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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	12/30/2021

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

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F 000	INITIAL COMMENTS Surveyor: 06365 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 12/28/21 through 12/30/21. Good Samaritan Society Sioux Falls Center was found not in compliance with the following requirement(s): F558, F565, F585, F609, F610, F657, F675, F686, F689, F698, F880.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Surveyor: 06365 Based on observation, interview, record review, and policy review, the provider failed to accommodate a home-like resident room environment and safely organized access to resident belongings for 4 of 20 sampled residents (20, 30, 34, 36). Findings include: 1. Observation and interview on 12/28/21 at 11:43 a.m. with resident 30 in Memory Lane lounge area revealed he: *Had recently ended hospice services because he wanted to receive therapy for his legs. *Was seated in a high back motorized wheelchair with his feet positioned on foot pedals and his legs covered with a blanket. *Moved his arms and hands using small gestures	F 558	1. By 1/31/22, the IDT will help resident 30 to reorganize belongings for his accessibility. Resident 34 has had multiple room changes to address concerns with accessibility and by 1/31/22 will be evaluated by OT to determine the most efficient room set up. By 1/31/22 IP or designee will assist residents 20 and 36 to organize belonging and store hygienically. 2. By 1/31/22, the IDT will evaluate all resident rooms and correct address any identified storage and access needs. 3. To ensure the deficient practice will not recur, housekeeping staff will assess resident rooms during cleaning and if the room	

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

Marsha Tordoff | Administrator | 1/24/22

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 558	Continued From page 1 while talking. *Moved the wheelchair using a knob control on one armrest. Observation on 12/29/21 at 8:28 a.m. of resident 30's room revealed a large supply of snack food items and beverages stored directly on the floor beside the head of his bed. The resident was not in the room at that time. Review of resident 30's electronic medical record (EMR) revealed a significant change in status minimum data set assessment (MDS) dated 11/18/21 noted he: *Was cognitively intact and able to communicate. *Reported it was "very important" for him to take care of his own belongings and have snacks between meals. *Needed weight-bearing support from staff for activities of daily living (ADL) to transfer between surfaces, maintain personal hygiene, use the toilet, and get dressed. *Had a "progressive neurological condition" that limited his ability to move limbs on both sides of his body. Further review of resident 30's EMR revealed the care plan initiated on 7/23/21 and revised on 11/22/21: *Addressed his need for ADL assistance and use of his motorized wheelchair. *Included "remind resident to not bend over the pick up dropped items" related to being at risk for falls. *Did not address how staff would help him with his preferences for taking care of his belongings nor how he would store his snacks to access them when he wanted.	F 558	is found unorganized by having personal items being stored on the floor, unusual persistent odors, food or snack items not being stored properly, they will report to social services to work with the resident and family to reorganize. On 2/3/22 Environmental services director and administrator will provide education to all housekeeping staff on the new expectations. 4. To monitor performance and ensure homelike environment, safely organized access to belongings the SS director or designee will randomly audit 5 rooms weekly x 4, every other week x 2, monthly x 1 and quarterly x 1. The results of those audit findings will be brought to the monthly QAPI Committee meeting by the Director of Social Services and continued until the facility demonstrates sustained compliance as determined by the committee.	2/11/22

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F 558	Continued From page 2 2. Resident 34 reported during interviews: *On 12/29/21 at 8:21 a.m., she did not like her bathroom because her wheelchair "gets stuck on the heater on the wall." *On 12/30/21 at 12:31 p.m., she had: -A limitation with the use of her left leg and arm. -Trouble opening the courtyard door when she wanted to go outside. -A smoking apron in her room. -A staff member was with her "sometimes" when she was smoking. Observation on 12/29/21 at 8:21 a.m. in the resident's room with the resident seated in her wheelchair near the bathroom entrance in her room revealed: *A large pile of personal belongings on the floor outside of the bathroom doorway next to her bedside dresser. *Her wheelchair was wider than the standard size and her left leg was positioned on a leg rest. *The heater in the resident's bathroom was on the wall opposite the toilet. *The open space in the bathroom between the toilet and the heater did not appear adequate for positioning the wheelchair for transferring onto the toilet. Interview on 12/30/21 at 12:44 p.m. with certified nursing assistants (CNAs) C and H revealed: *Resident 34 is "supposed to have the apron on" before she goes out to smoke. *The smoking apron is hanging by the courtyard door. Observation at that time with CNAs C and H revealed: *The apron was not hanging by the courtyard door.	F 558		

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*They found it buried underneath the pile of resident 34's belongings in her room.

Review of resident 34's EMR revealed a 5-day reentry MDS dated 11/25/21 noted she:
*Was cognitively intact, no problems with communication, and mild depression.
*Needed weight-bearing support from staff for ADLs to transfer between surfaces, maintain personal hygiene, use the toilet, and get dressed.
*Had medically complex conditions including neurological conditions resulting in left-sided weakness.

Further review of resident 34's EMR revealed the care plan initiated on 1/26/21 and revised on 12/20/21:
*Addressed use of a commode in her room because her wheelchair "does not fit" in her bathroom.
*Stated, "when she plans to smoke, assist with smoking apron and getting outside."
*Included "remind resident to not bend over the pick up dropped items" related to being at risk for falls.
*Did not address assistance with storage of personal items.

3. Observation on 12/29/21 at 8:30 a.m. of residents 20 and 36's shared resident room revealed:
*The privacy curtain was pulled between the door side of the room and the window side of the room. *Resident 36 occupied the window side.
*Multiple personal belongings were on her floor.
*A pervasive urine odor was present throughout the room.

Surveyor 29354

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F 558	Continued From page 4 Observation and interview on 12/29/21 at 12:28 p.m. with resident 36 revealed she: *Had a urostomy bag for two years. *Did not have any problems emptying it. *Pulled up her shirt to reveal the urostomy bag, which had approximately 60 milliliters (ml) of dark yellow urine in it. Observation in her bathroom at that time revealed: *A large urinary bag with 30 ml of dark amber urine was hanging on the wall towel bar above the toilet. *A basin with hairbrush and oral care supplies was on the back of the toilet with resident 36's name. *The bottom of the urinary bag hanging from the towel bar was touching the basin. *Another basin with a toothbrush and a hairbrush was sitting on the edge of the sink with resident 20's name on it. Surveyor 06365 Observation on 12/30/21 at 8:26 a.m. of resident 20 and 36's shared room revealed: *Personal belongings were still on the floor on resident 36's side of the room. *The basins for residents 36 and 20 were still sitting on the back of the toilet and edge of the sink, respectively. *The urine odor was still present. Interview on 12/30/21 at 8:28 a.m. with CNA H and certified medication assistant (CMA) M revealed: *They empty resident 36's urostomy bag but sometimes she takes care of it herself. *The urine odor may be because she spilled some urine.	F 558		

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F 558	Continued From page 5 *They will clean up her bed to try to eliminate the odor. *The roommate uses the toilet and is continent. *They are both independent with grooming. Interview on 12/30/21 at 8:43 a.m. with licensed practical nurse (LPN) G revealed: *The CNAs empty urostomy bags every shift. *Resident 36 sometimes empties the bag herself. *The urine odor is "something we have been trying to deal with for some time." Review of resident 36's EMR revealed a quarterly MDS dated 11/21/21 noted she: *Was cognitively intact with no communication problems. *Needed supervision from staff for ADLs to transfer between surfaces, use the toilet, and maintain personal hygiene, like combing hair and brushing teeth. Review of resident 20's EMR revealed an annual MDS dated 9/27/21 noted she: *Was cognitively intact with no communication problems. *Needed supervision from staff for ADLs to maintain personal hygiene. 4. Interview on 12/30/21 at 2:59 p.m. with assistant director of nursing services/infection preventionist (ADNS/IP) B revealed *There was no staff member assigned to help residents organize their rooms and personal belongings. *Resident toiletries were to be stored on separate shelves in each resident room bathroom. *Food items should not be stored on the floor. Interview on 12/31/21 at 3:25 p.m. with	F 558		

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F 558	Continued From page 6 administrator A confirmed there was no staff member assigned or process to oversee helping residents organize their personal belongings. Review of the Resident Handbook revealed residents could: *Bring personal belongings to the center with consideration to available space and safety restrictions. *Personalize their room with items that would "help them feel at home and as comfortable as possible." *Contact the maintenance department if there were items that needed to be hung on the walls. *Have food items brought into the center and staff would "assist with proper storage of food."	F 558		
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	F 565	1. By 1/28/22, the social worker will communicate the follow up being done in response to call light times for residents 1, 5, 11, 19, 25, 27, 28, 30, 31, 34, 39, 48 and 51. Those residents will be encouraged to visit with the Administrator if needed for additional case-by-case follow up. 2. December's resident council meeting minutes will be reviewed at the next scheduled January resident council meetings and follow-up will be given for any suggestions or concerns that were brought	

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F 565	Continued From page 7 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. §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: 06365 Surveyor: 45683 Based on interview, group meeting minute review, and policy review, the provider failed to follow up on call light response concerns and communicate the results of the investigation of those concerns for 13 of 13 residents (1, 5, 11, 19, 25, 27, 28, 30, 31, 34, 39, 48, and 51) who attended the surveyor resident group meetings. Findings include: 1. Interview on 12/29/21 at 3:00 p.m. with residents 1, 5, 11, 19, 25, 27, 28, 30, 31, 34, 39, 48, and 51 agreed: *They would have to wait for the staff not to be busy. *They would have to turn their call light on again as staff would shut them off and leave without assistance having been given. *These issues have been brought up at multiple resident meetings without any updates or	F 565	forward by 1/31/22. 3. To ensure the deficient practice will not recur, all concerns brought forward during the resident council meetings will be addressed and documented at the meeting. Any concerns needing additional follow up or action will be completed by the appropriate department and resolution communicated to the concerned resident within 1 week. At the next resident group meeting, the resolution will be shared. Minutes will be recorded and made available for all residents and posted in the activity room. All departments (Administration, Nursing, Activities, Dietary, Social Services and Environmental Services) will be represented at the resident council meetings. Members of the resident council group will be educated by the administrator by 2/1/22. 4. Monthly resident council meeting minutes will be auditing by the Administrator weekly times x 4, every other	

