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 12/07/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 12/4/23 through 12/7/23. Good Samaritan Society Sioux Falls Village was found not in compliance with the following requirements: F561, F583, F686, F725, F741, F761, F800, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 12/4/23 through 12/7/23. The area surveyed was accidents. Good Samaritan Society Sioux Falls Village was found in compliance.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in	F 561	1. By 12/28/2023 Dining director or designee will provide a weekly menu to residents 37, 66 and 69 as well as copies of our always available menu for their choice of meal. 2. By 1/02/2024 all residents will receive a choice of food preferences for meal trays served in their rooms. Activities staff will address the residents for their choice of meal and circle the option chosen. The kitchen will file the cards according to the meal and disperse the proper file with the right meal. Staff serving meals will place the meal card on each tray. The Dietary team will double check that all meal cards have been served by checking all residents' names off the main roster	01/04/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Bullin — TITLE: Administrator — (X6) DATE: 01/03/2024

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F 561	Continued From page 1 community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and policy review, the provider failed to ensure three of three sampled resident (66, 69, and 37) had the choice of food preferences for meal trays served in their rooms. Findings include: 1. Interview on 12/04/23 at 2:37 p.m. with resident 66 revealed: *She felt as though she would not get a choice when she received her breakfast room tray. *She stated that she sleeps until 9:30 a.m. but staff would bring her breakfast tray into her room, set it on her overbed table, and would not wake her up. *The food tray would sit on her bedside table until staff got her out of bed. *She stated that her breakfast would be cold by the time she was ready to eat. 2. Interview on 12/4/2023 at 3:23 p.m. with resident (69) revealed: *She stated that staff forgot to bring her meal tray a few times about a month ago, and when she asked for her meal tray, staff stated the kitchen was closed. *She stated the meals were often bad and she would request an alternative meal of macaroni and cheese. She stated she had requested the macaroni and cheese a lot recently due to poor	F 561	sheet. Nursing staff will ensure proper storing and reheating of any food is completed. If a tray needs to be heated, they will heat it to temp to food serving temperatures. 3. The dining director or designee will educate all culinary staff on the new meal ticketing process via in-service , if an employee is not able to attend in-service, then via phone call or quiz prior to next shift. Dining director or designee will educate nursing staff on roll out of new ticketing process, what to do with resident's meals that are left uneaten in rooms, safe ways to store and reheat food, as well as where to find thermometers in the kitchen via in-service, if employee is not able to attend in-service then via phone call or quiz prior to next shift. 4. To monitor performance and ensure ongoing compliance A.) Dining director or designee will Audit options for room trays logs (3 audits/day, different dining rooms each meal) daily for 14 days, once compliance goal is met, continue audit once daily, alternating between dining areas. B.) Resident dining interviews will be completed by dining management staff, 10	

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F 561	Continued From page 2 meals that were served. 3. Observation on 12/05/23 at 8:27 a.m. of resident 66 revealed: *The breakfast tray was already sitting in the resident's room. *The resident was still in bed asleep. Observation on 12/05/23 at 9:22 a.m. of resident 66 revealed: *She was getting assistance with getting up for the day from registered nurse (RN) J. *RN J stated that resident 66 liked to sleep in. *When asked about the resident's breakfast tray, RN J stated that she would be reheating her breakfast. 4. Interview on 12/5/23 at 2:44 p.m. with resident 37 revealed: *The resident was not given a choice on what he wanted to eat for meals. *Resident stated that in the past he would receive a menu and would have made his food preferences known by circling what items on the menu that he wanted to eat. *The resident stated he had not been receiving a menu anymore to have made those food choices. 5. Interview on 12/6/23 at 10.59 a.m. with certified nursing assistant (CNA) K revealed: *Breakfast was between 7:30 a.m. and 9:00 a.m. and the room trays were delivered between those times. *If a resident wanted breakfast after 9:00 a.m., the food would have needed to have been reheated because the kitchen was closed after 9:00 a.m. *CNA K stated that resident 66 was very independent, and did not like a lot of assistance	F 561	residents per week (alternating between meals and dining venues) for 4 weeks until substantial compliance/satisfaction is met. Dining Director or Designee will report results to QAPI quarterly.	

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F 561	Continued From page 3 and that the resident would request that her food be hot. *When asked if the food tray could have been delivered later, CNA K stated that it was a possibility, but the food would still have been reheated because the kitchen would have been closed. 6. Interview on 12/6/23 at 11:24 a.m. with resident 66 revealed: *Resident stated that in the past couple of days that the survey team was at the facility things were different, and the resident stated, "There were more staff here than usual." *Resident stated that she had eaten a cold breakfast in the morning and that the staff that assisted her in the morning had not asked if she wanted her food reheated. *She ate her meals in her room. *She stated that staff had in the past forgotten to bring her a lunch tray. That had happened at least twice and as recently as a couple of days ago. *She was not asked what her food preferences were for lunch that day. *There was no menu sheet in her room to have made her preferences known. 7. Interview on 12/6/23 at 11.36 a.m. food service worker L revealed: *Dietary staff depend on the CNAs to inform the dietary staff of which residents would be eating in their rooms for each scheduled meal service. *If the CNA did not let dietary staff know or pull the resident's dietary card, dietary staff would not know that a room tray would need to have been prepared for that resident. *The facility did not have a resident list available for the dining room staff to document which residents had received their meals and which	F 561		

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F 561	Continued From page 4 residents had not. 8. Interview on 12/6/23 1:21 p.m. with CNA K revealed: *All residents were given a printout of the week's meals. *Residents would circle their food preferences or write in what they would like to eat. *The sheets would be collected by the CNA and put on the counter next to the resident dietary cards in the dining room. *When asked what they would do for a resident who does not fill out a card, CNA K stated that they would assume "they do not care" what they get to eat. *There was no process to follow up with residents that had not completed the menu sheet. *When asked about resident 37 who was not offered a choice and had no menu in his room, CNA K stated that resident 37's wife would clean his room and might have thrown the menu away. 9. Interview on 12/6/23 at 4:30 a.m. with dietary regional director of operations M and director of dining services N revealed: -They had no formal process in writing to ensure resident's room trays were not missed. -Dietary staff were working on a process to ensure every resident had a dietary card. -Dietary management staff were currently evaluating that process. 10. Interview on 12/7/23 at 9:30 p.m. with Administrator B revealed: *The administrator performed weekly audits of the resident's dietary cards to ensure all the residents had one. *The facility had a process for using the dietary cards to ensure each resident received a meal	F 561		

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F 561	Continued From page 5 tray. *When asked about who was responsible for printing and providing residents with weekly menus to ensure their preferences were known, the administrator stated it was the dietary managers responsibility. *The facility had recently switched to a new contracted company to provide food services to the residents. *The facility had been in a transitional period and were trying to get back to the facility's previous practices regarding the delivery of menus to the residents. Review of facilities resident's rights booklet stated: *"The resident has the right to, and the facility must promote and facilitate resident self-determination through support of resident choice." *"The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident."	F 561		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 583	1. Resident 405 no longer resides in the facility. RN G and RN F was re-educated by clinical care leader at the time concern was identified. 2. All residents have the potential to be affected by this deficient practice. 3. To ensure the deficient practice does not recur, Director of Nursing or Designee will educate all charge nurses and medication aides confidentiality per policy by	01/03/2024

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F 583	Continued From page 6 §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure the privacy and confidentiality of resident electronic health records had been maintained by two of two observed registered nurses (RN) (F and G). Findings include: 1. Observation and interview with registered nurse (RN) F on 12/04/23 at 1:54 p.m. through 2:05 p.m. of a medication (med) cart in the 800 hallway of the rehab wing revealed the computer on top of the med cart was open. *The medication computer screen was facing the hallway and was opened to a resident's medication administration record. *The unattended computer screen was visible to	F 583	1/3/2024 via in-service , if employee is not able to attend in-service then via phone call or quiz prior to next shift. During morning rounding, nurse leadership or designee will observe laptops to ensure practices are being followed, if they are not action will be taken to correct. 4. To monitor performance and ensure ongoing compliance the Infection Prevention Specialist or designee will audit all medication carts on various shifts for computer screen closure when not in use and/or staff member present weekly x4, every other week x2, monthly x1 and quarterly x1. The results of those audit findings will be brought to the QAPI Committee meeting by the Director of Nursing or designee for review and revision as warranted for three months.	

