staff do not adhere to: *consistency in mask use and social distancing in activity and communal dining. *appropriate hand hygiene during resident perineal care task.	

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F 880	Continued From page 27 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: Surveyor: 40788 Based on observation, interview, record review, and policy review, the provider failed to maintain infection control practices for: *Mask use and social distancing by one of one sampled resident (45) not vaccinated for COVID-19 during a group activity. *Mask use and social distancing by one of one sampled resident (159) not vaccinated for COVID-19 during communal dining. *Proper hand washing by one of one licensed practical nurse (LPN) (J) after providing perineal care for one of one sampled resident (43). Findings include: 1. Observation on 5/25/21 at 3:20 p.m. of resident 45 revealed: *She was in an activity room playing bingo with a group of residents. *There was no social distancing (maintaining a distance of at least six feet) between any of the participants. *None of the participants had worn masks. Review of resident 45's medical record revealed a COVID-19 vaccination declination dated	F 880	ALL staff completing the care and/or assigned tasks have potential to be affected. Policy education/re-education about roles and responsibilities for the above identified assigned task(s) will be provided by June 15 and 16 by the administrator and DNS. System Changes: 3. Root cause analysis conducted answered the 5 Whys: the facility conducted a root cause analysis and answered the 5 whys of unvaccinated residents and peri-care for the residents for infection control. The unvaccinated resident Covid standard was answered by a root cause of processes for the communication not being fully communicated down to the front line caregiver level effectively. A change of how a resident being identified was made to fully communicate that to the staff. For peri-care the root cause of more skill training was identified for being more comfortable with cares. Skills fair is being conducted as well as more audits to help make a change for peri-care skills. Administrator, DON, infection control person, 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.	

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F 880	Continued From page 28 12/15/20. Interview on 5/26/21 at 8:36 a.m. with resident 45 in her room revealed she: *Was nonverbal but able to shake her head appropriately to answer yes and no questions. *Shook her head "no" when asked if she usually wore a mask and distanced from other residents during bingo. Interview on 5/26/21 at 10:57 a.m. with activity assistant G regarding resident 45's participation in bingo revealed he: *Had not known resident 45 was not vaccinated for COVID-19. *Had thought residents not vaccinated for COVID-19 had worn masks around others. *Confirmed none of the bingo participants had been asked to social distance. Interview on 5/26/21 at 5:24 p.m. with infection control nurse C regarding resident 45's participation in bingo revealed she: *Expected resident 45 and all other bingo participants had worn masks and socially distanced. *Expected activity assistant G to have identified any non COVID-19 vaccinated residents prior to initiating a group activity to ensure guidance for group activities had been followed. -Stated a daily resident report sheet was used by nursing staff to communicate identified resident needs such as resident who had chosen not to be vaccinated for COVID-19. -That information was shared with caregivers at each shift change to ensure appropriate infection control practices had been followed. Review of the 4/28/21 revised Activity Services	F 880	The administrator and DNS contacted the South Dakota Quality Improvement Organization (QIN) on June 14, 2021 and the QIN on education, re-education and frequent auditing of training/competencies around the core principles of infection control specifically hand hygiene and the CDC guidelines when residents are unvaccinated and in communal areas. We discussed the root cause analysis and the 5 Whys on CDC and CMS guidelines on unvaccinated residents as well as peri-care infection control practices. In addition, resources were provided from the QIN Quality Improvement Advisor to the facility on a variety of areas for infection control, tracking and auditing findings. Monitoring: 4. Administrator, DON, infection control person, 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 8 weeks, administrator, DON, and/or infection prevention nurse making observations across all shifts to ensure staff compliance with:	

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F 880	Continued From page 29 and Program Deliver Considerations for Pandemic/Epidemic Outbreak policy revealed: *Reopening Guidance: -"All residents should wear mask if unvaccinated residents are present." -"Unvaccinated residents should maintain social distancing in group activities." 2. Observation and interview on 5/25/21 at 4:15 p.m. with resident 159 revealed she: *Had declined a COVID-19 vaccination. *Wore a mask when moving between her room and the dining room then removed it while she waited to be served. *Put that mask back on after the meal when she moved from the dining room to her room. *Sat at a two person table with another resident who had not worn a mask into or out of the dining room. Observation on 5/26/21 at 12:15 p.m. of resident 159 in the north unit dining room revealed she: *Was at a table without a mask on waiting for the noon meal to be served. -That table was approximately three feet wide. *Was unable to socially distance from a tablemate. Interview on 5/26/21 at 12:20 p.m. with certified nurse aide I in that same dining room revealed she: *Stated there had been no residents unvaccinated for COVID-19 on that unit. *Said resident 159 usually sat at a two person table with one another resident. *Confirmed neither resident wore a face mask and had not social distanced while together at that table.	F 880	*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 2 months. Monitoring results will be reported by administrator, DON, and/or infection control person to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee and medical director.	

