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 |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 05/04/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOOD SAMARITAN SOCIETY CORSICA | 455 NORTH DAKOTA CORSICA, SD 57328 |

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| F 000 | INITIAL COMMENTS<br><br>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 5/1/23 through 5/4/23. Good Samaritan Society Corsica was found not in compliance with the following requirements: F550, F689, F697, and F880. | F 000 | Preparation and execution of this Response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.<br><br>On 5/22/2023 Administrator provided education to all staff on Resident 31s care plan and timely response to resident requests. All residents have the potential to be affected by the deficient practice. To ensure deficient practice does not recur, by June 1, 2023, Administrator will provide education on resident rights to all staff. During new hire orientation social services or designee will provide education on resident rights and timely response and sign new hire checklist to confirm completion. | |
| F 550<br>SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>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.<br><br>§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.<br><br>§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.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. | F 550 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Whitney Podzimek | TITLE: Administrator | (X6) DATE: 5/24/2023

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

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| F 550 | Continued From page 1<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the provider failed to ensure four of four staff members (licensed practical nurse N, and three unidentified staff members) addressed one of one sampled resident's (31) request for assistance with toileting.<br>Finding include:<br><br>1. Observation on 5/3/23 at 9:46 a.m. and interview on 5/3/23 at 9:50 a.m. with resident 31 revealed she:<br>*Was leaving the dining area and requested help going to the restroom.<br>*Was told by an unidentified staff member to go the her room, turn on her call light, and wait for someone to come and help her.<br>*Stopped at the nurses' station and asked another unidentifeied staff member to help her go to the restroom.<br>*Was told by that unidentified staff member through the sliding glass opening to go to her room and wait for someone to come and help her.<br>*Stopped a third unidentified staff member and asked for help and was again told to go to her | F 550 | The QAPI Coordinator or designee will audit by observation and interview residents at random to ensure requests are being met timely. QAPI Coordinator or designee will interview staff at random to ensure they have understand resident rights training and his/her responsibility to respond appropriately to requests. Audits will occur biweekly x2 and monthly x2. QAPI Coordinator or designee will report findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring. Substantial compliance will be achieved by 6/1/2023. | 6/1/2023 |

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| F 550 | Continued From page 2<br>room, turn her call light on and wait for someone.<br>*Had reached the closed door of her room.<br>*Attempted to enter her room and was told she could not enter while her roommate was being taken care of.<br>*Attempted to reenter her room and had the door shut in front of her.<br>*Yelled, "What are you supposed to do piss your pants."<br>*Said this happens all the time<br>*Was told by licensed practical nurse (LPN) N who exited her room fifteen minutes after resident 31 initally requested assistance to go inside, turn her call light on and wait for a CNA (certified nursing assistant) to help her.<br><br>Interview on 5/3/23 at 9:52 a.m. with LPN N about resident 31 needing help to go to the restroom revealed:<br>*Resident 31's normal routine after breakfast was to go to the bathroom.<br>*That she knew how to request help once she got to her room.<br>*She said, "that's just [resident 31]."<br>*She said resident 31's roommate was not clothed and staff did not want to open the door until her roommate was dressed.<br><br>Interview on 5/3/23 at 10:08 a.m. with director of nursing (DON) B in reference to LPN N's response to resident 31's request for help revealed she:<br>*Was unsure as to why resident 31 was treated the way she was.<br>*Expected that any resident that asked for assistance would have been helped no matter how many times the resident had made the same request. | F 550 | | |

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| F 550 | Continued From page 3<br>Interview on 5/3/23 at 4:20 p.m. with administrator A about resident 31's request for help going to the restroom after breakfast revealed she did not know why resident 31 was not immediately helped, but her expectation would have been that all residents are helped immediately no matter the issue.<br><br>Record review of resident 31's 3/10/23 care plan revealed "Encourage/remind resident to ask for help as needed and to avoid self transfers." | F 550 | | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, closed record review, and policy review, the provider failed to ensure environmental precautions were in place to prevent harm to one of one sampled resident (147) who received an injury to her right foot from a heat register on the wall in her room where her bed was located.<br><br>1. Observation and interview on 5/4/23 at 10:12 a.m. with associate maintenance mechanic F in the room where resident 147 resided while she was in the facility revealed:<br>*The room was currently not occupied by any residents. | F 689 | On 5/19/2023 the broken vent cover was repaired resolving jagged edge on vent; additionally a wooden cover has been added to the register/vent. On 5/23/2023 all other rooms were inspected and verified vent covers are in place and not in need of repair. To ensure deficient practice does not recur, by June 1, 2023, Administrator will educate all staff on how to report items in need of repair. By June 1, 2023, maintenance tech will add monthly observation of all rooms to ensure vent covers in place to preventative maintenance check. Administrator or designee will audit maintenance log to ensure reported concerns are addressed per policy and monthly preventative maintenance check is complete. Audits will occur monthly x3. | |