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F 583	Continued From page 7 any resident, staff, or visitors who would have been passing by the med cart. *The computer screen contained the following information: -The resident's (405) name. -The resident's room location. -The resident's picture. *RN F had come around the corner of the nursing station, saw the screen open and then turned the screen off. *He admitted that he should not have left the screen unlocked with resident information visible. *He stated the computer screen normally goes black after a minute or so. Observation and interview with RN G on 12/04/23 from 4:45 p.m. through 4:51 p.m. of a med cart in the 700 hallway of the rehab wing revealed: *The computer on top of the med cart in front of the nursing station was opened. *The medication computer screen was opened to a resident's medication administration record. *The unattended computer screen was visible to any resident, staff, or visitors that would have been passing by the med cart. *The computer screen contained the following information: -The resident's name. -The resident's room location. -The resident's picture. *RN G came out of a resident's room saw the computer screen was still visible with the resident's information on it and then locked the screen. *RN G stated she had forgot to turn the screen off and she would not normally forget to do that. *She admitted that she should not have left the computer screen unlocked with resident information visible.	F 583		

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F 583	Continued From page 8 Interview on 12/06/23 at 4:17 p.m. and again 12/07/23 8:57 a.m. with RN/clinical care leader H regarding the above observations revealed: *She expected the staff to black out and lock the medication cart computer screen when the nurse's had walked away from the med cart. Interview on 12/07/23 at 9:27 a.m. with director of nursing C about the above observations revealed: *She would have expected all nurses to have locked the medication computer screen prior to leaving the med cart unattended. *Agreed that when staff had not locked the computer screen when it was unattended the resident's personal information could have been viewed by anyone walking past the med cart. Review of provider's June 2021 Confidentiality policy revealed: *"Policy." -"Confidential information means business strategies, protected health information, medical records, patient lists and patient contact information, peer review records, employee data and salary information, financial data, strategic and business plans, computer programs, market research, market plans, and all other sensitive business information of actual or potential economic value that is subject to reasonable efforts to maintain its secrecy as part of normal operations." *"Procedure." _"Access to patient medical records will be limited to staff involved in the care and treatment of patient and to those conducting other legitimate healthcare operations such as quality reviews, compliance audits, accreditation	F 583		

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F 583	Continued From page 9 activities, etc." -"not to be posted or left in areas where others (visitors, patients, employees) who do not "Need to Know" the information may see it."	F 583		
F 686 SS=G	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: Based on interview, observation, record review, and policy review, the provider failed to ensure interventions were consistently implemented for two of two sampled resident (38 and 83) who developed a pressure ulcer. Finding include: 1. Telephone interview on 12/05/23 at 3:23 p.m. with resident 83's family member revealed: *The family member was concerned that the resident smelled of urine when they would visit and felt that he was not being checked and changed when he was incontinent. *The family member stated that they had voiced their concerns regarding that at the residents care conferences.	F 686	1. Documentation for resident 38 was updated to include repositioning at time it was identified missing. Consistent interventions for resident 83 include air mattress, roho cushion in wheelchair, heel boots and being offered supplements and repositioning. 2. By 1/3/2024, Director of Nursing or designee will review Braden scales for all resident- care plans will be reviewed and updated if necessary for those who trigger as high risk. 3. To ensure the deficient practice does not recur, Director of Nursing or Designee will educate all MDS Coordinators on pressure ulcer prevention per policy by 1/3/2024 via in-service. Process change will be the MDS Coordinators will be responsible completing the Braden scale and updating interventions per policy. Director of Nursing or Designee will also educate all nursing staff on repositioning and documentation per policy by 1/3/2024 via in-service, if employee is not able to attend in-service then	01/03/2024

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F 686	Continued From page 10 Interview on 12/6/23 at 7:30 a.m. with registered nurse (RN) manager I and RN J revealed: *Resident had an unstageable pressure ulcer on his left (L) heel that was originally identified in December 2022 during a routine skin check. *Resident had peripheral vascular disease that had made the healing of the pressure ulcer on the heel more difficult. *The resident had a stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with red or pink wound bed or may appear as an intact or open/ruptured blister) pressure ulcer to his buttock that was identified on May 2, 2023, that had since healed. *Interventions were put in place for the resident to wear heel boots and to have been repositioned every 2 hours before the development of the pressure ulcer to his right (R) buttock. *The certified nursing assistants (CNAs) were responsible for charting when interventions such as repositioning was completed. *Nursing staff were responsible for ensuring interventions were implemented and followed through by the CNAs. Review of resident 83's 4/16/2023 Braden scale for predicting pressure ulcer risk form revealed: *The resident had a score of 14 indicating a moderate risk for skin breakdown. *Interventions documented on the Braden scale included the following: -Frequent turning with a planned schedule. -Use foam wedges for 30-degree lateral positioning. -Pressure reduction support surfaces. -Maximal remobilization. -Protect heels. -Manage moisture.	F 686	via phone call or quiz prior to next shift. 4. To monitor performance and ensure ongoing compliance the Director of Nursing or designee will audit five residents, rotating to different residents for each audit, who are high risk for pressure ulcers with care planned interventions including devices, repositioning weekly x4, every other week x2, monthly x1 and quarterly x1. Audits will include auditing various shifts, reviewing documentation and observation of repositioning. The results of those audit findings will be brought to the QAPI Committee meeting by the Director of Nursing or designee for review and revision as warranted for three months.	

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F 686	Continued From page 11 -Manage Nutrition. -Manage friction and shear. Review of resident 83's most recent care plan revealed: *He had the potential for pressure ulcer development related to incontinence of bowel and bladder and right-sided weakness evidenced by a history of vascular and pressure ulcers. *Interventions initiated on 1/14/2020 and revised on 8/7/2023 had included assisting with turning and repositioning and offering the toilet at least every 2 hours. Review of the April 2023 repositioning documentation for resident 83 revealed multiple missing documentation that the resident was not repositioned that went from 4 to 20 hours in between documentation by the CNAs for repositioning every 2 hours. Interview on 12/7/23 at 8:15 a.m. with RN manager I revealed: *The documentation for repositioning had been a challenge to ensure interventions were completed. *Nurse managers had recently identified the issue of lack of repositioning documentation by the CNAs and were auditing charts to ensure that repositioning was being documented. *CNAs were made aware of interventions through group huddles and interventions were entered into the provider's Point Click Care system under the CNA tasks. *Documentation that the pressure ulcers were unavoidable was requested but the surveyor had received no documentation before exiting the facility.	F 686		

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F 686	Continued From page 12 2. Interview on 12/4/23 at 3:11 p.m. with resident 38 revealed: *She was not able to use her arms and legs and spent most of her time in bed. *She was not able to operate the call light system provided, used her cell phone to call the facility and contact the nursing staff. -She had called the facility around 1:00 p.m. that day, but her phone call went unanswered. -She called a little later but again her phone call was not answered. -At 1:30 p.m. a CNA came by her room and she was able to get her needs addressed. --She had needed her fan moved, the window shades pulled down, and a blanket placed over her. *She felt there was not enough staff during the evening shift, night shift, and on the weekends. -She dreaded the weekends. -She had difficulty getting her teeth brushed "at night [bedtime]." --She stated four out of seven days her teeth were not brushed at bedtime. --She had brushed her teeth every morning and bedtime when she lived at home. Observations and interviews on 12/5/23 included: *From 8:11 a.m. through 8:22 a.m. she was lying on her back in bed until registered nurse (RN)/clinical care leader R and agency licensed practical nurse (LPN) S came in and repositioned her. This surveyor stepped out and then returned to resume the interview. Observation and interview on 12/5/23 at 8:22 a.m. with resident 38 revealed: *She was laying tilted to her left side with a pillow under her right side on an alternating airflow mattress.	F 686		