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F 880	Continued From page 30	F 880		

Interview on 5/26/21 at 5:24 p.m. with infection control nurse C regarding resident 159 revealed she:
*Confirmed resident 159 had declined the COVID-19 vaccination.
*Stated a daily resident report sheet was used by nursing staff to communicate identified resident needs such as resident who had chosen not to be vaccinated for COVID-19.
-That information was shared with caregivers at each shift change to ensure appropriate infection control practices had been followed.
*Confirmed resident 159 and her tablemate should have worn their masks in the dining room unless they had been eating.
*Confirmed the two person table resident 159 sat at was not wide enough to facilitate social distancing from her tablemate.
*Said the provider's 4/27/21 updated guidance regarding communal dining for residents vaccinated and unvaccinated for COVID-19 had not been followed.

Review of the 4/27/21 revised Food and Nutrition Services Considerations for Pandemic/Epidemic Outbreak policy revealed:
*Communal Dining:
-"If unvaccinated residents are dining in a communal area (e.g., dining room) all residents should use face masks when not eating and unvaccinated residents should continue to remain at least 6 feet from others."

Surveyor: 41895
3. Observation on 5/27/21 at 8:19 a.m. of LPN J assisting resident 43 to the bathroom revealed:
*She was wearing a pair of gloves and used toilet paper to provide the resident with perineal care.
*With those same soiled gloves she had:

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F 880	Continued From page 31 -Pulled up the residents pants, assisted resident to the sink, assisted the resident to wash her hands and brush her hair. -Touched the wheelchair handles, oxygen tubing, water faucet, hand towel, hair brush, counter top, and bedside table. -Assisted resident out of the bathroom and put the wheelchair next to the bed. *She then removed those soiled gloves and performed hand hygiene. Interview on 5/27/21 at 8:33 a.m. with LPN J regarding the above observation revealed she: *Had not realized she did not remove her gloves and perform hand hygiene after performing the perineal care. *Agreed her gloves would have been soiled and she should have removed them and washed her hands. Interview on 5/27/21 at 2:36 p.m. with director of nursing B regarding the above observation and interview revealed she would have expected LPN J to remove her gloves and perform hand hygiene after assisting a resident with perineal care. Review of the provider's 4/6/21 Hand Hygiene and Handwashing policy revealed: *"2. If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based hand rub for routinely cleaning hands:" -"b. After having direct contact with another person's skin -c. After having contact with body fluids, wounds or broken skin -d. After touching equipment or furniture near the resident/patient -e. After removing gloves"	F 880		

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F 909 SS=E	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on observation, interview, and policy review, the provider failed to assess side rails on ten of fifteen sampled residents' beds (7, 9, 28, 32, 45, 46, 48, 53, 159, and 209) routinely as a part of a preventative maintenance program to ensure those side rails were in good working order and safe from possible resident entrapment. Findings include: 1. Observations made between 1:30 p.m. and 6:00 p.m. on 5/25/21 of the above residents' rooms revealed quarter length side rails on one or both sides of those beds. Interview on 5/27/21 at 8:15 a.m. with environmental services supervisor H regarding side rails revealed he: *Confirmed the environmental services department had installed those side rails. -They had been in place from the date the facility had opened. *There was no preventative maintenance schedule or evaluation of side rails after they were installed. *Relied on caregivers to submit a work order to environmental services to assess any side rail	F 909	All residents have the potential to be affected by this deficiency Maintenance department has serviced each of the remaining positioning bars to ensure safe and effective use of the positioning bars for functionality and safety. The maintenance department developed a checklist for each of the position bars to do scheduled maintenance on each of the positions bars annually to ensure safety and effective preventative maintenance of the positioning bars. The maintenance director or his designee will report to the QAPI committee on a monthly basis the audit results of the positioning bars. The results will be reported by maintenance director to the QAPI committee and if necessary make any recommendation for improvement. It will be continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	6/16/21

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F 909	Continued From page 33 concerns. Review of the 5/27/21 revised Bed Safety and Side Rail Entrapment Resources Packet policy revealed: *The purpose of the policy was to promote bed safety by inspecting the bed system for: "-Proper fit of mattress in the bed frame, no gaps or spaces -Proper installation of side rails or assistive devices such as grab bars -Rails or assistive devices designed for the bed frame manufacturer -Rails or assistive devices that meet the design elements of bed safety standards to avoid entrapment injuries or death." *Focus Audit (Page 5): -The bed system must be inspected annually. -Bed inspections were documented using a bed assessment and side rail safety audit or an electronic work order system. Surveyor: 40788	F 909		

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PRINTED: 06/08/2021
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST MARTIN VILLAGE	**4825 JERICHO WAY** **RAPID CITY, SD 57702**

(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: 40788 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 5/25/21 through 5/27/21. Good Samaritan Society St. Martin Village was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kyle Richards	Senior Director	6/17/21

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.