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F 565	Continued From page 8 resolutions. Interview on 12/30/21 at 8:37 a.m. with activities supervisor F: *She was new to this position, approximately three months ago. *The social worker (SW) D routinely attended the meetings. *When the resident group had concerns it should have been documented on a suggestion and concern form by SW D. *SW D was to forward the concern to the department head who it pertained to for follow up. Interview on 12/30/21 at 1:41 p.m. with administrator A stated social services director (SSD) E, tracked the concerns from the resident council meeting and gave those to the respective department managers for follow-up. She was unaware if resolutions and/or information was communicated back to the residents. SW D and SSD E had been unavailable for interview during survey due to being on medical leave at the time of the survey. Review of resident group meeting minutes revealed call light response times had been discussed: *On 11/8/21 and 12/13/21 on Memory Lane, the minutes reflected residents 19, 31, 34, 39, and 51 had been included in discussion. *On 11/1/21 and 12/6/21 on City View, the minutes reflected residents 5, 25, 28, and 48 had been included in discussion. Review of the provider's 9/16/21 Grievances, Suggestions or Concerns- Rehab/Skilled policy revealed:	F 565	week x 2, monthly x 1, and quarterly x 1 to ensure all resident concerns addressed in the meeting are investigated, action plan taken, resolution communicated to the resident, and then followed up with the residents at the next resident council meeting, and the minutes posted for all resident to review. The results of those audit findings will be brought to the monthly QAPI Committee meeting by the Administrator and continued until the facility demonstrates sustained compliance as determined by the committee.	2/11/22

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F 565	Continued From page 9 *The grievance official was responsible for the oversite of the grievance process. *The process included a written decision provided to the residents.	F 565		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally	F 585	1. The suggestion concern for resident 6 will be completed by 1/28/22 regarding care concerns regarding activities of daily living for the evening shift traveling CNA. Traveling CNAs contracted ended on 1/8/22 and renewal was not offered. 2. By 1/31/22, all January suggestion concern grievance forms will be reviewed to ensure an investigation and resolution has been completed. 3. To ensure the deficient practice will not recur, all concerns or grievances brought forth from any resident, will be documented on a suggestion concern form. Once documented on the suggestion concern form, that form will include documentation of the investigation, the actions taken to resolve the concern or grievance, and follow-up communicated to the resident. The IDT will sign off to affirm	

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F 585	Continued From page 10 (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a	F 585	completion and the form filed with Social Services. New suggestion concern grievances will be brought forward from social services and reviewed following stand-up meetings and brought to Dept. Head meeting for further follow-up. The administrator will educate the IDT on these changes on 2/1/22. 4. The Director of Social Services or designee will audit the suggestion concern grievance forms to ensure complete investigation and resolution communicated to the resident. Audits will occur weekly x 4, every other week x 2, monthly x 1, quarterly x1. The results of those audit findings will be brought to the monthly QAPI Committee meeting by the Director of Social Services and continued until the facility demonstrates sustained compliance as determined by the committee.	2/11/22

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F 585	Continued From page 11 summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement 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; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, record review, and policy review, the provider failed to ensure an investigation and resolution had been completed for a grievance related to verbalized by one of three residents (6) sampled with care concerns regarding activities of daily living. Findings include: 1. Interview on 12/28/21 at 2:50 p.m. in resident 6's room revealed: *He had some concerns about the evening shift at bedtime. *There was one staff member who did not wash him up or wipe him. *"She did not clean me." *She "made him sit on the toilet for 30 minutes."	F 585	**Addendum:** **1. The suggestion concern for resident 6 was investigated and resolution communicated to resident and daughter by 1/28/22 regarding care concerns regarding activities of daily living for the evening shift traveling CNA.** mt 2/3/22	

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	435046	A. BUILDING _____ B. WING _____	12/30/2021

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*He did not get "along with one of the gals."
-She was a "traveler."
*He identified the certified nursing assistant (CNA) to the surveyor.
*If he needed anything someone from City View would help him.
*He had not filed a formal complaint with the facility.

Observation and interview on 12/28/21 at 4:10 p.m. with resident 6 and his daughter in his room revealed:
*A half-full urinal containing urine on his overbed table.
*They thought the plan was to remove the CNA who cared for him at night.
*He confirmed the identified CNA had taken care of him once in the past week.
*"She never brought a washcloth into my room and had not done any personal care for him."
*At the care conference at the end of October 2021, they had reviewed he had gone two weeks without a bath.
-They told them hospice was bathing him.
-The nurse had told them it was his one bath a week.
-"They finally got it straightened out when he gets his baths.
-They give it to him on Tuesday and hospice gives it to him on Fridays."
*The administrator told her they were "short-staffed" and had not told her how they would fix it.
*She visited every day around 4:10 p.m.
-She has had to empty his urinal, sometimes it was almost running over with urine.
*A staff member had come into his room twice during the interview and had not offered to empty it.

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F 585	Continued From page 13 *She had visited with the assistant director of nursing services/infection preventionist (ADNS/IP) B three weeks ago regarding the CNA. -ADNS/IP B said, "it was a personality thing between resident 6 and the CNA." *The plan was to remove the CNA from caring for him at night. *He confirmed the CNA had taken care of him once in the past week. Review of resident 6's care plan revealed no entry/interventions related to not having a certain CNA care for him. Review of the facility grievance forms for the past sixty days had not included resident 6's conflict with a CNA. Interview on 12/29/21 at 1:30 p.m. with social worker (SW) D regarding resident 6 and the conflict with a CNA revealed: *She was not aware he had any conflict with a CNA. *Typically, they let her know when there were issues. *The grievance process was done as a group. -The grievance/concern form was routed to the department it affected. -It depended on what department and then that manager would follow-up on the grievance, route it to the other departments, and then the administrator would sign off on them. Interview on 12/29/21 at 1:50 p.m. with ADNS/IP B regarding resident 6 and the conflict with a CNA revealed: *The facility had assessed him to transfer one way and the family wanted him to transfer another way.	F 585		

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F 585	Continued From page 14 *The family said they would transfer him how they wanted to when they visited. *He was mad at the CNA because she said she had to transfer him according to their care plan. *She felt it had been a conflict of personalities. *She would not expect the conflict information to be on his care plan. *All residents have the right to have whoever they want to care for them. *She had not completed a grievance on that. -The social worker had not been informed. -They probably should have done a grievance on it. *There had been no further issues. *She strongly encouraged him to ask for a different CNA if he did not want her to help him. *She had not been aware the CNA had not been "washing him up." -Resident 6 nor his daughter had let her know about that. Interview on 12/30/21 at 10:00 a.m. with administrator A regarding resident 6 and the identified CNA revealed: *They had two SW. -The SW who dealt with grievances was not in the facility due to personal issues. -There would have been no reason SW D would have known about resident 6's concern. *The identified CNA was an agency CNA and had been employed for a ten-week contract. -Her contract would be ending in a few days. Review of the provider's 9/16/21 Grievances, Suggestions, or Concerns policy revealed: *Purpose: -"To document concerns, investigate findings and plan of correction. -To develop a systematic approach in resolving	F 585		

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F 585	Continued From page 15 grievances as a tool to ensure continuous quality of care." *Policy: -"Such grievances, complaints or concerns include those with respect to treatment that has been furnished, as well as those that have not been furnished." *Procedure: -"1. When a resident, patient, family member, visitor or employee expresses a concern or grievance, it will be received in an open, friendly, nonjudgmental manner and without discrimination or reprisal. -If the concern is an allegation of abuse, neglect, injury of unknown origin, misappropriation of resident property or exploitation, follow the abuse and neglect procedure." -"4. The grievance will be documented on the Suggestion or Concern [number of document] and submitted to the grievance official." -"6. An investigation must be completed for all grievances."	F 585		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve	F 609	1. Administrator reported Resident 10's incident following direction from the complaint coordinator on 1/21/22 to the Dept. of Health, Initial and Final. 2. All incidents since survey, 12/30/21, will be reviewed by the Administrator to ensure that and incident resulting in outside medical treatment was reported to the South Dakota	

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F 609	Continued From page 16 abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, record review, and policy review, the provider failed to ensure the South Dakota Department of Health (SD DOH) had been notified of a reportable incident for one of one sampled resident (10). Findings include: 1. Observation and interview on 12/28/21 at 3:20 p.m. with resident 10 revealed: *She was sitting in her electric wheelchair (w/c) with her feet elevated on the bed. *She was barefoot. -There was a large amount of edema to both of her feet and lower legs. -She had a dressing on her left anterior lower leg with the date 12/28/21 written on it. *She confirmed the area to her left anterior lower leg occurred when a staff member was going to assist her with repositioning. -The staff member had placed the mechanical lift sling behind her.	F 609	Department of Health by 1/31/22. 3. To ensure the deficient practice will not recur, all reportable incidents, including resident incidents or accidents that require outside medical treatment will be reported to the South Dakota Department of Health within required timeframes. On 1/20/22, all nurses were educated by the DNS to ensure they making the initial report to SDDOH for resident accident or incident that results in outside medical treatment. 4. All incident reports resulting in outside medical treatment will be reviewed by the Administrator to ensure compliance in reporting to the South Dakota Department of Health. The Administrator will review all incidents weekly x 4, every other week x 2, monthly x 1, quarterly x 1. The results of those audit findings will be brought to the monthly QAPI	

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F 609	Continued From page 17 -"Somehow the sling went forward, and her leg went under the bed. -"There was a lot of blood." -She felt it had been an accident. *She used the total mechanical lift during transfers. -They always used two people when doing a transfer with the total mechanical lift. -The staff member: --Had been in her room by herself when placing the sling. --Was waiting for the second staff member to come to her room. Continued interview on 12/29/21 at 12:10 p.m. with resident 10 regarding the above incident revealed: *She was in her electric w/c. *The certified nursing assistant (CNA) was on her right side. -She had placed the sling behind her. *When the CNA reached across the w/c she bumped the control panel, causing the chair to move forward. -Her legs went under the bed. *Usually, the staff or she had checked the control panel to see if it had been shut off. *She went to the emergency department and had 15 to 16 staples to the left anterior lower leg. Interview on 12/29/21 at 4:30 p.m. with administrator A regarding the above incident with resident 10 revealed: *The incident had not been reported to the SD DOH. *They had not considered the incident to be an "emergent issue." Continued interview on 12/30/21 at 9:50 a.m. with	F 609	Committee meeting by the Administrator and continued until the facility demonstrates sustained compliance as determined by the committee. **Addendum:** **1. On 2/3/22, IDT reviewed all incidents since 9/26/2021 and found all incidents requiring a state report were reported within the proper timeframes.** mt 2/3/22	2/11/22