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F 686	Continued From page 13 *She was to have been turned and repositioned every couple of hours, including throughout the night. *She stated that she had not been repositioned at all last night and had laid flat on her back all night. Observation and interview on 12/5/23 at 11:15 a.m. with resident 38 revealed she remained laying tilted to her left side with a pillow underneath her right side. Resident 38 stated she was supposed to have been turned and repositioned every two hours but now it had been three hours later and she had not been repositioned. Review of resident 38's electronic medical record revealed: *She was a quadriplegic. *Her current care plan included: -An intervention "I have natural teeth along with an upper partial, I need total assistance with my oral cares." --An intervention to "Turn/reposition approx. [approximately] every 2 hours; try to avoid right side due to ulcer. I do refuse to reposition at times." Interview on 12/7/23 at 9:58 a.m. with RN/clinical care leader R regarding resident 38 revealed: *She had the stage four pressure ulcer on her right ischium for almost two years. -The pressure ulcer was categorized as a "chronic pressure ulcer." *Their electronic health record was having problems with the task of turning and repositioning every two hours not "pulling into the system [not recording the task]." *She was not surprised to learn resident 38 had experienced difficulties with getting her teeth	F 686		

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F 686	Continued From page 14 brushed at bedtime. Review of the provider's 2/10/2023 Pressure Ulcer policy revealed that the provider would use prevention and assessment interventions to ensure that a resident entering a location without pressure ulcers would not develop pressure ulcers unless the individual's clinical condition demonstrated that the pressure ulcer was unavoidable.	F 686		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must	F 725	1. Residents 69 and 147 were interviewed on 12/22/2023 by Administrator and they indicated their call lights have been answered timely in the past week. Residents 49 and 137 were interviewed on 12/22/2023 by Social Worker and they indicated their call lights have been answered timely in the past week. We are continuing to interview and monitor call light times for residents 14, 37, 66, 68, 75, 80, 81, 84 and 96. Resident 1's call cord is placed correctly in room but resident 1 does want her recliner moved to prevent it from hitting call cord- recliner was moved on 12/22/23. 2. All residents have the potential to be affected by this deficient practice.	01/03/2024

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F 725	Continued From page 15 designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on the initial pool process, resident council interviews, resident interviews, family interviews, call light review, meal tray delivery observation, and policy review the provider failed to ensure there were sufficient staff to provide services to maintain the well-being of each resident including: *Call lights were answered in a reasonable time frame for 13 of 28 sampled residents (14, 37, 49, 66, 68, 69, 75, 80, 81, 84, 96, 137, and 147). *Room meal trays were delivered as scheduled. *Individual resident hygiene needs for nail care for three of three sampled residents (2, 12, and 16) were met. *The call light for one of one observed sampled resident (1) was accessible at all times. 1. Observation and Interview on 12/4/23 at 1:30 p.m. with resident 84 in his room revealed: *He had been resting in bed. *He had an oxygen concentrator in the middle of his room running at 5 liters. *A nebulizer machine with a mask and tubing was sitting on his nightstand. *He used his nebulizer machine for breathing treatments. *He turned on his call light if he was having trouble breathing. *Staff did not always answer the call light timely. *He stated sometimes he waited 30 minutes to an hour for staff to answer his call light. Review of the Call Light Device activity report for resident 84 from 11/6/23 through 12/6/23 there were 16 instances where the call light wait time	F 725	3. To ensure the deficient practice does not recur, Director of Nursing or Designee will educate all nursing staff by 1/3/2024 on answering call lights in a timely manner and placing call lights within reach of residents. Outliers exceeding 15 minutes will be reviewed and discussed at morning leadership meeting. Our call system alarms to walkies. Walkies will become mandatory as part of uniform for social services, nursing and administration. Escalation system set up for call system is as follows, C.N.A.s, C.M.A.s & Charge Nurses immediately, Nurse Leadership at 10 minutes, and Administration at 15 minutes. Outliers exceeding 15 minutes will be reviewed and discussed at morning leadership meeting. By 1/02/2024 all residents will receive a choice of food preferences for meal trays served in their rooms. Activities staff will address the residents for their choice of meal and circle the option chosen. The kitchen will file the cards according to the meal and disperse the proper file with the right meal. Staff serving meals will place the meal card on each tray. The Dietary team will double check that all meal cards	

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F 725	Continued From page 16 was from 32 minutes up to 102 minutes. 2. Confidential group interview conducted on 12/5/23 at 2:00 p.m. with seven residents revealed: *Two of seven residents had issues with meals and room trays. -Room trays were not delivered promptly. -Room trays were normally delivered between 9:30 to 9:45 a.m. and it was never hot. -Today a room tray was delivered at 8:25 a.m. and the food was hot, which never happens. -Residents were told at previous resident council meetings staff were working on the food temperature issues. *Four of seven residents had issues with call lights being answered on time. -Call lights were not always answered in a timely manner. -Residents had waited up to an hour for a staff member to answer the call light. -Call lights were not answered promptly during all scheduled shifts. -At times staff had entered the resident's room and turned the call light off without addressing their needs. -Staff stated they would be back to help them but sometimes the staff had not returned to assist them. -Residents then had to turn the call light back on to call for assistance. 3. Interview on 12/5/23 at 9:27 a.m. with resident 49 revealed staff were slow to answer her call light and had waited longer that 15 minutes. She stated on the weekends it took longer to get her call light answered than during the weekdays. Interview on 12/7/23 at 10:22 a.m. with director of	F 725	have been served by checking all residents' names off the main roster sheet. This process will improve consistency of meal tray delivery at scheduled meal times. To monitor performance and ensure ongoing compliance the Administrator or designee will audit call times for residents 14, 37, 49, 66, 68, 69, 75, 80, 81, 84, 96, 137 and 147 and outliers greater than 15 minutes weekly x4, every other week x2, monthly x1 and quarterly x1. The results of those audit findings will be brought to the QAPI Committee meeting by the Administrator or designee for review and revision as warranted for three months. QAPI committee will begin reporting outlier call times at QAPI meetings- tracking trends this way. To monitor performance and ensure ongoing compliance A.) Dining director or designee will Audit options for room trays logs (3 audits/day, different dining rooms each meal) daily for 14 days, once compliance goal is met, continue audit once daily, alternating between dining areas. B.) Resident dinging interviews will be completed by dining management staff, 10	

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F 725	Continued From page 17 nursing (DON) C confirmed they had computer software issues with tasks assigned being accurately recorded. 4. Interview on 12/7/23 at 12:16 p.m. with QAPI coordinator O revealed: *For the monthly QAPI committee a report was pulled for the average call light response times. *She stated that for the last few months at the QAPI meeting, the average response time had been between five to ten minutes. -For the QAPI committee the reports were pulled by hallways. The QAPI committee had not reviewed individual call light response times by room number. -She was not aware of any response times over 30 minutes. -She stated the report was pulled for trends and stated "We haven't seen anything significant." 5 . Interview on 12/4/23 at 2:14 p.m. with resident 68 revealed: *A resident who independently mobilized in a wheelchair wandered into her room and blocked her in the bathroom. * She had to wait forty minutes for the staff to respond to the call light. Interview on 12/6/23 at 11:30 a.m. with resident 68 revealed: *She had not received the correct medications by a temporary LPN that was on duty on 11/12/23 and on 11/24/23. She had documented on her calendar the above dates. *On 11/5/23 she had written a grievance that she had not gotten her bedtime medications. CNA returned to her room and stated the nurse had already administered them to her. *After discussion regarding the missed bedtime	F 725	residents per week (alternating between meals and dining venues) for 4 weeks until substantial compliance/satisfaction is met. The results of those audit findings will be brought to the QAPI Committee meeting by the Director of Dining Services or designee for review and revision as warranted for three months.	