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| F 689 | Continued From page 4<br>*The room measured 15'6" by 12'4" and had been built to accomodate two residents.<br>*Opposite the door entering the room was a large window with a heat register under the windowsill.<br>*The heat register was cool to touch.<br>*One of the heat registers metal vents was broken and had a jagged edge.<br>*There was one bed in the room, and it was pushed up against the wall with the heat register next to it.<br>*Associate maintenance mechanic F stated the heat register was a working register and was the main heat source for the room.<br>*There had been a different bed in the room when resident 147 was in the room and her bed was moved 3 to 4 inches away from the wall/heat register after staff had found her second right toe/foot injury.<br>*There had been two residents residing in that room until approximately 2 to 3 weeks ago and he was unsure of how the beds were positioned.<br>*He was unaware of the broken jagged edge on the heat register and was sure it had not been that way when resident 147 had resided in that room.<br>*He was not sure why that room was the only room in the facility without a wooden cover built over the heat register and stated the wooden covers over the heat registers in all the other rooms in the facility were there before he started working at the facility approximately 10 to 12 years ago.<br><br>Review of resident 147's medical record revealed:<br>*She was 106 years old and was admitted to the facility on 12/1/22 from another nursing home.<br>*Her 12/5/22 admission Minimum Data Set (MDS) assessment revealed she was rarely or | F 689 | Administrator or designee will report findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring. Substantial compliance will be achieved by 6/1/2023 | 6/1/2023 |

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| F 689 | Continued From page 5 | F 689 | | |

never understood and had short-term and long-term memory problems.
*Diagnoses included dementia, osteoarthritis, history of falls, insomnia, pain/discomfort, and a traumatic wound/skin tear on the right toe/foot.
*She was admitted to hospice care on 1/27/23.
*She died at the facility on 2/21/23.
*1/5/23 nursing progress note documented "Note Text: Res [resident] has been getting her legs off of the bed during the night and at times while she rests in the afternoon. Nurse requested an order for a repositioning pillow to lay alongside res while in bed to help keep feet and legs in bed. PCP [primary care provider] has agreed with this and sent order."
*1/12/23 nursing progress note documented " Note Text: Resident was found sitting beside bed, R [right] lateral side of leg were red from sitting on it. Looks like res [resident] slid out from her bed. No injuries noted. Vitals taken. Resident was noted to be restless and/or anxious on day of incident. Body pillow added for re--positional device, as resident has been hanging her leg off side of bed. No suspicion of abuse/neglect suspected."
*1/25/23 nursing progress note documented "Note Text: Heard res [resident]screamed "help" RN went and res [resident] stated "my toes are killing me" upon assessment noticed that res [residen] epidermis fell off unsure how she obtained a skin tear while laying in bed. Flaps unable to approximate. Send fax to provider to ask for treatment. For now, area is cleansed and Mepilex applied. Tried to give Tylenol to res [resident] however spitted medication out"
*1/30/23 nursing progress note documented "Note Text: At approximately 0500 CNA [certified nursing assistant] reports dressing is missing from resident's right lateral toe. Upon