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F 609	Continued From page 18 administrator A regarding the above incident with resident 10 revealed: *They had not completed an incident report. *She was not aware the incident should have been reported to the SD DOH. *She was using the guidelines from the SD DOH "Reportables of Injuries of Unknown Source and Reasonable Suspicion of a Crime." *She felt they had done a good job with reporting to the SD DOH. Review of resident 10's medical record revealed: *The 9/26/21 at 10:17 p.m. nurses progress note: -"Called to room by CNA. While helping resident, her joystick to her electric w/c was bumped and her LLE [left lower extremity] hit a metal plate on bed. -Sustained about a roughly 8 cm [centimeter] x 8 cm wound to LLE - large amount of blood and tissue loss from area. -Appears to be greater than 2 cm deep. -Approximated wound as much as able, at least 1 inch area still open. -Area cleansed with NS [normal saline], continues to bleed profusely. -Attempted to call Dr. [name of physician] office, no answer after 12 minutes. -Call to [name of certified nurse practitioner] with order received to send to ER [emergency room] for evaluation. -[Name of resident] chose to go by [name of transport company], as did not want to be transported on stretcher." *The 9/27/21 at 12:11 a.m. nurses progress note: -"Returned from ER via [name of transport company]. -Resident states no pain, has orders for antibiotics and wound care. -Orders to see PCP [personal care physician] in 2	F 609		

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F 609	Continued From page 19 or 3 days to assess the wound." Review of resident 10's care plan with the following dates revealed: *9/30/21: "Traumatic laceration to LLE (9/26/21)." *10/11/21: BIMS (Brief Interview for Mental Status) examination score was 15 points on 10/8/21 indicating she was cognitive. There had not been an incident report completed for resident 10 regarding the above incident. There was no documentation an internal investigation had been completed. There was no documentation the CNA involved in the above incident had been reeducated. Review of the provider's 10/11/21 Incident Report - Rehab/Skilled policy revealed: *"An Incident Report is not required if the resident's injury is a bruise or skin tear that meets all of the following criteria: -Does not require outside medical treatment, does not involve another resident, does not involve an employee, does not involve medical equipment such as a lift, -Was not caused by a fall and either an employee observed the incident or the resident is alert and oriented and can explain what occurred." *"An Incident Report is completed for each resident incident that occurs." Review of the Reporting of Injuries of Unknown Source and Reasonable Suspicion of a Crime on 12/30/21 at 9:50 a.m. received from administrator A revealed: *"Serious Bodily Injury is defined as an injury with: -That may require surgery, hospitalization, or rehabilitation." *"When in doubt with regard to whether an injury	F 609		

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F 609	Continued From page 20 qualifies as a "serious bodily injury" report using the earlier timeline." *"In the event reporting of other reportable events, these are times where a staff "debriefing" may be needed and is an opportunity to evaluate system processes and provide a learning/education opportunity."	F 609		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Surveyor: 41088 Based on observation, interview, record review, and policy review, the provider failed to ensure a thorough and accurately documented investigation had been completed for four of six sampled residents (6, 10, 42, and 46) with incidents. Findings include:	F 610	1. The incidents for Residents 6, 10, 42 and 46 will be re-reviewed by the IDT at the next Quality of Life meeting on 2/3/22 to ensure interventions in place remain accurate, medications are reviewed and current interventions being implemented match the care plan. 2. All incidents in January will be reviewed by 1/31/22 to ensure a thorough and accurately documented investigation has been completed. 3. To ensure the deficient practice will not recur, all fall incident reports will be reviewed monthly by the facility fall committee to ensure a thorough and completed investigation	

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F 610	Continued From page 21 1. Review of resident 42's medical record revealed: *She lived in the same room as her husband. *Her diagnoses of Alzheimer's, dementia, and hypertension. *She was not able to be interviewed. *She had falls on 11/16/21, 12/17, and 12/27/21. Review of her fall investigation reports revealed they did not address all areas for a thorough investigation because several sections of information were left blank: *11/16/21: -"Tripped on husband's chair had been handwritten next to section 4. -Section 4, the following areas were left blank: --Vision, not wearing glasses, does not wear glasses, difficulty seeing objects. --Mobility, lost strength, knees buckled, slipped, lost balance. --Sleep problems, noise/disrupted sleep, restless. --Equipment/Safety, wheelchair/bed brakes unlocked, bed/chair height not appropriate, personal alarms working, personal alarms removed, restraint in use, equipment. --Environmental, orientation, noise, clutter, lighting. --Continence, incontinent of urine, reports urgency, pain or frequency, incontinent of bowel, constipation, diarrhea, time last toileted; a.m./p.m. *12/17/21: -Section 4, the following areas were left blank: --Vision. --Sleep problems. --Equipment safety. --Environmental. *12/27/21: -Section 3, staff action had been left blank.	F 610	was completed. All nurses were educated by the DNS on 1/20/22 to complete all areas of the fall investigation and fall huddle sheet in their entirety to ensure the investigation is thorough and accurate. 4. The Administrator will audit incident reports to ensure a thorough and accurate investigation was completed, care plan updated, and changes communicated to direct caregivers. Audits will occur weekly x 4, every other week x 2, monthly x1, quarterly x1. The results of those audit findings will be brought to the monthly QAPI Committee meeting by the Administrator and continued until the facility demonstrates sustained compliance as determined by the committee.	2/11/22

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F 610	Continued From page 22 -Section 4, the following areas were left blank: --Vision. --Mobility. --Sleep problems. --Environmental. --Continence. -Section 8, medications within the last 8 hours was blank. -Section 9, where the fall occurred was blank. Interview on 12/30/21 at 1:36 p.m. with assistant director of nursing services/infection preventionist (ADNS/IP) B revealed: *They had identified their fall forms as being inconsistent. *She had noticed there had been many areas that were not filled out or blank in their documentation of falls. *She would expect nursing staff to fill out the documentation thoroughly when investigating falls. Surveyor: 29354 2. Interview on 12/28/21 at 2:50 p.m. in resident 6's room revealed: *"They dropped me in the tub room sometime in November 2021." *He felt it was partially their fault and his fault. *He had been standing beside the tub and got weak. *The wheelchair (w/c) was usually positioned behind him. *He went to sit down and the w/c was not there. He had not gotten hurt. Review of resident 6's electronic medical record (EMR) revealed: *He had an incident on 11/17/21 in the tub room where certified nursing assistant (CNA) C had	F 610		

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F 610	Continued From page 23	F 610		

assisted him to the floor.
*The 10/10/21 significant change Minimum Data Set (MDS) assessment revealed he:
-Was cognitive, the Brief Interview for Mental Status examination score was fifteen.
-Required extensive assistance of two people with the transfer.
-Had upper extremity impairment on one side and lower extremity impairment on both sides.
-Used a w/c or walker.

The Kardex report as of 12/30/21 revealed:
**Transfer:
-One assist using gait belt and walker for transfers throughout the rest of the day (w/c to recliner, w/c to toilet and vice versa)."

The care plan with the following revision dates for resident 6 revealed:
*12/16/21:
-Personal hygiene: Required assist of one staff.
-Transfer: One assist using gait belt and walker for transfers throughout the rest of the day (w/c to recliner, w/c to toilet and vice versa.)
-Was at risk for falls.
--Fall 11/17/21 (lowered to the floor).

Review of resident 6's 11/17/21 Slipped or Fell incident report revealed:
*Incident description:
-Nursing description: "Resident was lying on the floor in the shower room by the toilet and grab bars. Bare feet."
-Resident description: " Resident stated that he thought the wheelchair was behind him and he sat down."
-Predisposing situation factors had "improper footwear."
-Witnesses: "No witnesses found."

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F 610	Continued From page 24 -Summarize factors that may have contributed to this incident: "CNA stated she did not know he was a sit to stand." -"Resident was safely lowered to the floor by the bath aide. -Bath aide was re-educated on [the] location of Kardex for each resident to know how they transfer." *Fall Scene huddle worksheet which was not part of the medical record indicated he "sat back and no w/c." -He had bare feet, was using the bar in the shower room, and alert before and after the fall. *The 11/18/21 fall intervention meeting had been marked educate staff "regarding Kardex" transfers. Interview on 12/30/21 at 10:00 a.m. with administrator A regarding resident 6's 11/17/21 fall revealed: *CNA C was the bath aide and had been helping him out of the tub. *She had been assisting him with getting dressed. *He was going to sit down in the w/c. *He started to go down on the floor. *She assisted him to the floor. *CNA C should have been aware of how to transfer him. *She had been re-educated where to find the information on how resident 6 was to be transferred in the Kardex. *Administrator A was not sure if CNA C had used a gait belt during the transfer. -She would need to talk to CNA C first. *Their investigation had documented "no shoes." Interview on 12/30/21 at 10:15 a.m. with CNA C regarding resident 6's above incident revealed:	F 610		

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*She:
-Had not used a gait belt.
-Had glanced at the Kardex at some time, but there were so many to look at.
-Had not used the Kardex to see how he was to be transferred.
-Confirmed he had shoes on during the above incident.

Interview on 12/30/21 at 10:18 a.m. with administrator A regarding CNA C and resident 6 revealed:
*She had not followed the care plan for using a gait belt to assist when transferring him.
*Their investigation of the incident had documented he had not had shoes on and CNA C had confirmed he had.

Review of the provider's 9/17/21 Fall Prevention and Management-Rehab/Skilled Therapy and Rehab policy and procedure revealed:
*Purpose:
-"To promote resident well-being by developing and implementing a fall prevention and management program."
-"To identify risk factors and implement interventions before a fall occurs."
*Procedure:
-"19. Initiate [name of investigation tool] to document and ensure a thorough investigation of an occurrence or event involving a resident."