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F 725	Continued From page 18 medications the medication aide returned with her bedtime medications and administered them. *She stated that, "PM cares were mostly sufficient, but some staff should not be working here, there were more issues with the evening staff." 6. Interview on 12/4/23 at 2:23 p.m. with resident 96 revealed: She communicated with her IPad and wrote that she was concerned for herself when CNAs were not familiar with her and would attempt to provide care for her. 7. Interview on 12/4/23 at 4:48 p.m. with resident 14 revealed: that she was being cared for but that there were not enough staff and accidents happen when you have to wait for assistance from staff. Review of resident 14 Device Activity report from 11/6/23 to 12/7/23 revealed call light wait times from 39 minutes to 58 minutes. 8. Interview on 12/4/23 at 3:53 p.m. with resident 75 revealed: *There had been good staff that resigned, a good certified nursing assistant (CNA) had just left yesterday, because she was frightened by a resident's behavior. 9. Interview on 12/6/23 at 10:25 a.m. with CNA D revealed that she had received two days of training when she had begun her employment but stated she was okay because she had worked at the facility prior. Some staff have left because they had not received good training. 10. Interview on 12/6/23 at 10:25a.m. with D, certified nursing assistant revealed:	F 725		

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F 725	Continued From page 19 *" I received two days of training when I started here, I was okay because I was here before. Some staff have left because they did not receive good training." 11. Interview on 12/6/23 at 10:30 a.m. with RN E revealed: " Sometimes we get breaks, but if new admits or falls, sometimes that is just the way it goes, no break." 12. Interview on 12/6/23 at 1:48 p.m. with DON C revealed: *The nursing schedule was based on resident ratio and resident acuity. *She strived to staff above the bare minimum staffing. *Staff call-offs were filled by calling staff in or pulling staff from other areas of the nursing home. 13. Interview and record reviewed on 12/6/23 at 12:17 p.m. with administrator A regarding staffing revealed: *She provided documentation of each of the unit's bare minimum staffing needs. *Provided documentation with call light escalation response. 14. Review of resident 147 Device Activity report from 11/30/23 to 12/7/23 revealed call light wait times from 31 minutes to 36 minutes 15. Interview on 12/04/2023 at 2:37 p.m. with resident 66 revealed that she would wait long periods of time for staff to answer her call lights. Review of Resident 66's Device Activity Report from 11/6/2023 to 12/06/2023 revealed long call	F 725		

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F 725	Continued From page 20 light wait times from 37 minutes up to 142 minutes before the call light was answered by staff. 16. Interview on 12/4/2023 at 3:23 p.m. with resident 69 revealed that she would wait long periods of time sometimes up to an hour for her call light to be answered by nursing staff. 17. Review of resident 69's Device Activity Report from 11/6/2023 to 12/06/2023 revealed long call light wait times that went from 33 minutes up to 63 minutes before the call light was answered by staff. 18. Interview on 12/05/2023 at 2:44 p.m. with resident 37 revealed that he could wait up to an hour for staff to answer his call light. Review of Resident 37's Device Activity Report from 11/6/2023 to 12/06/2023 revealed long call light wait times from 34 minutes up to 90 minutes before the call light was answered by staff. 19. Observation on 12/5/23 at 9:28 a.m. with resident 2 in her room revealed: *She was sitting in a wheelchair in her room. She was not able to participate in the conversation. *There was an unidentified black and brown substance underneath her fingernails on her right hand. Interview at that time with LPN Q in the nurse's station revealed: *Resident 2 was receiving hospice services. *The resident was "constantly digging in her brief or her nose," so the unidentified substance was either "poop or blood." *Nail care was provided to residents on their bath days.	F 725		

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F 725	Continued From page 21 *At times, staff would write down on their paper bath schedule if nail care was provided, but not everyone had done that. Interview on 12/5/23 at 9:42 a.m. with infection preventionist P about resident nail care expectations revealed that it was her expectation for staff to perform nail care if they noticed that a resident needed their nails trimmed or cleaned. Observation and interview on 12/5/23 at 9:53 a.m. with resident 12 in his room revealed: *He showed the surveyor his nails and stated that he wanted them trimmed. *His nails were long and some of them were jagged and chipped. *There was an unidentified brown and black substance underneath his nails. *He could not recall the last time someone had helped him clip his nails. Observation and interview on 12/5/23 at 11:05 a.m. with resident 16 in his room revealed he: *Complained that his nails were "too long and dirty." *Said the last time his nails were clipped was about a month ago by his daughter. *Mentioned that he would do it himself, but his eyesight was not the best anymore. Interview on 12/7/23 at 9:21 a.m. with administrator A about nail care revealed: *Nail care was considered a "routine care" that was not necessarily documented. *She confirmed there was no documentation that nail care had been completed for residents 2, 12, and 16. *Nurses were expected to perform a weekly head-to-toe skin assessment, that would have	F 725		

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F 725	Continued From page 22 included looking at the resident's nails. *Direct care staff were expected to assist residents, or retrieve a nurse for assistance, with nail care any time it was noticed that a resident's nails were too long, jagged, or dirty. *Each resident had their personal nail brush and clippers. *It was an expectation for staff to ask a resident if they needed help with cleaning their nails if they noticed a resident's nails were dirty. *Since the previous survey, she and the leadership team started "angel rounds" where office support staff lay an eye on each resident each week. -They switched what was reviewed each week. -They reviewed residents' appearances to assess for cleanliness, clean and appropriate clothes, and whether residents were groomed per their preferences. *Neither she nor other members of the "angel rounds" had noticed or reported incomplete nail care. Review of residents 2, 12, and 16's electronic medical records confirmed there was no documentation of the last time any of those resident's nails were clipped, trimmed, or cleaned. Review of the provider's 12/4/23 "Routine Practice" policy revealed: *"Policy: Routine practices are services that are expected to be provided to all residents based on accepted, clinical guidelines and resident status and are not detailed on the care plan." *Under the "Guidelines" section: -"1. These guidelines are considered routine practice and will not be noted on care plans ... Check nail length and trim and clean on bath day	F 725		

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F 725	Continued From page 23 and as necessary." 20. Interview on 12/4/23 at 4:19 p.m. with resident 81 revealed he: *Had concerns about staffing, noting that he usually had to wait about 30 minutes for a staff person to answer the call light. *Stated, "I feel like if I get sick here, that I will die before someone comes to help me." Review of resident 81's call light "Device Activity Report" from 11/6/23 to 12/6/23 revealed: *He used his bedside call light 170 times. *There were 27 instances where the call light was answered more than 30 minutes after the call light was initiated by the resident. *More specifically, there were 8 instances of the resident having to wait over 45 minutes for care and services. -12/5/23, 124 minutes and 40 seconds. -12/4/23, 47 minutes and 38 seconds. -12/3/23, 84 minutes and 53 seconds. -12/2/23, 65 minutes and 2 seconds. -11/30/23, 67 minutes and 50 seconds. -11/26/23, 51 minutes and 18 seconds. -11/17/23, 55 minutes and 48 seconds. -11/11/23, 77 minutes and 44 seconds. *The longer wait times usually occurred around mealtimes and at bedtime. 21. Interview on 12/4/23 at 5:41 p.m. with resident 80 about staffing concerns revealed: *In her opinion, the staff were not quick. *She stated, "Sometimes no one comes. You never know if someone is going to come help or not." Review of resident 80's call light "Device Activity Report" from 11/6/23 to 12/6/23 revealed:	F 725		

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F 725	Continued From page 24 *She used her bedside call light 12 times. *There were 2 instances where the call light was answered more than 30 minutes after the call light was initiated by the resident. -12/3/23, 39 minutes and 2 seconds. -12/1/23, 35 minutes and 27 seconds. *The longer wait times usually occurred around mealtimes and at bedtime. 22. Interview on 12/5/23 at 3:22 p.m. with resident 137 and his wife revealed: *They both had concerns about staffing and having to wait a long time for staff to answer the call light. *At times, someone would answer the call light quickly and say, "I will be right back." They mentioned that on several occasions the staff member would not come back. *They have brought their concerns to the social worker before. "Things will get better for a while, but then they go back to being the same." Review of resident 137's call light "Device Activity Report" from 11/6/23 to 12/6/23 revealed: *He used his bedside call light a total of 81 times. *There were 6 instances where the call light was answered more than 30 minutes after the call light was initiated by the resident. -11/29/23, 32 minutes and 11 seconds. -11/27/23, 41 minutes and 34 seconds. -11/25/23, 34 minutes and 5 seconds. -11/14/23, 30 minutes and 18 seconds. -11/13/23, 35 minutes and 20 seconds. -11/8/23. 42 minutes and 44 seconds. *The longer wait times usually occurred around mealtimes and at bedtime. 23. Observation and interview on 12/4/23 at 3:51 p.m. with resident 1 revealed:	F 725		