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| F 689 | Continued From page 6<br>observation, noted that the resident now has a wound that is approximately 7cm [centimeter] x 3cm [centimeter] in size. This is larger than the previous measurement on 1-29-23 of 3cmx3cm. The wound bed is very red in color with some darker areas noted, the foot was resting on heater vent beside her, also has an intact blister to the fourth right toe. Covered blister in betadine, hydrogel applied and wrapped in gauze wrap, informed Dr. [residents physician name] of the condition of the foot."<br>*On 1/25/23 the wound RN (registered nurse) assessment and wound data collection documented a 3 centimeters (cm) length by 3 cm width skin tear wound with full thickness tissue loss and a red wound bed at the 5th toe and surrounding area of the right foot. The physician and family were notified, and wound care orders were obtained. The wound was cleansed with normal saline, a hydrogel dressing was placed over the wound and wrapped to secure in place with a bandage roll. Acetaminophen and morphine sulfate was to have been administered as needed with dressing changes.<br>*On 1/30/23 the wound RN assessment and wound data collection documented a new full thickness traumatic wound to the right lateral foot stating that it had increased in size, with increased redness and swelling and there was a blister to the right fourth toe measuring 2 cm length by 1.5 cm width. The physician and family were notified of the new wound and the new treatment orders were obtained for Betadine to the area twice daily.<br><br>Review of resident 147's comprehensive care plan initiated on 12/1/22 and revised through 2/21/23 revealed:<br>*Impairment to skin Integrity R/T [related to] | F 689 | | |

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| F 689 | Continued From page 7<br>dementia, osteoarthritis, and now has a traumatic wound/skin tear on the right toe/foot.<br>*Pain/discomfort R/T osteoarthritis and traumatic wound right toe/foot.<br><br>Review of the provider incident report dated 1/30/23 revealed:<br>*Resident's injury was due to her right foot resting on the heat register in her room.<br>*Her room had been arranged with the bed along the wall with the heat register next to the bed.<br>*Once the injury was identified and addressed by staff her bed had been moved away from the heat register on the wall.<br>*The physician and family were notified of the incident.<br>*Staff were educated at stand-up meetings during shift changes.<br><br>Interview on 5/3/23 at 5:08 p.m. with director of nursing (DON) B revealed:<br>*She stated resident 147's feet were always moving back and forth, she had foot and heel protector booties, but they had not stayed in place with her feet moving all the time.<br>*She stated room 105 had been the hospice room with only one bed in it until residents were moved to the facility from another nursing home in the area due to a fire.<br>*At that time, they had to have two residents in room 105, and she had thought that was why the bed was positioned against the wall with the heat register.<br>*She was unsure why room 105 was the only resident room in the facility that had no wooden cover built over the heat register.<br>*Her expectation would have been that the bed should have been moved away from the heat register on the wall when resident 147 was | F 689 | | |

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| F 689 | Continued From page 8<br>identified as kicking her feet off the bed between the bed and wall with the heat register in addition to the implementation of the body pillow.<br>*She would have expected the bed to have been moved away from the heat register when the resident obtained the skin tear on her toe before the wound from laying her foot on the heat register occurred.<br>*There had been two residents residing in room 105 until recently and the resident that had been in the bed by the wall with the heat register was cognitive.<br>*The two nurses that had worked the morning of 1/30/23 were not currently working at the facility. One nurse had resigned and the other was a contract travel nurse.<br><br>Interview on 5/4/23 at 10:48 a.m. with administrator A regarding resident 147 revealed:<br>*The resident's bed was moved away from the wall with the heat register after she had obtained the right toe/foot injury.<br>*Her expectation was that beds were not to have been positioned against a wall with a heat register.<br>*After the incident they completed staff education regarding safety, and positioning of resident beds away from heat registers.<br>*During her investigation she had completed audits that revealed room 105 was the only resident room in the facility without a wooden cover built over the heat register.<br>*She was unsure why room 105 had not had a wood cover built over the heat register but stated they were working with a contractor in town to complete that.<br>*Prior to residents moving to the facility from another nursing home after the fire it had not been an issue as that had been the hospice room | F 689 | | |

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that had only one resident and bed in it.
*Her audits included checking the heat register in room 105 at different times of day for several days and revealed that the heat register alternated between cool and warm to the touch but was never hot enough that it would have caused a burn.
*She was sure the broken vent with the jagged edge had not been there when resident 147's injury occurred. She had checked the register several times daily for several days and ran her hand along the register. She would have noticed it. She attributed the broken vent to when staff moved the head of the bed against the heat register.

Interview on 5/4/23 at 11:05 a.m. with CNA I regarding resident 147 revealed:
*She had worked with resident 147 the morning of 1/30/23 after the injury had been discovered.
*She had not seen the injury on the right toe and foot as it was covered with a dressing when she arrived but had been told it was a burn from her foot laying on the heat register.
*Resident 147's bed was positioned against the wall with the heat register until it had been moved that morning, staff found a burn on her right toe and foot.
*Staff were educated at a meeting regarding repositioning residents and safe bed placement after the incident with resident 147.
*Resident 147 was very stiff, not very mobile, and had a body pillow to assist with positioning.
*The other three CNAs working on 1/30/23 were no longer working for the provider.