Review of the provider's 9/17/21 Care Plan policy revealed:
*"Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical,

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F 610	Continued From page 26 functional, spiritual, emotional, psychosocial, and educational needs." *"The care plan will emphasize the care and development of the whole person ensuring that the resident will receive appropriate care and services." 3. Observation and interview on 12/28/21 at 3:20 p.m. with resident 10 revealed: *She was sitting in her electric w/c with her feet elevated on the bed. *She was barefoot. -There was a large amount of edema to both of her feet and lower legs. -She had a dressing on her left anterior lower leg with the date 12/28/21 written on it. *She confirmed the area to her left anterior lower leg occurred when a staff member was going to assist her with repositioning. -The staff member had placed the mechanical lift sling behind her. -"Somehow the sling went forward, and her leg went under the bed. -"There was a lot of blood." -She felt it had been an accident. *She used the total mechanical lift during transfers. -They always used two people when doing a transfer with the total mechanical lift. -The staff member: --Had been in her room by herself when placing the sling. --Was waiting for the second staff member to come to her room. Refer to 609, finding 1. Surveyor: 42477 4. Observation and interview on 12/28/21 at 10:29	F 610		

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F 610	Continued From page 27 a.m. with resident 46 in his room revealed he: *Was sitting in his wheelchair. *Had been very hard to understand. *Had signs on his wall reminding him to use the red call button for help. *Stated he has had many falls. Review of resident 46's November 2021 and December 2021 fall reports revealed: *Three of the four reports had not documented any predisposing environmental factors such as: -Slippery floors. -Noise. -Poor lighting. -Floors Cluttered. -Floors Uneven. *Three of the four reports had no predisposing situation factors marked such as: -Improper footwear. -Alarm sounded. -The alarm did not sound. -Psychopharmacological medication. -Sidereal up. *There had been no mention if he was continent or incontinent at the time of the falls. Review of the provider's fall intervention meeting checklist revealed: *The checklist was completed as a result of a fall that happened in November 2021. *The form had the following areas: -Ambulatory residents. -Alarms/Equipment. -Staff interventions/Other. *There were 91 items on the checklist to mark/review. -One area had been marked, that area was: --Educated staff to keep the bed at the transfer level position.	F 610		

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F 610	Continued From page 28 Review of resident 46's EMR revealed: *He had a nursing order to provide a cream soda if he had gone 24 hours without falling. -This had been implemented in February 2020. *When he had gone more than 24 hours without a fall he had not always received a cream soda. Interview on 12/30/21 at 1:36 p.m. with ADNS/IP B and MDS coordinator L revealed: *The cream soda intervention for resident 46 had worked for a while. *They agreed if a reward was implemented, it should be followed consistently. *They agreed that fall investigation reports should be completed in their entirety. *Resident's care plans should be reviewed and revised as a result of each fall investigation.	F 610		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657	1. Resident 42 and 46's care plans will reviewed by 1/31/22 by the MDS Coordinators to ensure accuracy in regards to preventing future falls, skin integrity issues and reflecting current needs. 2. All care plans will be reviewed by 2/11/22 to ensure interventions for preventing future falls, promoting skin integrity and the reflection of their current needs are updated and correct.	

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F 657	Continued From page 29 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Surveyor: 41088 Based on record review, interview, and policy review, the provider failed to ensure 2 of 2 sampled residents (42 and 46) had care plans that had been revised and updated to include interventions to prevent further falls, skin integrity issues and reflect their current needs. Findings include: 1. Review of resident 42's undated revised care plan revealed: *She was admitted on 2/4/20. *Her diagnoses of: Alzheimer's disease, dementia, depression, pressure ulcers on her sacrum and right heel, and a history of falls. *She had falls on 11/16/21, 12/17/21, and 12/27/21. *The fall on 11/16/21 had resulted in her hospitalization and a broken hip that required surgery. *She had been independent with mobility prior to her hip surgery. *Focus area: The resident is at risk for falls related to dementia, left hip fracture evidenced by confusion, pain. Initiated on 2/4/20, revised 12/28/21, which was during the current survey. -Goal: "Resident will be free of falls through the	F 657	3. To ensure the deficient practice will not recur, IDT will review 2 resident care plans following each stand up meeting to ensure they accurately reflect prevention of falls, skin integrity issues and accurately reflect current care needs. 4. The DNS will randomly audit 5 care plans to ensure they accurate reflect the residents current care needs and services provided. Audits will occur weekly x 4, every other week x2, monthly x1, quarterly x 1. The results of those audit findings will be brought to the monthly QAPI Committee meeting by the DNS and continued until the facility demonstrates sustained compliance as determined by the committee.	2/11/22

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F 657	Continued From page 30 review date." Initiated on 2/4/20, revised on 10/13/21. -Interventions: --"Remind resident not to bend over to pick up dropped items. Encourage use of grabber or to ask for assistance. Initiated on 2/4/20. --Encourage resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility such as fun and fitness and music therapy." Initiated on and revised on 2/4/20. --Ensure that resident is wearing appropriate footwear such as fully enclosed slip-resistant shoes or gripper socks when ambulating or mobilizing in a wheelchair. Initiated on 2/4/20. --Monitor resident for significant changes in gait, mobility, positioning device, standing/sitting balance and lower extremity joint function. Initiated on 2/4/20. --Review as indicated for significant changes in cognition, safety awareness, and decision-making capacity. Initiated on 2/4/20. --Place Dycem in her recliner. Initiated on 12/21/21, which had been five weeks after her fall with a major injury. ---This was the only intervention added to her care plan that had been related to falls. Refer to F610, finding 1. Surveyor: 42477 2. Review of resident 46's electronic medical record (EMR) revealed he four falls from November 2021 through December 2021. Refer to F610, finding 4. Review of resident 46's December 2021 care plan revealed: *He had 26 falls in 2021.	F 657	**Addendum:** **1. The center's stand up meeting occur each business day in the morning.** **2. All resident care plans will be reviewed.** **3. Each business day, IDT will review the care plan of any resident who experienced an incident since the previous business day and 2 additional residents, going in alphabetical order to put all residents on an on-going review plan, to ensure they accurately reflect prevention of falls, skin integrity issues and accurately reflect current care needs.** mr 3/3/22	

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F 657	Continued From page 31 *Rounding every hour on resident 46 had been implemented on his care plan after his last fall on 12/9/21. *Offering him a cream soda if he had not fallen for 24 hours was not on his care plan. *He had many interventions on his care plan, some of those items had been on there since 2016. *There was an intervention to keep his wheelchair close to him and not his walker. -He no longer used a walker. Interview on 12/30/21 at 1:36 p.m. with assistant director of nursing services/infection preventionist B revealed she had: *Expected care plans to be revised and reviewed during each fall investigation. Refer to F610, finding 4. *Agreed interventions should be updated. *Stated the cream soda intervention had worked at one time. *Agreed it should be followed through on to be effective, and needs to be reassessed. Review of the provider's 9/17/21 care plan policy revealed: *"Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. Any problems, needs and concerns identified will be addressed through use of departmental assessments, the Resident Assessment Instrument (RAI) and review of the physician orders." *"The interdisciplinary team will review care plans at least quarterly. Care plans also will be	F 657		

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F 657	Continued From page 32 reviewed, evaluated and updated when there is a significant change in the resident's condition."	F 657		
F 675 SS=E	Quality of Life CFR(s): 483.24 § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on observation, interview, record review, admission packet review, facility assessment review, group meeting review, and surveyor group meeting, the provider failed to ensure a quality of life that included a timely staff response to resident call lights by all staff, licensed and unlicensed, ensuring a smooth delivery of care and services for: *Seven of seven residents (1, 6, 9, 12, 32, 43, and 253) who were observed and interviewed. *Sixteen of sixteen residents (Memory Lane 16, 19, 22, 31, 34, 36, 39, and 51; City View 5, 12, 25, 28, 32, 38, 48, and 52) who were documented as in attendance at November and December resident group meetings where call light response was discussed. *Thirteen of thirteen residents (1, 5, 11, 19, 25, 27, 28, 30, 31, 34, 39, 48, and 51) who attended the resident group meeting with surveyors where call light response was discussesd.	F 675	1. By 2/11/22, administrator will host a special session of resident council and update residents on the plan for ensuring timely response to resident call lights. 2. By 2/11/22, a call light report for the month of January will be generated and analyzed for trends, particularly, in longer call light wait times, peak times, day of the week, shift changes, staffing levels, etc. 3. To ensure the deficient practice will not recur, Administrator will continue to randomly audit call light reports on a weekly basis and analyzing patterns and trends with any identified longer call light wait times with regards to peak times. Administrator or designee will observe staff at random times 3 times a week for 1 month and then as directed by QAPI to ensure call lights	

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F 675	Continued From page 33 Findings include: 1. Observation and interview on 12/28/21 at 3:20 p.m. with resident 253 revealed she: *Had been in the facility for a couple of weeks. *Was not depressed but her situation "really depresses" her. *Had been independent until she sustained an injury as a result of a motor vehicle accident. *Had now lost her independence since her accident and coming to the nursing home. *Had never been in a long-term care facility before but she did not believe she had been receiving the best care. *This was because she had to wait so long to have her call light answered. *Stated when it came to that, she had to wear a "diaper" and felt like she was a baby again. *Had not received the choice to use a bedside commode. *Used a bed pan when staff answered her call light in time. *Would much rather use a bed pan but staff does not answer her call light in time so she has to use her "diaper." Review of resident 253's call light logs revealed: *In 12 days: -She had 20 call lights over 15 minutes. -Two of those times were 51 minutes and 54 minutes in length. 2. Observation on 12/29/21 around 2:15 p.m. revealed approximately 20 staff members were in the City View hallway in response to a fire drill that just occurred. Observations on 12/29/21 between 2:20 p.m. and 3:20 p.m. on the City View hallway revealed:	F 675	are not turned off until the resident's need is met. 4. Administrator or designee will audit the resident room hallways for call light response/surveillance by all staff weekly x 4, every other week x 2, monthly x 1, quarterly x 1. The results of those audit findings will be brought to the monthly QAPI Committee meeting by the Administrator and continued until the facility demonstrates sustained compliance as determined by the committee. **Addendum:** **1. On 1/24/22, Social worker provided written communication and talked with each resident about the plan for call light response.** **2. Social services or designee will ask about call light response during care conferences.** **3. Administrator or designee will review performance with** MT 2/3/22	2/11/22

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F 675	Continued From page 34 *Resident 9's call light was illuminated. *At 2:25 p.m., minimum data set (MDS) coordinator O went into resident 9's room. *Resident 9 asked for help in being changed. *MDS Coordinator O stated she would find someone to help her and turned the call light off. *At 2:38 p.m., the call light came back on. *An unidentified activity assistant went into resident 9's room to deliver mail. *At 2:54 p.m., the call light was back on. *At 2:59 p.m., the call light had been turned back off. *Surveyor went into resident 9's room just before 3:20 p.m. The resident was lying in bed. Interview with resident 9 at that time revealed she: -Had been asking for help. -Thought it had been taking so long because she needed to be changed. -Was soiled with urine. *Surveyor informed resident 9 she would find a staff member to assist her. The resident replied: -"Oh, you are going to save me?" -"Thank you, now I will have all sorts of people come in and help me." *Surveyor asked certified nursing assistant (CNA) P if she could help resident 9. *CNA P changed and helped resident 9 in approximately four minutes. Review of resident 9's call light log for 12/29/21 revealed: *Her call light was pressed at 2:19 p.m. and remained on for eight minutes and 47 seconds. *At 2:50 p.m., it had been pressed again and remained on for six minutes and seven seconds. Review of resident 9's toileting documentation	F 675	**frontline staff at least monthly, and when trends are identified drill down with focus group to determine cause of extended call light times and potential solutions.**	

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revealed the last documented toileting was on 12/29/21 at 10:25 a.m.

During the interview on 12/29/21 at 3:20 p.m. with MDS coordinator I regarding the surveyor's observations of resident 9's call light:
*The surveyor informed her that resident 9 laid in her room for over an hour waiting for staff assistance.
*MDS coordinator I:
-Confirmed resident 9 asked to be changed.
-Stated she asked two CNAs charting at the desk to care for resident 9.
-Had not checked to see if resident 9 had been taken care of.
-Confirmed resident 9 required the assistance of one person for toileting and transferring.
-Did not help resident 9 at the time she answered the call light because she had some other things she had to get done.