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F 725	Continued From page 25 *She was lying in bed. *The call light cord was lying on the floor beside the bed. *When asked where her call light was, she was unable to find it. *Further inspection of the call light cord revealed it was not connected to the call mechanism on the wall. Observation on 12/5/23 at 9:30 a.m. in resident 1's room revealed: *She was seated in her wheelchair next to her bed. *Her eyes were closed. *The call light was attached to her right arm sweatshirt sleeve. Observation and interview on 12/5/23 at 9:35 a.m. with CNA FF revealed she: *Gathered the call light cord and untangled it from the resident's half-side-rail and another cord that was lying on the floor. *Discovered yhat the end of the call light had not been connected to the wall unit. *Checked and the call light was not activated. *Connected the call light and tested it and then the call light was activated. *Unhooked the call light and it activated. *Turned the call light off at the wall unit without connecting the end of the cord and the call light did not activate. *Agreed if the call light was not connected to the wall unit and it was shut off it would not alarm again. *Stated there was not enough room between resident 1's bed, recliner and her roommate's recliner. -It was easy for the call light to become disconnected from the wall unit.	F 725		

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F 725	Continued From page 26 *Resident 1 did use her call light, not all the time but at least once a day. *Agreed it was important for residents to have working call lights to call for assistance. Review of resident 1's device activity report from 11/6/23 at 12:00 a.m. to 12/6/23 at 11:59 p.m. revealed: *The call light had been activated on 11/28/23 at 12:35 p.m. and had not been activated again until 12/4/23 at 5:46 p.m. *The call light had been activated on 11/14/23 at 9:04 p.m. and had not been activated again until 11/24/23 at 3:31 p.m. *The call light had been activated on 11/8/23 at 12:43 p.m. and had not been activated again until 11/12/23 at 5:41 p.m. *She used the call light on a daily basis between 11/6/23 and 11/8/23, 11/12/23 and 11/14/23, and 11/24/23 and 11/28/23. Interview on 12/07/23 at 2:52 p.m. with RN/clinical care leader R revealed she: *Had not been aware of the above information. *Agreed no call light should ever be inoperable for a resident. *Would have thought staff would have checked that the call light was not only close for the resident to have used but also connected to the wall. Review of the provider's 8/1/23 Call Light - R/S (Rehabilitation/Skilled), LTC, Therapy & Rehab policy revealed: *Purposes included: -To ensure the resident always had a method of calling for assistance. -To promptly answer a resident's call light. *Procedures included:	F 725		

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F 725	Continued From page 27 -When a resident's call light was observed/heard, go to the resident's room promptly. -Respond to the request as soon as possible. Turn the call light off and inquire about the resident's request. -When leaving the room, place call light within easy reach of the resident.	F 725		
F 741 SS=E	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing non-pharmacological interventions.	F 741	1. By 1/3/2024 resident 132 no longer resides on special care unit. Residents 105 and 106 no longer reside in the facility. 2. By 1/3/2024, the other residents in special care unit will be reviewed for behaviors and staffing needs by Social Services Supervisor. 3. To ensure the deficient practice does not recur, Social Services Supervisor or Designee will educate special care unit staff how to bring concerns forward in regards to staffing and resident behaviors. Once a concern is brought forward Social Services Supervisor or designee will document and file concern. Concerns will be reviewed by IDT made up of Director of Nursing, Social Services Supervisor, Administrator and Activity Supervisor. Facility leadership will review behaviors daily and IDT will meet monthly to discuss concerns and behaviors and staffing needs on	01/03/2024

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F 741	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure sufficient staff to provide services to maintain the well-being of each resident for three of seventeen sampled residents (105,106, and 132) who resided in the special care unit (SCU). Findings include. 1. Observations and interviews on 12/4/23 at 3:07 p.m. when entering the SCU until 3:30 p.m. revealed: *Resident 132 was walking behind her wheelchair with her husband walking beside her. *Resident 105 was seated on a recliner in the living room. He had yellow and green bruising noted around his eyes, cheeks, and over his nose. He would attempt to stand and then would sit down again. He had done this repeatedly. *Resident 106 was walking around the living room, hallway, and dining area. One staff redirected him away from other residents. He was talking, but he could not be understood. He would clench his fists from time to time or hit one hand with the other. *Staff present included certified nursing assistant/medication aide (CNA/MA) BB, CNA Z, and homemaker AA. *Another unidentified CNA was present. She had stated she was on light duty due to a shoulder injury and only provided activities for the residents. *Homemaker AA stated she liked to be in SCU to help out. They needed more people to help distract and keep the residents busy. *CNA/MA BB stated there were times when a resident might require one-to-one supervision for an entire shift. There were not enough staff to	F 741	special care unit. Routine rounding will take place in special care unit to monitor. 4. To monitor performance and ensure ongoing compliance Social Services Supervisor or Designee will audit all new special care admissions and five current residents in order to ensure services are being provided to meet well-being of each resident weekly x4, every other week x2, monthly x1 and quarterly x1. The results of those audit findings will be brought to the QAPI Committee meeting by the Director of Nursing or designee for review and revision as warranted for three months.	

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F 741	Continued From page 29 always give those residents one-to-one supervision. Observations on 12/4/23 from 5:30 p.m. through 6:30 p.m. revealed: *Resident 132 was seated on the floor in front of a chair in the living room. *She was visibly agitated and would not cooperate with CNA/MA BB and CNA Z. *During that time homemaker AA and the unidentified CNA were not in the SCU. *CNA DD was there and assisted other residents in using the bathroom. *Resident 106 was walking around the living room and into the dining area. He was talking loudly and clenching his hands into fists. *Resident 105 was still seated in the recliner and attempted to stand many times. *Activity Supervisor X entered the SCU and started to set the dining tables for the evening meal. -After she completed that she assisted resident 106 on a one-to-one basis due to his agitation. *The other residents were either sitting in chairs in the living room or in the dining area. *Some of them would get up from their chair and walk to another chair and sit down. Observation on 12/5/23 at 1:30 p.m. revealed: *Resident 132 was attempting to walk by herself and staff had to assist her to prevent a fall. *Resident 106 was walking with another staff redirecting him away from other residents. He appeared agitated with his talking and hand clenching. Observation and interview on 12/7/23 at 9:30 a.m. with CNA/MA DD revealed: *CNA/MA DD was in the medication room.	F 741		

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F 741	Continued From page 30 *Residents were seated in the living room. *Christmas music was playing softly. *CNA/MA DD stated it was nice now but breakfast was really hard. She stated the residents were very wound up and there were only two staff to assist them all. *She stated with some of the resident's behaviors, some of the residents might not get the attention they need. 2. Review of resident 105's electronic medical record (EMR) revealed: *He has had episodes of verbal aggression towards other residents and visitors. *He had episodes of becoming violent towards other residents and staff. When staff intervened he would grab their hands and arms and squeeze them and even twist them at times. *Law enforcement had to be used to assist staff due to his violent episodes and he was then transferred to the hospital for evaluation and medication adjustments. 3. Review of resident 106's EMR revealed: *Many episodes of aggression to other residents and to staff. *He has had numerous medication changes. *Has been hospitalized at the Veterans Administration (VA) psychiatric ward twice due to these aggressive behaviors. Interview on 12/6/23 at 2:30 p.m. with licensed social worker W, activity supervisor X, and registered nurse/clinical care leader I revealed: *They have had weekly meetings with the VA and their geriatric psychiatric practitioners regarding resident 106. *They were aware that resident 106's behaviors have escalated and most of the time required	F 741		

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F 741	Continued From page 31 one-to-one staff. *They were not able to provide that amount of staff all the time. *The staff for the SCU was not based on the acuity of the residents.	F 741		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to ensure the medications within two of two medication carts on the rehabilitation wing were	F 761	1. No specific resident were identified. 2. All residents have the potential to be affected by this deficient practice. 3. To ensure the deficient practice does not recur, Director of Nursing or Designee will educate all charge nurses and medication aides on appropriately securing medication carts when unattended by 1/3/2024, if employee is not able to attend in-service then via phone call or quiz prior to next shift. 4. To monitor performance and ensure ongoing compliance the Director of Nursing or designee will audit all medication carts on various shifts to ensure they are locked while unattended weekly x4, every other week x2, monthly x1 and quarterly x1. The results of those audit findings will be brought to the QAPI Committee meeting by the Director of Nursing or designee for review and revision as warranted for three months.	01/03/2024

