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
	435045	A. BUILDING _____ B. WING _____	C 07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

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F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 7/25/23. Areas surveyed included dietary services and quality of care. Good Samaritan Society Sioux Falls Village was found not in compliance with the following requirement: F684.	F 000	F684 Quality of Care 1. At time of survey, resident one was no longer a resident at Good Samaritan Society Sioux Falls Village.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on closed record review, record review, interview, and policy review, the provider failed to ensure one of four sampled residents with a diagnosis of generalized anxiety disorder received their scheduled lorazepam (medication administered for anxiety) as ordered by the physician. Findings include: 1. Review of resident 1's closed electronic medical record revealed: *The resident had an admission date of 10/25/21. *The resident had diagnoses of generalized anxiety disorder, chronic obstructive pulmonary disease, morbid obesity, and major depressive disorder.	F 684	2. By 08/10/2023, Director of Nursing or Designee will identify all missed medication, by reviewing MARS from July 2023 for medication availability from pharmacy and administration. We will audit and findings will be addressed as warranted. 8/10/23 3. To ensure the deficient practice will not recur, Director of Nursing or Designee will educate all charge nurses and medication aides on E-kits availability, medication acquisition receiving dispensing and storage policy by 08/10/2023. During daily clinical meeting PCC dashboard will be reviewed for missed medications and actions will be taken to correct.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Ballum | TITLE: Administrator | (X6) DATE: 08/07/2023

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

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F 684	Continued From page 1 2. Review of resident 1's electronic medication administration records and the electronic medical records revealed the following: *May 2023 the following medications were not administered due to availability: -Refresh Solution 1.4-0.6% eye drops given for dry eyes was not administered. The drug was not available on the following dates and times: 5/15/23 at bedtime, 5/16/23 in the morning, 5/18/23 in the morning, 5/19/23 in the morning, and on 5/24/23 at bedtime. -Furosemide 40 milligram (mg) given for generalized edema was not administered because the drug was not available on 5/26/23. *June 2023 the following medications were not administered due to availability: -Lorazepam 2 mg given at bedtime related to catatonic disorder due to known physiological condition was not administered because the drug was not available on the following dates: --6/13/23, 6/14/23, and 6/15/23. -Mirtazapine 30 mg given at bedtime for major depressive disorder was not available on 6/22/23. *On 6/16/23 at 11:15 a.m. a mood/behavior documentation revealed: The nurse had gone into the resident's room to administer her morning medications. The resident was sitting in her recliner and started saying "My blood pressure will be different today than before. It come from my heart. Jesus saved me." Then the resident started quoting scriptures from the bible. Then awhile later the resident started yelling "help" every five seconds. The nurse then asked her what was wrong and the resident replied, " I am having a heart attack, I think, but maybe not." Denied pain, Vital signs were stable. No shortness of breath. No other sx [signs] of heart attack noted. The resident was using her call light frequently and even had called 911 saying, "I	F 684	4. To monitor performance and ensure ongoing compliance the Director of Nursing or designee will audit the administration records of 10 random residents 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 Nursing or designee and continued until the facility demonstrates sustained compliance as determined by the committee. 5. Substantial compliance will be achieved by 08/10/2023.	

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F 684	Continued From page 2 called you by accident." -The above mood/behavior was exhibited two days after not having received her scheduled lorazepam for two nights. *On 6/16/23 the residents primary physician visited and his progress notes included the following: -"[The name of the resident] is anxious. Nursing did relay later that [name of the resident] had been out of lorazepam for a couple of days, so has not had her bed times dose X 2 days (nor PRN [whenever needed]). Was given PRN dose in the afternoon and her anxiety seems to clear up somewhat." 3. Interview on 7/25/23 at 10:00 a.m. with director of nursing (DON) A regarding resident medication availability revealed: *Nurses were responsible for ordering and re-ordering medications from the pharmacy. *The majority of the residents received their medication from a regular pharmacy used by the facility. *There were emergency drug kits (E-Kit) in each of the resident areas and the rehabilitation area. *Lorazepam was in the E-Kit in the rehab area and was accessible by the nurses to obtain medications if the medication was not available from the pharmacy. Interview on 7/25/23 at 10:30 a.m. with licensed practical nurse (LPN) B regarding ordering and re-ordering resident medications revealed: *She had been employed for one year. *She had never cared for a resident who had any other pharmacy then the one used more prevalently by the facility. *She would assume there was a process to follow for residents who were getting their medications	F 684		

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F 684	Continued From page 3 from another pharmacy, but she was unsure as to what that process would have been. Interview on 7/25/23 at 10:45 a.m. with LPN C regarding ordering and re-ordering resident medications revealed: *She was a traveling nurse. *The nurse was responsible for ordering resident medications from the pharmacy. *She was aware of the unavailability of the lorazepam for resident 1 that had occurred from 6/13/23 through 6/15/23. *There was a lack of communication from the pharmacy that resident 1 had utilized. *The medication had been re-ordered on June 13,2023, the pharmacy had not communicated with the nurse that the physician order for the lorazepam needed to be renewed. *The pharmacy usually delivered the medications in the evening when the resident medications had been ordered, but the lorazepam for resident 1 had not been delivered. *Resident 1 had not received her bedtime lorazepam for three nights from 6/13/23 through 6/15/23. *She had felt it was a communication error between the nurses and the pharmacy. *She was unsure why the nurses would not have used the resident's PRN lorazepam 1 mg medication card for the scheduled bedtime dose. Interview on 7/25/23 at 11:00 a.m. with clinical care leader D regarding the bedtime scheduled lorazepam for resident 1 revealed: *She has been employed for 4 years. *There was an insurance issue with the pharmacy that the facility had used for the majority of the residents. *Resident 1's current insurance would only accept	F 684		

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F 684	Continued From page 4 a certain pharmacy. *The nurse had called the pharmacy on 6/14/23 regarding the lorazepam, and was instructed that a new prescription was needed prior to filling the lorazepam. *The lorazepam was delivered on 6/16/23 and was administered at bedtime. *The nurses could have taken the lorazepam out of the EKit or could have taken the lorazepam out of resident 1's current PRN lorazepam 1 mg medication card. She was unsure as to why the nurses had not done that. Interview on 7/25/23 at 11:20 a.m. with DON A regarding resident 1's unavailable lorazepam revealed: *She was not aware that resident 1 had not received her lorazepam for three nights. *There had been issues with resident 1's pharmacy regarding timely delivery, ordering, and re-ordering medications. *She was not sure why the nurses would not have gotten the lorazepam out of the E-Kit or used the resident's PRN lorazepam for the schedule dose at bedtime. *The resident should have received her scheduled medication as ordered. Review of the provider's 3/2/23 Medications: Acquisition Receiving Dispensing and Storage policy revealed: *The purpose of the policy was to ensure accurate ordering from the pharmacy. *Licensed nursing employees were responsible for ordering from the pharmacy. *The medication orders/changes were communicated to the pharmacy. *Licensed nurse and/or medications aides were responsible for reordering of medication per their	F 684		

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F 684	Continued From page 5 pharmacy system as state law allows. *Discrepancies and omissions were reported promptly to the issuing pharmacy and the charge nurse. *The required medication should have been obtained from either the emergency drug box, or from the dispensing pharmacy.	F 684		