3. Interview on 12/28/21 at 10:52 a.m. with resident 12 revealed she had:
*Been in the facility for about two and a half years.
*Concerns with staff.
*Stated it took a long time for staff to answer the call lights; nights and weekends seemed to be worse.
*Been left on the toilet for thirty minutes before.

Review of resident 12's call light logs revealed an instance in December 2021 where she had her toilet call light on for 26 minutes and 15 seconds.

Surveyor: 29354
4. Interview on 12/28/21 at 2:20 p.m. with resident 1 in her room revealed:
*She was sitting in a recliner, with her feet

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F 675	Continued From page 36	F 675		

propped up on her wheel chair.
*Some of her concerns had included not getting her call light answered soon enough.
*She had not timed how long it was but thought "maybe between 10 to 20 minutes."
*They divided up the hallways so "you never knew who was going to take care of you."
-"This was done for how many residents were in the building."
*Sometimes she might be considered City View and sometimes she might be considered Memory Lane.
*The staff were assigned to different units.
*If she were part of City View they were on the "end of the receiving line for getting help."
*She was never informed who was to be taking care of her.

Review of resident 1's 12/17/21 quarterly MDS assessment revealed:
*Brief Interview for Mental Status examination score was fifteen indicating she was cognitive.
*She required:
-No staff assistance with transferring and toilet use.
-Minimal assistance of one staff for personal hygiene.

Review of resident 1's call light log response time from 11/1/21 through 12/27/21 revealed:
*There were a total of sixty-five call light response times.
*Of these the call light response time was:
-Seven times from 15 to 20 minutes.
-Three times from 20 to 30 minutes.
-Three times over 30 minutes with the longest being 49 minutes.

5. Interview on 12/28/21 at 2:50 p.m. with resident

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F 675	Continued From page 37 6 revealed he had: *Some concerns about the evening shift at bed time. *To wait for staff to answer his call light. *To sit on the toilet for 30 minutes. *His daughter had timed the call light once and "it was 26 minutes before they came in to see what I wanted." Interview on 12/28/21 at 4:10 p.m. with resident 6 and his daughter regarding call lights and the care he had received revealed: *After 8 minutes the call light will ding, that was how you knew how long a call light had been on. *Administrator A had told her they were "short staffed" and had not told her how they would fix it. *She had them "pull his call light report over a weekend." -There were 4 times in a 48-hour time frame it took over 20 minutes to answer his call light. Review of resident 6's call light log response time from 11/1/21 through 12/28/21 revealed: *There were a total of 217 call light response times. *Of these, the call light response time was: -Twenty-two times from 15 to 20 minutes. -Eleven times from 21 to 30 minutes. -Four times from 31 to 40 minutes. -Two times from 41 to 45 minutes. -One time for 52 minutes. -Thirteen times over 15 minutes while he was on the toilet. Surveyor: 41088 6. Interview on 12/28/21 at 2:37 p.m. with resident 32 revealed: *She had been a resident at the facility since July 2021.	F 675		

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F 675	Continued From page 38 *Had been on hospice care since 11/11/21. *Call lights had been answered slowly since she admitted. *There had been long waits after meals and in the evenings. *She had filed grievances with the facility. *States she has complained but the situation has not changed. *Long waits had caused her to have incontinence accidents at times. Review of resident 32's medical record revealed: *She had a brief interview for mental status score (BIMS) of 15 indicating she was cognitively intact. Review of resident 32's call light log response time from 11/1/21 through 12/27/21 revealed: *There had been a total of 682 call light response times. *Of those response times: -35 had been from 15 to 20 minutes. -25 had been from 20 to 30 minutes. -8 had been over 30 minutes with the longest being 50 minutes 26 seconds. Interview on 12/30/21 at 10:58 a.m. with administrator A revealed: *She had been aware there were resident concerns about call light response times. *She could go back and review cameras to see what had happened. *Resident 32's room had been hard to visualize from the hallway. *She would like to see call lights answered between 5 and 7 minutes by staff or less. *She had been tracking any call lights that took longer than 15 minutes. *She thought the response times had improved in December.	F 675		

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F 675	Continued From page 39 *The problem times had been from 6-9 a.m. and at bedtime. *They had attempted to make changes but had found it a difficult problem to resolve. Surveyor: 45683 7. Interview on 12/29/21 at 3:00 p.m. with residents 1, 5, 11, 19, 25, 27, 28, 30, 31, 34, 39, 48, and 51 agreed: *They would have to wait for the staff not to be busy. *They would have to turn their call light on again as staff would shut them off and leave without assistance having been given. *These issues have been brought up at multiple resident meetings without any updates or resolutions. Review of resident group minutes revealed concerns were discussed about call lights not having been answered in a timely manner by: *Current residents 16, 19, 22, 31, 34, 36, 39, and 51 from memory lane on 11/8/21 and 12/13/21. *Current residents 5, 12, 25, 28, 32, 38, 48, 52 from city view on 11/1/21 and 12/6/21. Refer to F565. Surveyor: 06365 8. While observing staffing activity on Memory Lane hallway on 12/29/21 at 8:40 a.m., resident 43 called out from her room for this surveyor's attention: *The resident explained a staff member had just dropped off her breakfast tray but did not provide any silverware. *Her call light was already on at that time. *While this surveyor continued observations, 3-4 staff members walked by her room without stopping to ask what she needed.	F 675		

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F 675	Continued From page 40 *After less than 2 minutes, CNA H stopped at her room, went to get silverware, and immediately returned. Interview on 12/29/21 8:42 a.m. with CNA H revealed: *She started as a contract CNA one month ago. *The CNAs have assigned units. *She helped with breakfast in the dining room and then did room tray delivery. *Two CNAs share the assignments in the Memory Lane hallway. Interview on 12/29/21 at 2:13 p.m. with CNA H reported: *She learned resident routines by talking with the residents and rounding with the CNA that worked the shift before hers. *When a call light is on, the light outside the resident's room goes on, and a light and bell alarm display/sound from a panel at the nurse's desk. *She tried to answer call lights within 3 - 7 minutes. *Staff are supposed to change the light from white to green when they answer it so everyone knows someone is helping the resident. *When she starts her shift, she gets an assignment sheet that tells her which group of residents she is working with. *On that day, she was assigned to 17 residents on Memory Lane and her partner was assigned to 15 residents. *They have to work together to transfer four residents that used the total lift and four residents that used the stand-aid. *A float CNA would help to manage the workload better.	F 675		

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F 675	Continued From page 41 Review of the Resident Handbook in the resident admission packet revealed: *A call light is located beside the resident bed and in each resident bathroom. *Pressing the button or pulling the cord "sends a signal to the nursing staff that you need assistance." *A light in the hallway "above your door will light up and alert staff that you are in need of assistance." Review of the facility assessment completed on 11/17/21 revealed: *The facility-wide assessment is to "determine what resources are necessary to care for its residents competently." *There question regarding "appropriate staffing to meet the needs of the residents" was answered, "Yes." *Coordination and continuity of care tools, processes, and staff assignments include: -Nursing shift reports are "given daily to all care team members." -"Kardex and care plans along with "pocket lists" with resident care needs. -Two-way radio and phone communication for all nursing staff. -Team members participate in "daily stand-up and huddle meetings" led by the director of nursing services. -Staff are scheduled "to areas that meet their strengths and abilities," and staffing is "consistent." -Daily review of schedules and assignment worksheets. *Staffing needs and resident "acuity" are measured, monitored, and evaluated weekly by the Administrator.	F 675		

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F 675	Continued From page 42 Interview on 12/30/21 at 1:25 p.m. with administrator A revealed: *The quality assurance committee was currently working through a performance improvement project (PIP) related to call light response times. *She pulls a call light report that includes a random two days every week. *The PIP currently did not include on the floor surveillance of call light response times. *They have used the hallway video cameras to validate call light response times when necessary. *Ancillary staff will help answer call lights during high demand times until they can bring on a float.	F 675		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Surveyor: 41088 Based on observation, interview, record review, and policy review, the provider failed to ensure: *One of one sampled resident (42) who was at risk of skin breakdown had preventative	F 686	1. Resident 42's care plan has been reviewed and updated in regards to prevention of further skin breakdown. 2. By 2/11/22, for any resident who hadn't has a Braden Scale completed in the last 30 days, one will be completed. MDS Coordinator will review trends in Braden scores and update care plans for any residents who have had an increase in risk for skin breakdown. 3. To ensure the deficient practice will not recur, center will continue Pressure Ulcer/Wound PIP	

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F 686	Continued From page 43 measures implemented and followed to prevent pressure ulcers from developing, and had thorough documentation of skin and wound assessments. *Ongoing monitoring, assessment, and documentation for three of six sampled residents (9, 35, and 50) who were at risk for skin breakdown. Findings include: 1. Observations of resident 42 on the following dates and times revealed: *12/28/21 at 10:50 a.m. the resident had been lying on her bed on her left side with legs bent and pulled up into a fetal position. *12/29/21 at 9:23 a.m. the resident had been lying on her bed on her back with legs extended to the end of the bed. *12/29/21 at 3:13 p.m. the resident had been lying on her left side with her legs bent and pulled up into a fetal position. *12/30/21 at 7:44 a.m. the resident had been lying on her bed on her back with her legs extended to the end of the bed. *The resident had not worn heel protectors or had her heels elevated in any of the above observations. *Her heel protectors had been on top of her dresser on each of the above observations. Interview on 12/29/21 at 9:23 a.m. of resident 42's husband (resident 18) revealed: *His wife used to be very active, and they had taken walks to the park regularly before she fell and broke her hip. *Her Alzheimer's disease had progressed since then and she had declined. *She had not eaten meals well and had lost weight.	F 686	and will add a section in our meeting minutes that addresses wound interventions, specifically for those that are not consistent or lacking in resident compliance. PIP Team will then decide whether to continue or change the interventions to ensure the care plan matches the resident's current needs. The DNS or designee will generate a report weekly and compare Braden scores. DNS and wound nurse will review those residents' skin care plans and place new interventions for those that have increased risk for breakdown. MDS Coordinator/Wound Nurse will provide reeducation to nurses by 2/11/22 on the completeness and accuracy of the Skin Observation assessments to ensure each area is completed. 4. DNS or designee will randomly audit the Skin	