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F 761	Continued From page 32 appropriately secured when unattended. Findings include: Observation on 12/04/23 at 4:45 p.m. of one medication cart in the 700 hallway of the rehab wing and interview on 12/04/23 at 4:51 with RN G revealed: *The medication cart was unattended. *The medication cart was unlocked with random residents in the area of the cart. *RN G had come out of a resident's room and stated, "I forgot to lock the cart." *RN G stated she forgot to lock the cart and she doesn't normally forget to do that. *She admitted that she should not have left the medication cart unlocked. Observation on 12/07/23 at 8:48 a.m. of both medication carts in the 700 and 800 hallways of the rehab wing revealed: *The medication carts were unattended. *The medication carts were unlocked. *Multiple staff and resident were walking in the area of the unlocked medication cart. Interview on 12/06/23 at 4:17 p.m. and on 12/07/23 at 8:57 a.m. with RN H (unit manager) regarding the above observations revealed: *She expected the staff to lock the medication cart when they walk away from the cart. *She would conduct re-education. Interview on 12/07/23 at 9:27 a.m. with DON C about the above observations revealed: *She would have expected all nurse to have locked the medication carts prior to leaving them unattended. *Agreed that the medication carts were not locked when unattended residents and staff were in the	F 761		

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F 761	Continued From page 33 area of both medication carts. *Agreed the staff would need to be re-educated about locking the medication carts when not in use.	F 761		
F 800 SS=F	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: A. Based on observation, interview, record review, and policy review, the provider failed to: *Maintain the following essential kitchen equipment in a clean and sanitary manner free from rust, dust, food crumbs, grime, and limescale buildup: -One of one dishwasher located in the main kitchen. -The top of all the steamers and ovens in the main kitchen. *Properly temp foods to prevent the spread of cross-contamination by one of one food service worker (L). *Ensure one of one food service worker (L) performed hand hygiene and changed gloves at the proper times during one of one observed lunch service. *Ensure the mechanically altered foods that were being served to residents during one of one observed lunch service were at a safe hot-holding temperature. *Ensure one of one food service worker (U) had worn a beard guard while working with food to	F 800	1. By 12/28/2023 Dining director or designee will provide a weekly menu to residents 37, 66 and 69 as well as copies of our always available menu for their choice of meal. Menu options for all residents will include available beverages to ensure beverages are served with meals. Staff identified having improper practices (handwashing/glove usage/beard guard/proper temperature taking technique/reheating of food) were educated and actions were corrected immediately to address all concerns. Cleaning of dishwasher was accomplished 12/22/23 and tops of steamers and ovens were also cleaned 12/22/23. Identified staff received education regarding location of cleaning schedules checklists on 12/22/23. Cleaning schedules for all areas will continue to be in place for staff use. 2. All residents have the potential to be affected by the deficient practice. Corrective action/training will be addressed with all staff members. Dining Services will re-	01/04/2024

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F 800	Continued From page 34 prevent the physical contamination of food. Findings include: 1. Observation and interview on 12/4/23 at 1:53 p.m. in the main kitchen revealed: *Food service workers (FSW) L and V were washing dishes at the time of the observation. *The dishwasher had what appeared to have been a large rust stain, limescale buildup, and an unidentified brown crusty substance on top of the machine. *There was a thick layer of grime and limescale buildup on the inside door of the dishwasher. *FSW L said that he cleaned the dishwasher every shift that he was scheduled. He would take it apart, spray down the inside, clean the parts, and replace them afterward. *Neither one was aware if there was a cleaning schedule or checklist. They were not sure of when the dishwasher was last de-limed. Interview on 12/4/23 at 2:30 p.m. with cook Y about their kitchen cleaning practices revealed: *There was a cleaning schedule that was posted outside the manager's office. *They developed a more comprehensive cleaning schedule within the past couple of months. *He was primarily responsible for keeping up with the cleaning schedule. Observations throughout the initial kitchen walkthrough on 12/4/23 from 1:53 p.m. to 2:30 p.m. revealed: *There was a layer of dust, grease, and food particles that was covering the top of all the ovens and steamers in the kitchen. Continued observations in the main kitchen on 12/6/23 at 11:04 a.m. revealed the equipment	F 800	train dietary staff utilizing Morrison Living training materials, as well as on-the-job visual training. New staff will have the same comprehensive training upon onboarding, and all staff will revisit the protocol twice within the year minimum. Training topics will include, but are not limited to, proper glove use, hand washing, beard guard use, food temperature taking and reheating, dining service standards and meal options for room trays. Dining services Director or designee will be responsible for auditing staff members to ensure compliance with federal and state regulations. By 1/04/24, Dining Service Director or designee will in-service 100% dining staff, if staff not able to attend, a 1:1 phone or quiz on proper temperature taking and reheating of food, handwashing, glove usage, beard guards, prompt beverage service, and meal options for room trays will be completed. By 1/04/24, DSD or designee will train Dishwashers on cleaning dish machine and Cooks on cleaning of the steamer and ovens. Starting 12/27/23, dining services will institute "Compass	

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F 800	Continued From page 35 was in the same condition as it was on the 12/4/23 observation. Review of the provider's "Production Staff Cleaning Schedule" for November and December 2023 revealed: *The dish machine was to have been cleaned weekly. Staff were to "Delime and clean unit thoroughly inside and out. Polish outside." -There was no documentation to indicate that the dishwasher had been cleaned or de-limed in November or December. *There were five convection ovens, one gas oven, and one steamer listed on the cleaning schedule that were to have been cleaned weekly. *For the ovens, the schedule indicated "Clean oven racks. Thoroughly clean interior. Thoroughly clean exterior." -Convection oven #1 was cleaned the first week in November and had not been cleaned since. -Convection oven #2 was cleaned the first, third, and fourth week in November and had not been cleaned since. -Convection oven #3 was cleaned the second week in November and the first week in December. -Convection oven #4 was cleaned the third week in November and the first week in December. -Convection over #5 was cleaned the first and fourth week in November and had not been cleaned since. -There was no documentation that the gas oven had been cleaned in November or December. *For the steamer, the schedule indicated "Thoroughly clean ... All items should be cleaned after each use, take apart and clean thoroughly as scheduled." -The steamer was cleaned the first and second week in November and had not been cleaned	F 800	Group Food Safety and QA Program" providing weekly training topics on on-going basis. 3. To ensure deficient practice will not recur, Dining Services Director or designee will audit compliance of food temp logs, handwashing, glove usage, and beard guard usage, prompt beverage service and resident meal selections for room trays as follows: 4. Dining services Director or designee will monitor performance and ensure ongoing compliance, the following will occur: A). Auditing compliance of food temp log documentation, procedure, and task completion will occur weekly x4, every other week x2, monthly x1, and quarterly x1 for day and evening shifts. B). Auditing compliance of handwashing, glove usage, and beard guard procedure use will occur weekly x4, every other week x2, monthly x1, and quarterly x1 for day and evening shifts. C). Auditing of prompt beverage service during meals and of meal options provided for room trays will occur weekly x4, every other week x2, monthly x1, and quarterly x1 for day and evening	

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F 800	Continued From page 36 since. 2. Observation on 12/6/23 of the lunch meal service from 11:32 a.m. to 1:26 p.m. in the Friendship dining room revealed: *By 11:40 a.m., the food designated for the Friendship dining room was loaded into a thermal cart. *FSW L left the kitchen with the cart at 11:46 a.m. *He arrived at the Friendship dining room kitchenette at 11:48 a.m. The hot-holding wells and plate warmers were already turned on. *At 11:52 a.m., FSW L started loading the pans of food into the hot-holding wells. *He put on gloves without performing hand hygiene. *He started to temp the food at 12:03 p.m. -The menu for lunch was beef brisket or ham with pineapple, scalloped potatoes, green beans, and a butterscotch pudding dessert. *He used two different food thermometers. There were plenty of single-use thermometer probe wipes available. He did not sanitize either thermometer before placing the probes into the resident's food. *He removed thermometer #1 from its sheath and placed it into the beef without cleaning the probe first. *He removed thermometer #2 from its sheath and placed it into the green beans without cleaning the probe first. *He cleaned thermometer #1 with a single-use probe wipe. He used the same probe wipe to clean thermometer #2. *He put thermometer #2 into the ham with pineapple. *He went to grab another thermometer probe wipe and dropped the package on the floor. He grabbed the package off the floor and continued	F 800	shifts. . D). Food Safety and Sanitation Quick Pulse Audit, which will include a review of food storage, food handling, preparation and work areas, cleanliness and infection control compliance, will occur weekly x4, every other week x2, monthly x1, and quarterly x1. E). Auditing of cleaning schedule and task completion will occur weekly x4, every other week x2, monthly x1, and quarterly x1. Dining Services Director or designee will report audit findings to QAPI committee for review and revisions as warranted for three months.	