Interview on 5/4/23 at 11:20 a.m. with registered nurse (RN) G regarding resident 147 revealed:
*She was not working the day the residents' injury

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happened.
*She had never seen the wound as dressing changes were completed by the treatment nurse.
*She knew the wound was from trauma, but it was never clear as to whether it was a burn or from her foot rubbing against the heat register after her foot had fallen off the side of the bed between the bed and wall with the heat register.
*The resident's bed was positioned against the wall with the heat register.
*Her bed had been moved away from the wall with the heat register after the injury was discovered.

Interview on 5/4/23 at 11:35 a.m. with licensed practical nurse (LPN) H regarding resident 147 revealed:
*The resident's bed was positioned against the wall with the heat register until her injury and then the bed had been moved.
*The resident was very stiff, moved her feet, and had a body pillow to assist with positioning.
*She worked as the treatment nurse and completed dressing changes for resident 147's right toe and foot wound along with the hospice nurse.
*The wound was called a burn and it appeared as a burn. The redness went away but then the area turned black.
*She was told the burn occurred after the resident's right foot had laid against the heat register.
*The wound treatments were painful for the resident. The resident had been given morphine that had helped with the pain. They applied betadine to the wound and then wrapped it with a dressing.
*She could not remember any meetings regarding the incident, safety, or bed placement.

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| GOOD SAMARITAN SOCIETY CORSICA | 455 NORTH DAKOTA CORSICA, SD 57328 |

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| F 689 | Continued From page 11<br>*There had been residents in that room since but the bed was not placed up against the heat register.<br><br>Review of the providers 2/10/23 Resident Environment policy revealed:<br>*"Purpose<br>-To ensure an appropriate resident environment<br>*Policy<br>-The center will provide a safe, clean, comfortable and homelike environment"<br>-"Resident rooms will be designed and equipped for adequate nursing care, safety and comfort" | F 689 | | |
| F 697 SS=D | Pain Management<br>CFR(s): 483.25(k)<br><br>§483.25(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and policy review, the provider failed to adequately manage pain for one of one sampled resident (15) who had pain. Findings include:<br><br>1. Observation and interview on 5/2/23 at 10:53 a.m. with resident 15 revealed he:<br>*Was exiting the bathroom after he had shaved with an electric razor.<br>*Had been grimacing while walking in his room.<br>*Had moved to the facility from another nursing home when that facility had closed.<br>*Has had frequent pain and he felt that it had not improved. | F 697 | By June 1, 2023 DNS will educate all nurses on expectation for managing pain and follow-up to ensure PRN medications are effective. Any resident experiencing uncontrolled pain may be affected. To ensure deficient practice will not recur, Director of Nursing will educate all nurses/med aids on identifying resident pain and use of appropriate pain scale (numerical or pain-ad scale). Staff will be educated on non-pharmacological and pharmacological interventions, consistent communication with physicians as well as follow up to ensure pain medication effectiveness. IDT will review residents MAR and pain medication usage in interdisciplinary meetings and follow up on pain management orders when appropriate. | |

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| F 697 | Continued From page 12<br>*Felt that the staff had not wanted to increase his pain medications.<br>*Had been getting Extra Strength Tylenol in the evenings and it "doesn't cut it."<br>*Has had pain in his rectum from his colon cancer and pain in his shoulders and legs.<br>*Had used ice and heat packs on his painful joints provided by the staff.<br>*Had no family.<br>*Had a doctor appointment scheduled for that day with his surgeon regarding his rectal pain.<br>*Stated that his doctors had informed him after his ileostomy (a surgical procedure to create an opening through the abdomen into the ileum portion of a person's intestines for the purpose of waste elimination due to colon or rectal dyfunction) was placed that he was not healthy enough to have any more surgeries.<br><br>Review of resident 15's medical record revealed:<br>*He had been admitted on 9/21/22<br>*His Brief Interview for Mental Status assessment score was 13 indicating that his cognition was intact.<br>*His diagnoses included:<br>-Malignant neoplasm of ascending colon.<br>-Gastrostomy status.<br>-Ileostomy status.<br>-Other intervertebral disc degeneration, thoracolumbar region.<br>-Bilateral primary osteoarthritis of the knee.<br>-Other chronic pain.<br>-Gout, unspecified.<br>-Fecal impaction.<br>-Alcohol dependence, in remission<br><br>Review of resident 15's April 2023 and May 2023 medication administration record (MAR) revealed physician's orders for: | F 697 | DNS or designee will audit random residents by medical record review and interview to ensure adequate pain control and physician follow up. Audits will occur weekly x4 and monthly x2. DNS or designee will report findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring. Substantial compliance will be achieved by 6/1/2023 | 6/1/2023 |