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F 686	Continued From page 44 *She developed sores due to not being as active and lying down more often. *The nurses had applied dressings to her heels and "behind." *She had boot protectors that were supposed to be on when she was in bed. *"They don't put them on her any more." Review of resident 42's electronic medical record (EMR) revealed: *She had been independent with mobility before to her fall. *She currently used a walker with a gait belt and staff walked next to her. *Her appetite had been poor. *She had a fall on 11/16/21 that resulted in surgery and hospitalization to repair a broken left hip. *She returned to the nursing home on 11/19/21. *Her mobility had declined significantly since her broken hip. *Physician orders: -On 11/27/21 for Mepilex to her sacrum every three days to prevent skin breakdown. -On 11/19/21 for barrier cream to be applied prn (as needed) for skin breakdown had not been administered the month of November or December. -On 12/22/21 for Mepilex to be applied to both heels daily and prn. -On 12/22/21 for Mepilex to be applied to the sacrum daily in morning and prn to prevent skin breakdown related to stage II pressure ulcer of sacral region. The following Braden skin assessments for risk of skin breakdown were completed: *Readmission assessment on 11/19/21: no risk with a score of 19.	F 686	Observation assessments of 5 residents for accuracy and completeness weekly times 4, every other week x 2, monthly x 1, quarterly x 1. The results of those audit findings will be brought to the monthly QAPI Committee meeting by the DNS and continued until the facility demonstrates sustained compliance as determined by the committee. **Addendum:** **1. For residents 9, 35, and 50, by 2/3/22 a skin assessment was completed and scheduled to be completed weekly.** **2. By 2/11/22, PIP team will review all residents with Braden scores indicating moderate to high of risk of breakdown and ensure skin assessment are scheduled and completed weekly.** mt 3/3/22	2/11/22

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F 686	Continued From page 45 *Assessment on 11/26/21: mild risk with a score of 16. *Assessment on 12/10/21: mild risk with a score of 17. *Assessment on 12/20/21: moderate risk with a score of 14. *Assessment on 12/23/21: mild risk with a score of 15. *Assessment on 12/24/21: mild risk with a score of 15. Review of resident 42's undated care plan revealed: *Focus: "The resident has impairment to skin integrity related to recent fall evidenced by surgical incision. Stage II pressure wound coccyx 12/21/21. Stage I pressure wound to right heel. 12/21/21. Left hip incision healed." 12/14/21. Initiated 12/21/21. -Goal: "Resident will have no complications related to coccyx and right heel wound through the review date." Initiated 12/21/21. -Interventions: --"Monitor location, size and treatment of skin injury. Report abnormalities, failure to heal, symptoms of infection, maceration, etc. to health care provider. Mepilex applied to coccyx as ordered by primary care physician." Initiated 11/24/21. --"Identify potential causative factors and eliminate/resolve where possible." Initiated 2/4/20. --"Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short." Initiated 2/4/20. --"Keep skin clean and dry. Use lotion on dry skin. Do not apply on site of injury." Initiated 11/24/21. --"Turn and reposition in bed and chair	F 686		

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F 686	Continued From page 46 approximately every 2 hours and prn. Heel boots on when in bed or recliner." Initiated 11/19/21. Revised 12/23/21. --"Elevate heels off bed." Initiated 11/19/21. --"Weekly skin observation by licensed nurse." Initiated 11/19/21. --Provide pressure relieving/reducing device in wheelchair (Roho cushion to wheelchair and recliner) and an air mattress to bed. Heel boots in bed and seated in recliner if heel rests on foot rest. Gripper socks only. No shoes until the right heel would heal. Foam dressing to bilateral heels and sacrum/coccyx as ordered by primary care physician." Initiated 11/24/21. Revised 12/23/21. Review of resident 42's skin assessments revealed: *They were to be done weekly. *There had been ten weekly skin assessments missing in 2021: -7/1, 8/3, 8/10, 8/24, 8/31, 9/24, 10/5, 10/12, 11/2, and 11/16. *The skin assessments had not been filled out completely. -The items missing had been medications and conditions that may affect the resident's skin. -Measurements of the area. -Descriptions of the surrounding skin. -Education that had taken place. *The12/20/21 skin assessment had identified an area on her coccyx. --The medications and conditions section had been blank. --Mepilex and an air mattress had been added as interventions, which was over a month since she fell and broke her hip. *Review of resident 42's wound assessments revealed they had not been completed thoroughly	F 686		

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F 686	Continued From page 47 and had many blank sections, including measurements of wound areas and a description of skin tissue surrounding the wound. *On 12/20/21: -Site: Coccyx. -Stage II pressure ulcer. -Description: Purple area not open; 3 centimeters width (cm) X 1 length cm. -No depth was noted. -Comments: Purple area not open: with red area. -The wound characteristics area had been left blank. *On 12/21/21: -Site: Right heel. -Stage I pressure ulcer. -Description: Non-blanchable redness. -1.3 cm length X 1 cm width, no depth noted. -Measured area of redness. -Interventions: Heel boots on when in bed and in recliner if heel rests on footrest. The provider had implemented interventions for resident 42 to prevent skin integrity issues after her fall, but had failed to follow through and ensure that the interventions had been completed and documented thoroughly. Interview on 12/30/21 at 7:48 a.m. with certified nursing assistant (CNA) R regarding resident 42 revealed she: *Was familiar with the resident. *Shared that the resident had been independent before her fall and now had less mobility. *Checked the Kardex to make sure she was aware of any changes in her care. *Knew she had heel boots that were to be put on her when she was in bed. *Was aware the resident took the heel boots off at times.	F 686		

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F 686	Continued From page 48 *Knew the resident was to be repositioned every two hours. Interview on 12/30/21 at 7:58 a.m. with CNA Q regarding resident 42 revealed: *She knew she had boot protectors that were to be worn when she was in bed. *She had increased skin issues since she broke her hip and was more tired and staye din bed more often. *They repositioned her every couple of hours and tried to make sure her boot protectors were on. *At times, she was not cooperative with keeping them on. Interview on 12/30/21 at 1:46 p.m. with assistant director of nursing services/infection preventionist (ADNS/IP) B and minimum data set (MDS) coordinator L revealed: *Interventions should be in place to prevent skin problems from occurring for residents and followed by staff. *Resident 42 had been a challenge to work with and had refused to wear boot protectors at times. *Any refusals should be documented by the staff. -They found three instances of refusals from resident 42 documented. *They agreed the skin and wound assessments had not been completed thoroughly but should have been. Surveyor: 42477 2. Review of the EMRs for three residents (9, 35, and 50) revealed missing assessments and/or documentation: *Resident 9: -Braden skin assessments completed on 9/27/21 and 12/27/21 determined she was at risk for skin breakdown.	F 686		

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F 686	Continued From page 49 -Her last weekly skin assessment was completed 10/7/21. *Residents 35 and 50: -Skin assessments had been completed weekly. -The assessments that were completed were missing: --Medications that may affect the resident's skin. --Measurements of any areas. --Descriptions of the surrounding skin. --Any interventions or education that took place. Interview 12/30/21 at 1:36 p.m. with ADNS/IP B and MDS coordinator L revealed: *If a resident was determined at risk for skin breakdown, then weekly skin observations would be completed. *Even if a wound had resolved, they would continue to do weekly skin assessments if the resident was at risk. *MDS coordinator L, who also works as the wound nurse, she found some wound assessments overdue or not completed thoroughly. Review of the provider's May 2021 Wound and Pressure Ulcer Management policy revealed: *"To provide current and consistent standards in practice in wound care management." *"A comprehensive management program to prevent development of a pressure ulcer or other skin conditions (Braden, following interventions identified on care plan, nutritional intervention, speciality surfaces, etc.)"	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689	1. By 1/28/22, an assessment for safety and supervision plan will be put in to place for Residents 30 and 34.	

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F 689	Continued From page 50 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 06365 Based on observation, interview, record review, and policy review, the provider failed to adequately assess and provide supervision for 2 of 4 sampled residents (30 and 34) residents that smoked. Findings include: 1. Resident 34 reported during interviews: *On 12/29/21 at 10:25 a.m., she had trouble opening the courtyard door when she wanted to go outside. *On 12/30/21 at 12:31 p.m., she: -Lit her cigarettes herself. -Wore a pouch around her neck that contained her cigarettes and lighter. -Had a limitation with the use of her left leg and arm. -Wore a smoking apron that she had in her room. -"Sometimes" had a staff member with her when she smoked. -"Sometimes" had to wait for staff to respond to the doorbell so they could let her back into the building. Observation on 12/30/21 at 12:27 p.m. of the courtyard entrance off the activity room revealed the door: *Was cracked open, letting in cold air. *Had to be pulled to close all the way. *Required some strength to open it for passage through the doorway.	F 689	2. By 1/28/22, all other residents that smoke will be assessed for safety and supervision and plan will be put into place. 3. To ensure the deficient practice will not recur, based on the completion of the Tobacco Use assessment, for those residents that need to be supervised, designated smoking times will be established so a staff member can be available to monitor. All staff will be educated by administrator on smoking times and the safety interventions for each resident by 2/11/22. 4. MDS Coordinator will observe staff and residents during designated smoking time to ensure adequate supervision and safety interventions are in place. Audits will occur weekly x 4, every other week x 2, monthly x 1, quarterly x1. The results of those audit findings will be brought to	

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F 689	Continued From page 51 Observation at that time also revealed no smoking aprons hung by the doorway for residents to use when smoking. Interview on 12/30/21 at 12:44 p.m. with certified nursing assistants (CNAs) C and H revealed: *Resident 34 is "supposed to have the apron on" before she goes out to smoke. *The smoking apron is hanging by the courtyard door. Observation at that time with CNAs C and H revealed: *No smoking apron was hanging by the courtyard door. *They found it buried underneath the pile of resident 34's belongings in her room. *Wrapped in the apron was an unopened pack of cigarettes and a lighter. Review of the electronic medical record (EMR) revealed a tobacco use assessment dated 11/11/21 that reported the resident: *Had modified independence by making "decisions regarding tasks of daily life." *Needed assistance to open the door due to her right side deficit. *Could "always" light her cigarette. *Needed a smoking apron. *Had a history of dropping a cigarette that resulted in a burn on her right breast. Review of resident 34's EMR revealed a 5-day reentry minimum data set assessment (MDS) dated 11/25/21 noted she: *Was cognitively intact, no problems with communication, and mild depression. *Needed weight-bearing support from staff for	F 689	the monthly QAPI Committee meeting by the MDS Coordinator and continued until the facility demonstrates sustained compliance as determined by the committee. **Addendum:** **1. A facility specific addendum addressing assessment and supervision of residents was added to the policy for "Smoking and Tobacco Use – Rehab/Skilled and Outpatient Therapy".** mm 2/3/22	2/11/22