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F 800	Continued From page 37 without changing gloves, performing hand hygiene, or throwing that package away. *He used that probe wipe from the package that was dropped on the floor to clean thermometer #1 and placed the probe into a pan of cheeseburgers. *He used that same probe wipe for thermometer #2 and placed that probe into the pan of "small and bite-sized" mechanically altered vegetables. *He used that same probe wipe for thermometer #1 and placed that probe into the pan of "minced and moist" mechanically altered beef. *He used that same probe wipe for thermometer #2 and placed it into the "minced and moist" mechanically altered vegetables. *He used that same probe wipe for thermometer #2 and placed it into the pan of "pureed" mechanically altered vegetables. -FSW L said that the pureed vegetables were not up to the required minimum holding temperature of 135 degrees Fahrenheit. -He suggested dropping the pan down into the hot water of the hot-holding wells. Director of dining service (DDS) N said that was not a proper way to bring the temperature back to an acceptable level. -DDS N took that pan of pureed vegetables back to the kitchen to heat it to an appropriate temperature. *FSW L used that same probe wipe for thermometer #2 and placed the probe into the "minced and moist" mechanically altered beef. -The beef was temped below the required hot-holding temperature of 135 degrees Fahrenheit. -He turned the hot-holding wells back up to "high" and indicated that would help. -He took no further action to ensure the mechanically altered beef was brought to the	F 800		

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F 800	Continued From page 38	F 800		

appropriate temperature before it was served to the residents.
*At 12:29 p.m., he removed the aluminum foil covers from all the pans of food. He pushed the aluminum foil down into the trash can and wheeled the trash can out of his walkway. His gloved hands touched the trash can liner and the sides of the trash can. He did not change his gloves or perform hand hygiene before he started to plate the food.
-The only time FSW L put on a new glove was when DDS N asked him to change his gloves. He pulled a glove from his pocket and changed only the right glove without performing hand hygiene.
*FSW L wore those same gloves throughout the entire meal service.
-During the meal service, he touched the drawer handles, cupboard door handles, and fridge door handles. He did not change gloves or perform hand hygiene.
-To prepare a plate of food for a resident, he would use his gloved hand to grab a stack of plates from the plate warmer. His thumbs would touch the top side of the plate where the resident's food was placed, which potentially contaminated the plates and the subsequent food that was placed on the plates.

Interview on 12/6/23 at 1:48 p.m. with FSW L about the above observation revealed:
*He confirmed he did not reheat the mechanically altered food back to an appropriate temperature. He justified his actions by him turning the hot-holding wells to their highest temperature position.
*When temping foods, he said he only used a probe wipe once before throwing it away. He did not have any comments about the above observations of him reusing one probe wipe

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 800	Continued From page 39 multiple times. *When asked about his glove use, he justified his actions by indicating that there was nothing in the trash can when he put the aluminum foil in there. *He was not aware that he did not need to wear gloves when serving food if every food item had an individual serving utensil. Interview on 12/7/23 at 10:16 a.m. with administrator A, the food service company's regional director of operations M, executive chef T, and director of dining service N revealed: *Executive chef T indicated that it was his expectation for staff to bring food back to the kitchen if the food was not at 135 degrees Fahrenheit or above. -If the food was not at the minimum required temperature, the safe practice was to heat it back to at least 165 degrees Fahrenheit for 15 seconds. *They confirmed that FSW L should have taken all the food that was not up to the appropriate temperature back to the kitchen to heat it to the proper temperature. *They also confirmed that the thermometer probe wipes were one-time-use only and should not have been reused multiple times. *Executive chef T stated that to his knowledge, staff were to wear gloves when serving food. He was not aware that gloves were not needed if each food item had an individual serving utensil. Review of the provider's January 2023 "Meal/Tray Assembly Procedures" policy revealed: *"Policies: Meal service is prompt and accurate, to ensure temperatures and nutrient content of food is preserved." *"Procedures: ...Records temperatures no more than 30 minutes prior to meal service."	F 800		

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F 800	Continued From page 40 -"If hot food is below standard, it must be reheated up to 165 [degrees Fahrenheit] for a minimum of 15 seconds." Review of the provider's January 2023 "Meal Quality and Temperature" policy revealed: *"Policies: Food and drinks are palatable, attractive, and served at a safe and appetizing temperature to ensure resident satisfaction and to meet nutrition and hydration needs." *"Procedures: -Kitchen: ...Menu items will have the temperature measured using an accurate thermometer and documented on the log. --Thermometers are cleaned and sanitized before use, between food items, and after use with approved sanitizer wipes or solutions. --If hot or cold food temperatures do not meet standards, corrective actions are implemented and documented on log. --All replacement pans will have the food temperature measured before serving. -Dining Room/Pantry: --If temperatures are not optimal at the receiving location, corrective action is taken and documented on the taste and temperature log. --Record temperatures before using replacement pan." Review of the provider's January 2023 "Hand Hygiene" policy revealed: *"Policies: In the Food & Nutrition Services Department: All associates associated with the handling of food shall wash hands. Hands are washed with soap and water at the following times: - ...Before putting on gloves. After handling garbage. After removing gloves."	F 800		

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F 800	Continued From page 41 Review of the provider's February 2023 "Food Handling Guidelines [Hazard Analysis Critical Control Points]" policy revealed: *"Procedures: Contamination Precautions" -"Hands should be scrubbed following appropriate hand washing techniques according to facility/community policy (e.g., ...before putting on gloves ...)." -"Use clean sanitized equipment and food contact surfaces ...for each task." -"Single use disposable gloves are worn when preparing foods that will not be cooked again (ready-to-eat foods) and while serving food. Gloves are to be placed over clean hands. Gloves are changed between tasks or if punctured or ripped. Hands are washed after gloves are removed." *"Hot Holding Temperatures: -Foods should be held hot for service at a temperature of 135 [degrees Fahrenheit] or higher. -Hot holding devices should not be used to heat food, i.e., warmers, Bain Marie, etc. The temperature of each pan of food removed from a hot hold device should be checked prior to being placed into service." *"Reheating: -If a food that is being held hot for service falls below 135 [degrees Fahrenheit], corrective action is taken and documented ..." 3. Observation on 12/7/23 at 8:17 a.m. in the Friendship dining room revealed that FSW U was not wearing a beard guard while serving breakfast. Every other person with facial hair who was observed handling food during the survey had worn a beard guard. B. Based on observation, interview, record	F 800		

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F 800	Continued From page 42 review, and policy review, the provider failed to: *Provide four of four unidentified residents at an assisted dining table with beverages promptly for one of two meal services observed. *Serve the room trays in the 500-hallway in a timely manner. *Provide a meal option for three of three sampled residents (37, 66, and 69) who chose to eat their meal in their room. *Ensure the provided diets were palatable for residents who voiced complaints at the confidential resident council meeting, and for other residents who had voiced complaints about the food throughout the survey. Findings include: 1. Observation and interview on 12/4/23 from 5:05 p.m. to 5:27 p.m. in the main dining room revealed: *Four residents were sitting at an assisted dining table, three females and one male. -Their meals were served at that time. None of them were offered beverages. *Interview at that time with an unidentified nurse aide revealed that there was no seating chart, and she did not know the resident's names. *At 5:17 p.m., a staff member served them their choice of beverage. The male resident had already finished eating his meal by the time his beverage was served. Interview on 12/7/23 at 10:16 a.m. with administrator A, the food service company's regional director of operations M, executive chef T, and director of dining service N revealed: *It was an expectation that staff offer a beverage to residents as they came into the dining room for a meal. *Administrator A specified that for those residents	F 800		