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| F 697 | Continued From page 13<br>*Gabapentin oral capsule 300 milligrams (mg) via G-Tube four times a day for pain at 4 a.m., 12 p.m., 5 p.m. and 10 p.m.<br>*Hydrocodone-acetaminophen 5-325 mg 1 tablet by mouth three times a day for pain at 4 a.m., 10 a.m. and 10 p.m.<br>*Menthol-methyl salicylate (Liniments) 10-15% (percent) analgesic external cream topically to the anal area two times a day for pain.<br>*4% Lidocaine external patch applied to the coccyx topically in the evening and removed in the morning.<br>*Acetaminophen extra strength tablet 1000 mg by mouth every 6 hours as needed for pain.<br>*Voltaren (Diclofenac Sodium (Topical)) Gel 1 % two times a day as needed for pain in the shoulders and knees.<br><br>Review of resident 15's 4/6/23 care conference revealed:<br>"Does complain of tail bone/bottom pain and cannot find relief. Says it is tolerable but it just doesn't go away."<br><br>Review of resident 15's care plan initiated 9/21/22 and revised through 4/5/23 revealed:<br>*"The resident chronic pain R/T malignant neoplasm of colon, osteoarthritis, intervertebral disc degeneration E/B chronic back/rectum pain"<br>*"Resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain"<br>*"Meds as ordered, offer prn (as needed) meds."<br>*"Notify health care provider if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain."<br>*"Evaluate the effectiveness of pain interventions about an hour after prn med given."<br>*"The resident has a mood problem R/T Anxiety, | F 697 | | |

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| F 697 | Continued From page 14 | F 697 | | |

failing health status/chronic pain, Hx of alcohol abuse E/B becomes anxious at times"
-"Allow him time to verbalize his feelings. Assist resident in developing/Provide resident with a program of activities that is meaningful and of interest."

Review of Communication/Visit with Physician notes regarding resident 15 revealed:
*On 11/29/22, the resident had been seen by his physician.
-The physician had written an order for the resident's hydrocodone/acetaminophen to have been decreased from four times a day to two times a day.
*On 12/29/22, the facility staff faxed communication to resident's physician:
-"Res [Resident] is not having good pain control; using Norco (hydrocodone-acetaminophen) 5-325mg at 0400 and 2100 scheduled. Tylenol 1000 mg prn q 6 hours. Res is requesting daytime pain medication."
*On 12/29/22, the resident's physician faxed communication to facility staff:
-"See on Tues [Tuesday] to discuss this. Will need to know where pain is & how he rates it"
*On 1/4/23, the resident had been seen by his physician.
-His pain had been discussed.
-He had requested his hydrocodone to have been given more often.
*On 1/7/23, the resident had been seen by his physician.
-His pain had been discussed.
-He had been having increased pain so he was started on Meloxicam (a medication for pain) daily and then was to have been rechecked in two weeks.
*On 1/31/23, resident had been seen by his

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| F 697 | Continued From page 15<br>physician.<br>-His pain had been discussed.<br>-Meloxicam had been discontinued as he stated his pain control had not improved.<br>-Gabapentin had been increased to 100 mg TID (three times a day) for three days and then 300 mg TID.<br>*On 2/28/23, resident had been seen by his physician.<br>-His pain had been discussed.<br>-His orders had not been revised.<br>*On 3/14/23, resident had been seen by his physician.<br>-His pain had been discussed.<br>-Orders had been given to use the Recticare cream (a cream applied on the skin of the rectal area to relieve symptoms of pain, itching, burning, swelling, or irritation) four times a day and the Voltaren gel 1% to the shoulders and knees twice daily.<br>*On 3/21/23, the resident had visited with his physician.<br>-His pain had been discussed.<br>-The physician had asked the resident if he would have liked to have seen a surgeon to evaluate the cause of his rectal pain.<br>-He stated he would have liked to have done that.<br>-He stated that his shoulder and knee hurt when he used them, that the pain had gone away, and the pain was tolerable.<br><br>Review of the Pain Level Summary from 4/3/23 through 5/3/23 revealed:<br>*Out of the one hundred and twenty-four opportunities when resident 15 was asked to rate his pain (1 being the least amount of pain and ten being the worst pain possible) , resident rated the pain at:<br>-10 ("worst possible") 30 times. | F 697 | | |