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F 689	Continued From page 52 activities of daily living (ADLs) to transfer between surfaces, maintain personal hygiene, use the toilet, and get dressed. *Had medically complex conditions including neurological conditions resulting in left-sided weakness. Further review of resident 34's EMR revealed the care plan initiated on 1/26/21 and revised on 12/20/21 state, "when she plans to smoke, assist with smoking apron and getting outside." 2. Interview and observation on 12/28/21 at 11:45 a.m. with resident 30 in a lounge area revealed he: *Smoked when he wanted to. *Kept his cigarettes with him. He showed how they were stored in a pack belted around his waist. *Did not use a smoking apron because he could smoke safely. *Said the doors to the courtyard "are hard to open." He asked the surveyor to push on the door at that time, and the door opened without resistance. *Moved his high back motorized wheelchair through the doorway into the courtyard using a knob control on one armrest. The surveyor followed the resident to the other side of the courtyard. *Pointed out there was a door-bell outside the door on the other side of the courttyard to alert staff when he was ready to come back in. *Said they usually answer the buzzer right away but said it is not very loud. *Pulled out a cigarette, safely lit it, and began to smoke. An observation about five minutes later on	F 689		

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F 689	Continued From page 53 12/28/21 revealed: *Resident 30 buzzed the doorbell outside the courtyard door off the activity lounge. *This surveyor faintly heard the sound while typing at a table in the activity lounge. *Activities supervisor F got up from her desk in the corner of the lounge by the courtyard door and opened the door for resident 30. Review of the tobacco use assessment dated 7/25/21 in the EMR for resident 30 revealed: *He was moderately cognitively impaired. *He had no problems with vision or dexterity and can always light his cigarette. *There was no history of incidents related to smoking. *He was able to get himself out and back into the center. Further review of resident 30's EMR revealed the care plan initiated on 7/23/21 and revised on 11/22/21 noted he: *Had "Impaired cognitive function" with "impaired judgment and decision making." *Used a motorized wheelchair with cueing for safe driving. *Needed ADL assistance due to lower extremity weakness. *Was independent with tobacco use. Review of resident 30's revealed a significant change in status MDS dated 11/18/21 noted he: *Was cognitively intact and able to communicate. *Reported it was "very important" for him to take care of his own belongings. *Needed weight-bearing support from staff for ADL to transfer between surfaces, maintain personal hygiene, use the toilet, and get dressed. *Had a "progressive neurological condition" that	F 689		

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F 689	Continued From page 54 limited his ability to move limbs on both sides of his body. No updated tobacco use assessment was found in the EMR for resident 30. 3. Review of the provider policy for smoking and tobacco use issued on December 2000, and revised last on 4/17, revealed: *All Good Samaritan Society (GSS) locations "implemented procedures to establish a smoke-free environment." *Some GSS locations allow smoking and tobacco use "only in the designated areas outside." *For those locations, the designated area "must be readily visible for employee observation, must be free of hazardous materials and provide adequate ventilation, and must be physically separate from common areas used by non-smokers." *Residents that smoke "must not pose a safety hazard to themselves or others." The policy does not specify the requirement to assess or reassess the resident's tobacco use. Interview on 12/30/21at 12:22 p.m. with administrator A said: *The provider policy is the only policy regarding tobacco use. *She would write up an addendum to address assessment of residents and other supportive interventions.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who	F 698	1. On 1/4/22, registered dietician reviewed lab work and nutrition status and had no recommended	

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F 698	Continued From page 55 require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on interview, record review, and dialysis contract review, the provider failed to ensure two of two sampled residents (4 and 35) receiving hemodialysis had: *Received phosphorus binder medication as scheduled to ensure the medication was effective, and in order to prevent potential side effects of elevated phosphorus levels. *Their care plans were updated in accordance with the provider's dialysis contract. Findings include: 1. Review of resident 35's electronic medical record (EMR) revealed she had: *End stage renal disease (ESRD) and was receiving outpatient hemodialysis. *Orders for phosphorus binders [medication] due to her kidneys' inability to filter out phosphorus. *The phosphorus binders were to be given with food to bind and remove phosphorus. *Been documented to have many episodes of itchiness. -Itching can be a side effect of high phosphorus. Review of resident 35's 12/16/21 through 12/30/21 medication administration record (MAR) logs revealed she had received her phosphorus binders late 13 out of 15 times. 2. Review of resident 4's EMR revealed he had: *ESRD and was receiving outpatient hemodialysis.	F 698	changes for resident 4 and 35. 2. No other residents in the facility are currently receiving dialysis treatment. 3. To ensure the deficient practice will not recur, resident 4 will receive Tums on the way to the dining room for breakfast. For resident 35, a note will be placed with room tray to alert staff to notify the nurse so medication can be given at the correct time. Nurses and medication aides were re-educated by the DNS on 1/20/22 to give phosphorus binders with meal. 4. DNS or designee will audit to ensure medication given in accordance to meal times. Audits will occur weekly times 4, every other week x 2, monthly x 1, quarterly x 1. The results of those audit findings will be brought to the monthly QAPI Committee meeting	

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F 698	Continued From page 56 *Orders for Tums to be given during his meals. -This was ordered as a phosphorus binder. Review of resident 4's 12/16/21 through 12/30/21 MAR logs revealed he had received his phosphorus binders late 8 out of 15 times. Interview on 12/30/21 at 7:56 a.m. with registered nurse (RN) K revealed she had not been aware that resident 4 and resident 35 were to be given their phosphorus binders before meal time. Interview on 12/30/21 at 2:57 p.m. with assistant director of nursing service/infection preventionist (ADNS/IP) B revealed she would expect phosphorus binders to be given as ordered, prior to meal services. 3. Review of the provider's February 2021 Dialysis Contract revealed the nursing facility's care plan would indicate hospital preference for each dialysis patient in case of emergency hospitalization was required while at the dialysis unit and the information would be shared with the dialysis unit. Review of resident 4 and 35's December 2021 care plan revealed their hospital preference had not been listed on their care plan in case they required hospitalization.	F 698	by the DNS and continued until the facility demonstrates sustained compliance as determined by the committee. **Addendum:** **1. On 1/18/22 for resident 35 and on 1/24/22 for resident 4, MDS coordinator updated their care plans to reflect hospital of choice. Hospital choice has been shared with the dialysis unit.** MT 3/31/22	2/11/22
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880	1. The administrator, DON, and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for	

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F 880	Continued From page 57 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (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.	F 880	the above identified areas. All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by DNS or designee by 1/29/22. 2. ALL residents and staff have the potential to be affected if appropriate monitoring and response to identified COVID-19 positive cases is not carried out per plan. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by DNS or designee by 1/21/22. 3. Administrator, DNS and consultant Quality Improvement Advisor conducted a Root Cause Analysis answered the 5 Whys on 1/20/22. Medication Aides during Day Med Pass will begin asking residents if they are experiencing COVID symptoms to create an additional opportunity for	

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F 880	Continued From page 58 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Surveyor: 06365 Surveyor: 42477 Based on observation, interview, record review, and policy review, the facility failed to implement an adequate surveillance system to: *Monitor respiratory status for 2 of 20 sampled residents (10 and 36) and one randomly observed resident (45) who may have been symptomatic for coronovirus (COVID-19). *Ensure visitor guidelines were accurately posted and followed during COVID-19 response. Findings include:	F 880	resident symptoms to get captured, and appropriate follow-up by the charge nurse to occur. During an outbreak, the Confirmed COVID Checklist will be utilized which includes the need to post the proper outbreak signage for visitors. Administrator, DON, 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 and documentation. Facility Administrator contacted the South Dakota Quality Improvement Organization (QIN) on 1/21/22. Administrator and Quality Improvement Advisor discussed in detail the F880 deficiency and review each of the Five Why's. Advisor was pleased with our root cause analysis and provided some additional resources via email including a new Nursing	

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F 880	Continued From page 59 1. Interview on 12/28/21 at 10:15 a.m. with administrator A and assistant director of nursing services/infection preventionist (ADNS/IP) B revealed there were no residents confirmed or suspected with COVID-19, but the facility was in outbreak status due to employees that had tested positive. Review of the provider's list of COVID testing for residents during the days of the survey revealed three residents (10, 36, and 45) that displayed or reported symptoms to surveyors were not documented on the list as tested. a. Observation and interview on 11/28/21 at 4:15 p.m. and on 11/29/21 at 1:15 p.m. with resident 36 as she moved towards the dining room in the hallway with her wheelchair revealed: *She reported feeling tired, not feeling well, and wondered if she should be going to the dining room. *She sniffled and it sounded as if she had congestion in her upper respiratory system. *She did not have a face mask on. Observation and interview on 11/30/21 at 8:00 a.m. with resident 36 revealed: *She reported "feeling better today." *She did not sound congested when she spoke. *She did not have a face mask on. Surveyor 29354 b. Observation and interview on 12/28/21 at 3:20 p.m. with resident 10 in her room revealed: *She put on her mask *Although she stated she felt better she continued with an occasional cough and nasal congestion. *Confirmed she had been experiencing cold symptoms over the past few weeks.	F 880	Homes Visitation poster from CMS to post for visitors and include in facility's next weekly family notification. 4. Administrator, DON, and/or designee will conduct auditing and monitoring 2 to 3 times weekly over day shifts to ensure identified and assigned tasks are being done as educated and trained. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. *Staff compliance in the above identified area. *Any other areas identified through the Root Cause Analysis. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be	

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F 880	Continued From page 60 *They had "checked her for COVID-19 and it had been negative." Observation and interview on 12/29/21 at 12:10 p.m. with resident 10 in her room revealed she: *Put on her face mask. *Continued with an occasional cough and nasal congestion. *Felt better. Surveyor 42477 c. Observation and interview on 12/28/21 at 12:20 p.m. of resident 45 revealed: *He was laying in his bed, his room was dark. *He stated he was not feeling well and was not going to eat lunch. Surveyor 06365 d. Review of the electronic medical records for residents 10, 36, and 45 revealed: *Screening of the residents' temperatures and oxygen saturations were completed with normal results. *There were no progress notes regarding their symptoms or reports of not feeling well. Interview on 12/30/21 at 11:37 a.m. with ADNS/IP B revealed: *Any residents exhibiting any symptoms should be tested for COVID-19. *The decision to test a resident for COVID was based on: -The presence of symptoms. -Whether they were in close contact with someone who tested positive. *She was not aware that residents 10, 36, and 45 had reported symptoms and/or were not feeling well. *None of those residents had been tested for	F 880	reported by administrator, DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	2/11/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	12/30/2021