PRINTED: 06/08/2021
FORM APPROVED
OMB NO. 0938-0391

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

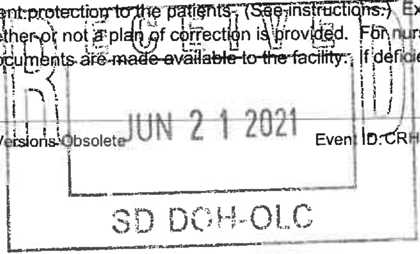
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435134	A. BUILDING 01 - SERENITY PLACE B. WING ______	05/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST MARTIN VILLAGE	4825 JERICHO WAY RAPID CITY, SD 57702

(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 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 5/26/21. Good Samaritan Society-St. Martin Village 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 the deficiency identified at K226 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 226 SS=D	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain the fire-resistive design of the horizontal exit and building separation wall (between the independent living building and the nursing home). The east leaf of the 90-minute fire-rated laminated wood doors only had one point of latching. Findings include:	K 226	All Residents are potentially affected in the smoke compartment. The panic bar hardware rod was reinstated for an interim measure in order to positively latch to the strike plate in the door frame to provide two latching points by the maintenance department. The automatic door opener was taken out of service until new hardware of an electronic striker plate system can be installed by our vendor in order to provide two positive latching points. Out of service signs were placed on the automatic door opening buttons by maintenance department.	6/17/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kyle Richards
TITLE: Senior Director
(X6) DATE: 6/17/21

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.



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435134	A. BUILDING **01 - SERENITY PLACE** B. WING ______	**05/26/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST MARTIN VILLAGE	**4825 JERICHO WAY** **RAPID CITY, SD 57702**

(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 226	Continued From page 1 1. Observation on 5/26/21 at 10:00 a.m. revealed the two-hour, fire-rated separation wall between the independent living building and the nursing home had ninety-minute, fire-rated alternate swing laminated wood doors which require two points of latching. The west leaf of the alternate swing doors leading out of the nursing home correctly had a top latching bar into the frame connected to the panic bar affixed horizontally on the door, along with a thermal pin in the lower half of the leading edge of the door as the second point of latching. The east leaf of the alternate swing doors had only one point of latching, a thermal pin located in the lower half of the leading edge of the door and a magnetic lock device on the upper edge of the door at the frame. The magnet did not provide a positive second point of latching as required for the door. The panic bar hardware was designed to have a rod extending upward to a strike plate in the door frame. A rod was not in place connecting the panic bar hardware to a strike plate in the frame. Holes in the door leaf showed the hardware had been installed at one time but had been removed. The hardware was designed for the installation of both latching rods and strikers. Interview on 5/26/21 at 10:00 a.m. with the maintenance supervisor confirmed the lack of a second point of latching to the top of the door frame. He revealed the magnet lock had been installed for the east leaf several years ago with a push-button door opener that would open the east leaf into the nursing home when activated. He was unaware the magnet did not provide the required second point of latching for a ninety-minute fire-rated door.	K 226	The maintenance director or his designee will audit the hardware is positively latching one per week for three weeks then once every other week x 3 times, and finally once a month for three months. The maintenance director or his designee will report to the QAPI committee on a monthly basis the audit results of the positively latching door has two points of latching. The QAPI committee will review the audit results and if necessary make any recommendations for improvement.	

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

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	435134	A. BUILDING **01 - SERENITY PLACE** B. WING ______	**05/26/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST MARTIN VILLAGE	**4825 JERICHO WAY** **RAPID CITY, SD 57702**

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K 226	Continued From page 2 The deficiency could affect 100% of the occupants of the smoke compartment.	K 226		

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
	68237	A. BUILDING: ______ B. WING ______	05/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST MARTIN VILLAGE	4825 JERICHO WAY RAPID CITY, SD 57702

(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: 40788 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 5/25/21 through 5/27/21. Good Samaritan Society St. Martin Village was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 40788 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 5/25/21 through 5/27/21. Good Samaritan Society St. Martin Village was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kyle Richards	Senior Director	6/17/21