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| F 697 | Continued From page 16<br>-7-9 ("very severe pain") 43 times.<br>-4-6 ("Moderate to severe pain") 33 times.<br>-1-3 ("mild to moderate pain") 8 times.<br>-0 ("no pain") 10 times.<br><br>Of the 124 opportunities when resident 15 was asked to rate his pain, PRN Tylenol was given 11 times.<br>*Of those 11 prn Tylenol extra strength administrations, 4 of those administrations were deemed "ineffective" by the resident.<br>-No other interventions were documented by the nurse at those times.<br><br>Interview on 5/3/23 at 2:24 p.m. with resident 15 revealed:<br>*His pain had not been tolerable, but he felt the nursing staff were doing everything they could when he said he had pain.<br>*The rectal pain had not been tolerable.<br>-He was not able to lie on his right side because of his ileostomy or on his left because of his feeding tube (a tube surgically placed into the digestive system to deliver liquid nutrition) so he had to lay on his back when he was not up walking.<br>*He was not able to recall having been asked about his pain tolerance level.<br><br>Interview on 5/3/23 at 2:39 p.m. with licensed practical nurse (LPN) H regarding resident 15 revealed she:<br>*Knew the resident's pain had been an ongoing issue.<br>*Was aware that his doctor had not wantd to increase his dose of hydrocodone/acetaminophen so the resident could have that medication every 6 hours.<br>*Had educated the resident on repositioning to | F 697 | | |

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| F 697 | Continued From page 17 | F 697 | | |

relieve pain.
*Had been working the night shift and regularly saw no physical signs of pain when she had talked to the resident.

Interview on 5/3/23 at 3:07 p.m. with the director of nursing (DON) B regarding resident 15's pain revealed:
*If a resident had been having pain, the staff would have given physician ordered prn pain medication, reevaluate if the medication had been effective and if it had not been effective, the nursing staff would have given a different medication, if available, or called the doctor to increase the pain medication.
-The nursing staff would have called the emergency room for a new pain medication order if the doctor was not available.
*She had assumed the reason the physician had not increased the resident's pain medication from 3 times a day to 4 times a day had something to do with his history of addiction.
*She agreed that they should have advocated harder for resident 15 regarding his pain.
*She agreed that an interdisciplinary team should have been involved with resident 15's pain management care.

Interview on 5/4/23 at 11:16 a.m. with resident 15 regarding his pain and the increase of his gabapentin revealed he:
-Believed it was working.
-Felt that only getting Tylenol and gabapentin at 4 in the afternoon was not helping his pain since that was when he had experienced the most pain.

Review of the providers December 2022 Pain Management policy revealed:
*"POLICY:

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| F 697 | Continued From page 18<br>-All residents will receive interdisciplinary consultations on assistance in managing pain.<br>-Individualized approaches will be developed to address the resident's pain management needs in a holistic manner.<br>-The licensed nurse will assess current pain levels and develop with the physician and interdisciplinary team interventions that may be non-pharmacological, as well as pharmacological.<br>-The licensed nurse will review response to medication intervention and work closely with the physician to assist in the individualized pain management plan.<br>-The nurses working directly with residents must continually monitor and observe the resident for success of the pain management plan and report to the nurse manager and prescriber as necessary to keep the resident comfortable." | F 697 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, | F 880 | By June 1, 2023 Infection Control Nurse or Designee will educate all staff on expectation for proper hand hygiene and glove use. Infection control nurse or desigee will provide education to nurses on hand hygiene and glove use during glucometer checks and enteral feedings and enteral medication administrations. Residents having glucometer checks, enteral feedings/medication administrations have the potential to be affected by the deficient practice. To ensure deficient practice does recur, by June 1, 2023, Infection Control Nurse or Designee will re-educate all staff on infection prevention strategies surrounding hand hygiene and glove use. | |