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

(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 61 COVID-19. Interview on 12/30/21 at 12:35 p.m. registered nurse (RN) K revealed surveillance of symptoms included: *Nurses collected residents' vitals of temperature and oxygen saturations. *The certified nursing assistances (CNAs) reported when a resident had symptoms. Interview on 12/30/21 at 12:42 p.m. with CNAs C and H confirmed they report symptoms to the nurse "if they know about [a resident having] them." Review of the provider policy for infection preventions related to acute respiratory syndromes, coronavirus (COVID), dated 11/28/21, revealed policy statements to: *Minimize the number of individuals who come in contact with a patient under suspicion for COVID-19. *Residents are screened at least daily for symptoms of COVID-19 including fever, chills, shortness of breath, difficulty in breathing, cough, sore throat, new loss of taste or smell, new sputum production, congestion, runny nose, fatigues, aches, headache, nausea, vomiting, or diarrhea. *Resident testing is completed in accordance with state and federal guidance. *Residents should wear a face covering or mask when 6 feet of distance cannot be maintained for communal activities, unless all resident participants were fully vaccinated. Surveyor 42477 2. Observation on 12/28/21 at 10:00 a.m. of the facility's front entrance revealed:	F 880		

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	435046	A. BUILDING _____ B. WING _____	12/30/2021

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

(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 62 *There were no signs to let visitors know the facility was currently in outbreak status. *A visitor wearing a mask walked upstairs to the resident rooms. *He did not perform hand hygiene or complete the COVID-19 screening to verify no presence of symptoms. Observation on 12/28/21 at 10:50 a.m. revealed: *A visitor was leaving a resident's room on the City View hallway . *Licensed practical nurse N, at that time: -Informed the surveyor the visitor was supposed to be wearing a face shield since the facility was in outbreak status. -Said she was going to text other staff members to inform them visitors were to wear face shields. Observation on 12/28/21 at 12:00 p.m. in the facility's main dining room revealed: *There were two visitors with residents, neither visitor was wearing a mask. *ADNS/IP B brought one of the visitors a mask to wear. *The other visitor sat with a resident at the dining room table without a mask while the resident ate. Observation on 12/28/21 at 3:50 p.m. revealed two visitors sitting in a resident room with a mask pulled down underneath their nose. Interview on 12/30/21 at 3:02 p.m. with ADNS/IP B revealed: *Visitors should stop at the front entry to screen themselves or have a staff member complete their screening. *Visitors should wear face masks while visiting. *Visitors are not expected to wear face shields. *There was not a staff member assigned to	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	12/30/2021

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

(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 63 oversee this being completed. *She thought the other visitor in the dining room was eating but had not realized until later that he was not eating. Review of the provider policy for infection preventions related to acute respiratory syndromes, coronavirus (COVID), dated 11/28/21, revealed policy statements for: *Posting "facility outbreak status" at the entrance. *Making visitors aware of the potential risk during an outbreak investigation. *Screening visitors and restricting visitation for visitors with symptoms of COVID-19. *Expecting visitors to wear a face covering.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	12/30/2021

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

(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: 06365 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 12/28/21 through 12/30/21. Good Samaritan Society Sioux Falls Center was found in compliance.	E 000		

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

Dennis Tadoff | Administrator | 1/24/22

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.

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
	10679	A. BUILDING: _____ B. WING _____	12/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 W 2ND ST SIOUX FALLS, SD 57104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement Surveyor: 27198 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 12/28/21 through 12/30/21. Good Samaritan Society Sioux Falls Center was found not in compliance with the following requirement(s): S169.	S 000		
S 169	44:73:02:18(5-7) Occupant Protection The facility shall take at least the following precautions: (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters shall be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors. Any other exterior doors shall be locked or alarmed. The alarm shall be audible at a designated staff station and may not automatically silence when the door is closed; (7) A portable space heater and portable halogen lamp, household-type electric blanket or household-type heating pad may not be used in a facility; This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 27198 Based on observation, testing, and interview, the provider failed to ensure an electrically audible alarms on all unattended exit doors were provided for two of nine exit doors (south dining room exit and east lower-level exit). Findings include:	S 169	1. The maintenance staff unable to determine why alarms are not sounding appropriately so outside vendor has been contacted to schedule repair and maintenance to these 2 exit doors identified in the survey report. In the meantime, these exit doors remain locked at all times for resident safety. 2. The maintenance staff have inspected all other exit doors to ensure they are locked, alarmed or attended. No other concerns were identified with the other exit doors. 3. The Environmental Services Supervisor or designee with randomly audit our exit doors monthly for 3 months	

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

Marissa Tindoff — Administrator — 1/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10679	A. BUILDING: _____ B. WING _____	12/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 W 2ND ST SIOUX FALLS, SD 57104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 169	Continued From page 1 1. Observation at 2:12 p.m. on 12/28/21 revealed the exterior exit door at the south end of the dining room was not locked or monitored. Testing of that door at that same time revealed no alarm sounded when the door was opened. Interview with environmental services supervisor at the same time as the observation confirmed that condition. He stated he was new to the position and was not aware of the requirement for exterior doors to be locked, alarmed, or monitored. 2. Observation at 3:27 p.m. on 12/28/21 revealed the east exterior exit door in the middle of the lower-level wing was not locked or monitored. Testing of that door at that same time revealed no alarm sounded when the door was opened. Interview with environmental services supervisor at the same time as the observation confirmed that condition. He stated he was new to the position and was not aware of the requirement for exterior doors to be locked, alarmed, or monitored.	S 169	to ensure the door is either locked, alarmed or attended. The results of those audit findings will be brought to the monthly QAPI Committee meeting by the Environmental Services Supervisor and continued until the facility demonstrates sustained compliance as determined by the committee.	2/11/22
S 000	Compliance/Noncompliance Statement Surveyor: 06365 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 12/28/2021 through 12/30/2021. Good Samaritan Society Sioux Falls Center was found in compliance.	S 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/28/2021

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

(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: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 12/28/21. Good Samaritan Society Sioux Falls Center (building 01) was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K281 and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 281 SS=D	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation and interview, the provider failed to ensure adequate illumination of means of egress was provided at one randomly observed exit (north east stairwell). Findings include: 1. Observation on 12/28/21 at 3:45 p.m. revealed a marked exit stairwell in the north east wing corridor. The exit stairwell was provided with two	K 281	1. The marked exit identified in the survey report has been repaired and is now illuminated. 2. All other marked exits could be affected and problematic. The Environmental Services Supervisor or designee will inspect all other marked exits to ensure they are illuminating properly. If any additional are identified, they will be repaired immediately. 3. The Environmental Services Supervisor or designee with	

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

Marcia Tordoff | Administrator | 1/24/22

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/28/2021

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

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K 281	Continued From page 1 multiple lamp light fixtures (top of stairwell and bottom landing). In those two fixtures none of the lighting elements (bulbs) were functioning. Lighting is required to be provided so that stairwell is not left in darkness. That lighting also must be capable of providing one and one-half hours of emergency lighting upon loss of normal power. Interview with the environmental services supervisor at the time of the above observation confirmed that condition. He stated he was not aware that exit discharge was not in compliance with the minimum lighting requirements. This deficiency has the ability to affect one of eight smoke compartments.	K 281	randomly audit our exit doors monthly for 3 months to ensure the marked exit is illuminating. The results of those audit findings will be brought to the monthly QAPI Committee meeting by the Environmental Services Supervisor and continued until the facility demonstrates sustained compliance as determined by the committee.	2/1/22
K 712 SS=E	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on record review and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (inadequate	K 712	1. Environmental Services Supervisor along with a neighboring GSS Environmental Services Supervisor walked through the fire drill procedure together to familiarize him and staff of our center's fire drill procedure. 2. All required fire drills for each shift were completed in the month of December. 3. Fire drills compliance has been added to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/28/2021

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

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K 712	Continued From page 2 number of required fire drills). Findings include: 1. Record review and Interview with the environmental services supervisor on 12/28/21 at 1:15 p.m. revealed: *There was no documentation of fire drills being conducted for quarter three (July, August, September) or for quarter four (October, November, December) 2021. *He confirmed those findings and believed the drills were being conducted by others. *He was unaware the minimum number of fire drills per the required frequency had not been met for each shift for the facility in 2021. 2. Interview with the administrator that same day revealed: *She believed that environmental services supervisor had been conducting fire drills. *She was unaware the minimum number of fire drills per the required frequency had not been met for each shift for the facility in 2021. The deficiency had the potential to affect 100% of the occupants of the facility.	K 712	center's monthly Safety Committee Meeting Minutes to ensure they are reviewed and audited for completion each month. Environmental Services Supervisor will also audit fire drills completion monthly for 3 months. The results of those audit findings will be brought to the monthly QAPI Committee meeting by the Environmental Services Supervisor and continued until the facility demonstrates sustained compliance as determined by the committee.	2/11/22

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

PRINTED: 01/14/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	12/30/2021

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

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E 000	Initial Comments Surveyor: 06365 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 12/28/21 through 12/30/21. Good Samaritan Society Sioux Falls Center was found in compliance.	E 000		

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

Deanna Tordoff | Administrator | 1/24/22

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	435046	A. BUILDING 02 - BUILDING 02 - 1965, 1972, AND 2000 ADDITION B. WING _____	12/28/2021

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

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K 000	INITIAL COMMENTS Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 12/28/21. Good Samaritan Society Sioux Falls Center (building 02) was found not in compliance with 42 CFR 483.90 (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 deficiency identified at K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 712 SS=E	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on record review and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (inadequate number of required fire drills). Findings include:	K 712	1. Environmental Services Supervisor along with a neighboring GSS Environmental Services Supervisor walked through the fire drill procedure together to familiarize him and staff of our center's fire drill procedure. 2. All required fire drills for each shift were completed in the month of December. 3. Fire drills compliance has been added to the center's monthly Safety	

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

Marissa Tordoff | Administrator | 2/9/22

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING 02 - BUILDING 02 - 1965, 1972, AND 2000 ADDITION B. WING _____	12/28/2021

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

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K 712	Continued From page 1 1. Record review and Interview with the environmental services supervisor on 12/28/21 at 1:15 p.m. revealed: *There was no documentation of fire drills being conducted for quarter three (July, August, September) or for quarter four (October, November, December) 2021. *He confirmed those findings and believed the drills were being conducted by others. *He was unaware the minimum number of fire drills per the required frequency had not been met for each shift for the facility in 2021. 2. Interview with the administrator that same day revealed: *She believed that environmental services supervisor had been conducting fire drills. *She was unaware the minimum number of fire drills per the required frequency had not been met for each shift for the facility in 2021. The deficiency had the potential to affect 100% of the occupants of the facility.	K 712	Committee Meeting Minutes to ensure they are reviewed and audited for completion each month. Environmental Services Supervisor will also audit fire drills completion monthly for 3 months. The results of those audit findings will be brought to the monthly QAPI Committee meeting by the Environmental Services Supervisor and continued until the facility demonstrates sustained compliance as determined by the committee.	2/11/22