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| F 880 | Continued From page 19<br>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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. | F 880 | By June 1, 2023, Infection Control nurse or designee will audit infection control with glucometer checks, enteral feedings/medication administrations and proper glove use/hand hygiene. Audits will occur weekly x4 and monthly x2. InfectionControl Nurse or designee will report findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring. Substantial compliance will be achieved by 6/1/2023. | 6/1/2023 |

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| F 880 | Continued From page 20<br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and policy review, the provider failed to ensure:<br>*One of one licensed practical nurse (LPN) H performed appropriate hand hygiene, glove use, and procedural technique for:<br>-One of one sampled resident (23) during a blood glucose check.<br>-One of one sampled resident (15) during the administration of medication and enteral formula through a gastrostomy tube (G-tube is a tube inserted into the abdomen to deliver nutritional supplement or medications into the body).<br>1. Observation and interview on 5/2/23 at 5:10 p.m. with LPN H while performing a blood glucose check for resident 23 revealed:<br>*Without removing her soided gloves, she picked up the supplies she had brought into the resident's room and brought them out to the the treatment cart.<br>-She disposed of the soiled lancet and other disposables in the correct receptacles.<br>-Then placed the container of test trips into a container on the cart along side alcohol swabs and cotton balls used for other residents' blood glucose testing needs.<br>*She agreed:<br>-She should not have picked up the container of unused test strips with a soiled glove.<br>-She should have removed her soiled gloves, | F 880 | | |

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| F 880 | Continued From page 21<br>performed hand hygiene, and then picked up the container of unused test strips.<br><br>2. Observation 5/3/23 at 10:00 a.m. of LPN H while performing an enteral bolus tube feeding and medication administration for resident 15 revealed she:<br>*Performed hand hygiene before preparing resident's medications in the medication room.<br>*Knocked one container of IsoSource onto the floor, picked it up off the floor and placed it back on the barrier without wiping it off.<br>*Put on a pair of gloves without performing hand hygiene.<br>*Went into the resident's bathroom to fill up cups with water for flushing the feeding tube in between each medication that would have been administered.<br>*Removed the tube feeding supplies (syringe, beaker, and towel) from drawer in resident's room with those same gloved hands.<br>*Used a syringe to check residual in the resident's stomach with those same gloved hands.<br>*Then administered the resident's medications in tube.<br>*Placed the used containers into the trash, removed her gloves, performed hand hygiene, and then exited the resident's room.<br><br>Interview on 5/3/23 at 5:36 p.m. with LPN H revealed she:<br>*Agreed that she should have washed the IsoSource container before placing it on the barrier.<br>*Agreed that she should have washed her hands before donning gloves and after removing those gloves.<br><br>Interview on 5/4/23 at 11:06 a.m. with infection | F 880 | | |

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| F 880 | Continued From page 22<br>control nurse D revealed she:<br>*Stated that the staff had the initial infection control training when they started employment and then annually.<br>*Had "stand ups" (short staff meetings) every afternoon and morning to reinforce infection control practices.<br>*Performed a minimum of twenty hand hygiene audits monthly for all staff.<br>*Would have expected the nurse to have removed her soiled gloves after performing blood sugar check.<br>*Would have expected that hand hygiene would have been performed before and after donning gloves.<br><br>Interview on 5/4/23 at 10:05 a.m. with director of nursing (DON) B regarding the above tube feeding observations with LPN H revealed she:<br>*Would have expected that after the IsoSource fell on the floor, it would have been cleaned, hand hygiene would have been done, and a new barrier would have been placed if the contaminated IsoSource was placed on the original barrier.<br>*Would have expected the nurse to have performed hand hygiene before and after glove use.<br><br>Review of the provider's March 2022 Hand Hygiene policy revealed:<br>*"POLICY:"<br>"-All employees in patient care areas (unless otherwise noted in their policy) will adhere to the 4 Moments of Hand Hygiene and 2 Zones of Hand Hygiene.<br>1. Entering Room<br>2. Before Clean Task<br>3. After Bodily Fluid/Glove Removal<br>4. Exiting Room | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 05/04/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY CORSICA | 455 NORTH DAKOTA CORSICA, SD 57328 |

| (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 23<br>5. Zones: Patient zone and Health-care zone"<br>"-Gloves are a protective barrier for the HCW according to standard precautions.<br>1. Gloves are never to be reused or sanitized.<br>2. Hand hygiene should be performed after glove removal."<br>"-Compliance with hand hygiene is routinely monitored in all patient care areas by hand hygiene observers who have gone through training."<br>*"PROCEDURE:<br>-HCW [Health Care Worker] will use waterless alcohol-based hand sanitizer or soap and water to clean their hands:<br>--When entering patient room<br>--Before preparing or administering medications<br>--Before donning sterile gloves<br>--If gloves are used to perform a clean/aseptic procedure, hand hygiene must be completed before donning gloves.<br>--After removing gloves regardless of task completed<br>--After contact with a patient's [resident's] non-intact skin, wound dressing, secretions, excretions, mucous membranes, as long as hands are not visibly soiled<br>--When entering healthcare zone (supply drawers, linen drawers or cupboards)<br>--When exiting patient [resident] room" | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 435089 | A. BUILDING _____ B. WING _____ | 05/04/2023 |

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| GOOD SAMARITAN SOCIETY CORSICA | 455 NORTH DAKOTA CORSICA, SD 57328 |

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|---|---|---|---|---|
| E 000 | Initial Comments<br><br>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 5/1/23 through 5/4/23. Good Samaritan Society Corsica was found in compliance. | E 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Whitney Podzimek
TITLE: Administrator
(X6) DATE: 5/24/2023

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

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 |
|---|---|---|---|
| | 435089 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **05/03/2023** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **GOOD SAMARITAN SOCIETY CORSICA** | **455 NORTH DAKOTA**<br>**CORSICA, SD 57328** |

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|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 5/3/23. Good Samaritan Society Corsica was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities.<br><br>The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K920 in conjunction with the provider's commitment to continued compliance with the fire safety standards. | K 000 | Preparation and execution of this Response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. | |
| K 920<br>SS=F | Electrical Equipment - Power Cords and Extens<br>CFR(s): NFPA 101<br><br>Electrical Equipment - Power Cords and Extension Cords<br>Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of | K 920 | On 5/19/2023 Electrical Contractor provided permanent power to fixed ventilation equipment in the exterior areas (lean-to) adjacent to the kitchen. All residents have the potential to be affected by the deficient practice. To ensure deficient practice does not recur, by June 1, 2023, a task will be added to our preventative maintenance schedule for quarterly monitoring of temporary power sources. If temporary power sources are identified, maintenance technician will work with electrical contractors for permanent power solutions. Environmental Services Supervisor or designee will audit for temporary power sources weekly x 4 and monthlyx 2. Environmental Services Supervisor will report findings to the QAPI Committee monthly. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Whitney Podzimek

TITLE
Administrator

(X6) DATE
5/24/2023

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **05/03/2023** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **GOOD SAMARITAN SOCIETY CORSICA** | **455 NORTH DAKOTA**<br>**CORSICA, SD 57328** |

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| K 920 | Continued From page 1<br>10.2.4.<br>10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the provider failed to provide permanent power to fixed ventilation equipment in one area (the exterior lean-to adjacent to the kitchen). The provider must comply with the National Fire Protection Association (NFPA 70), National Electrical Code (NEC) article 400.8(1).<br><br>1. Observation on 5/3/23 at 11:45 a.m. revealed the ventilation equipment (HVAC) for the commercial kitchen refrigerator/freezer located in the lean-to adjacent to the kitchen was connected electrically by a flexible cord. Flexible cords may not be used instead of fixed wiring of a permanent device.<br><br>Interview with the plant operations manager at the time of the observation confirmed that finding. | K 920 | The QAPI committee will determine on-going interventions and monitoring. Substantial compliance will be achieved by 6/1/2023. | 6/1/2023 |

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 |
|---|---|---|---|
| | 10609 | A. BUILDING: _____ B. WING _____ | 05/04/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY CORSICA | 455 N DAKOTA AVE CORSICA, SD 57328 |

| (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<br><br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 5/1/23 through 5/4/23. Good Samaritan Society Corsica was found in compliance. | S 000 | | |
| S 000 | Compliance/Noncompliance Statement<br><br>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 5/1/23 through 5/4/23. Good Samaritan Society Corsica was found in compliance. | S 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Whitney Podzimek

TITLE: Administrator

(X6) DATE: 5/24/2023

STATE FORM 6899 2JUJ11 If continuation sheet 1 of 1

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