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F 800	Continued From page 43 who sit at the assisted dining table, their beverages might be served at the same time as the meal was served to avoid accidents and spills. *It was not a normal practice to serve beverages after a resident was finished with their meal. 2. Observation and interview on 12/6/23 from 11:32 a.m. to 1:26 p.m. in the Friendship dining room and the 500-hallway revealed: *By 11:40 a.m., the food designated for the Friendship dining room was loaded up into the thermal cart. *FSW L left the kitchen with the cart of food at 11:46 a.m. *The posted time for lunch service was from 12:00 p.m. to 1:30 p.m. *FSW L arrived at the Friendship kitchenette at 11:48 a.m. and started loading the pans of food into the hot-holding wells at 11:52 a.m. -There were several residents already in the Friendship dining room by that point. *He started to temp the food at 12:03 p.m. *He started to plate the food at 12:33 p.m. *By 12:51 p.m., the last table in the dining room was served and FSW L started to plate up the room trays. *Interview at that time with FSW L revealed that he was also responsible for delivering food to the provider's other nursing homes across the city. Sometimes the meals were late because he could not get back to the facility in a timely manner. *The first room tray cart was loaded by 1:11 p.m. and a nursing staff left the dining room to deliver the meal trays to the residents in their rooms. *The second room tray cart was loaded by 1:17 p.m. and certified nurse aide (CNA) K left the dining room with the cart to deliver the meals to	F 800		

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F 800	Continued From page 44 the residents in the 500-hallway. *By 1:26 p.m., the last room tray was served. *Interview at that time with CNA K revealed that meals were usually not served this late. Interview on 12/7/23 at 10:16 a.m. with administrator A, the food service company's regional director of operations M, executive chef T, and director of dining service N revealed: *They agreed that the lunch meal service the previous day took longer than usual. *Executive chef T mentioned that they should have pulled someone else to serve lunch in the Friendship dining room since FSW L arrived back to the facility later than expected. Refer to F725, finding 3. Review of the provider's January 2023 "Meal/Tray Assembly Procedures" policy revealed there was no description of expectations for timing of meal service or room trays. 3. Refer to F561. 4. Interview on 12/4/23 at 3:53 p.m. with resident 75 revealed: *She would have given the food service a -30 out of a 10 rating. *The food tastes terrible. *There were uncooked scrambeled eggs at times. *Some residents buy their groceries because the food served by the kitchen was not good. 5. Interview on 12/5/23 at 2:23 p.m. with resident 68 revealed: *The food was icky and was of substandard quality. *The carrots have brown spots on them and the	F 800		

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F 800	Continued From page 45 green beans have long stems. *The melons were are over ripe. *She would depend on her family for groceries. *The weekly menu's were better but the quality of food had not improved. *Cold food items were placed on a hot plate at times. *Supper room trays would be delivered between five and six p.m.	F 800		
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 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:	F 880	**Directed Plan of Correction** **Good Samaritan Society Sioux Falls Village** **F880** **Corrective Action:** 1. For the identification of: Lack of appropriate cleaning and maintenance of: *Bi pap equipment. *Mechanical lifts *Lack of appropriate hand hygiene between tasks. **The administrator, DON, infection control nurse and/or designee in consultation with the medical director will review, revise, and create as necessary policies and procedures for the above identified areas.** **Please do read 2567 findings.** All facility staff who provide or are responsible for the above cares and services will be educated/re-	01/04/2024

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(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 46 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents 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:	F 880	educated by **1/3/23 via in-service, those not in attendance will be educated via phone or quiz prior to their next scheduled shift. Education for the nursing Department will be completed by Infection Prevention Nurse/Director of Nursing or Designee, and include CPAP/BiPAP cleaning schedules, proper hand hygiene per policy and mechanical lift cleaning per policy. The housekeeping department will also be educated completed by Administrator or Designee, this will include mechanical lift cleaning education per policy.** **Identification of Others:** 2. Individual residents and other residents have potential to be impacted when resident care equipment is not appropriately maintained, and hand hygiene is not done. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by **1/2/23 via in-service, those not in attendance will be educated via phone or quiz prior to their next**	

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 12/07/2023

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 880	Continued From page 47 Based on observation, interview, and policy review, the provider failed to ensure that infection control practices were maintained for the following: *One of one sampled resident's (26) Bilevel Positive Airway Pressure (BiPAP) machine was cleaned on a regular basis according to the policy. *One of one certified nurse aide (CNA) (EE) had not cleaned or sanitized a resident mechanical stand aide machine in between resident use. *One of one CNA (EE) had performed hand hygiene after personal care was provided and before assisting one of one sampled resident (12) with putting his nasal cannula back on. Findings include: 1. Observation and interview on 12/5/23 at 8:38 a.m. with resident 26 in his room revealed: *There was a BiPAP machine sitting on his overbed table. *He indicated that he had not cleaned the machine, and he was not sure if the staff had ever cleaned the machine. *There was a buildup of moisture, a thick white substance that appeared to have been mucus, and flakes of an unknown white substance that appeared to have been flakes of skin on the inside of the mask. *The mask was zip-tied to the hose. Interview on 12/7/23 at 9:41 a.m. with CNA GG and CNA EE about resident 26's BiPAP machine revealed: *Neither of them had ever cleaned his mask, the reservoir, or the tubing. *They said that either the night shift performed that task, or maybe one of the nurses was responsible for completing that task.	F 880	**scheduled shift by Director of Nursing or designee.** **System Changes:** 3. Root cause analysis conducted answered the 5 Whys: staff involved were agency staff member which leads facility to believe there were gaps in the knowledge on facility specific infection control policy and procedure. Facility also believes there is a breakdown in communicating supply needs to our purchasing specialist. Facility purchasing specialist or designee will formally track CPAP/BiPAP machines in the facility. The facility will increase the number of hand hygiene audits/observations. Facility will continue with more frequent audits of lift cleaning and CPAP cleaning. Checklist will be initiated for nursing order checklist to include CPAP and BiPAP cleaning per manufactures recommendations. Re-education 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.	

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F 880	Continued From page 48 Interview on 12/7/23 at 12:42 p.m. with registered nurse and clinical care leader I about resident 26's BiPAP mask revealed: *There was supposed to have been a nursing order to clean his mask twice weekly, but she had missed adding that order to the resident's treatment administration record. -She entered a nursing order into his electronic medical record that morning to clean his machine twice per week after it had been brought to her attention by the surveyor. *She confirmed that there was no documentation to show that they had been cleaning his BiPAP machine. *She suspected that his BiPAP machine had not been cleaned or maintained at all during his stay at the facility. Review of resident 26's active orders revealed there was an order entered on 12/7/23 at 11:39 a.m. for "Nursing Order: CPAP/BIPAP Cleaning 2x/week. See policy for cleaning instructions," which was scheduled to have been completed during the day shift on Wednesdays and Sundays. Review of the provider's 10/30/23 "Non-Invasive Respiratory Support" policy revealed: *"Procedure: -System Checkout: 1. Inspect the device and be sure the enclosure is not broken, and all components are secure." *The policy had not specified how often the BiPAP machine and its components (mask, hose, water reservoir) should have been cleaned or replaced. Review of the user guide for resident 26's BiPAP	F 880	**Director of Nursing** contacted the South Dakota Quality Improvement Organization (QIO on **12/21/23)** and included discussions on enhancing compliance with infection control items such as hand hygiene, lift cleaning, and CPAP cleaning. Resources were requested from the QIN on better teaching strategies.	

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F 880	Continued From page 49 machine revealed: *Only pages 8, 9, and 10 were provided. *On page 8, there was a warning which read, "Regularly clean your tubing assembly, humidifier and mask to receive optimal therapy and to prevent the growth of germs that can adversely affect your health." *Page 9: -"Cleaning: You should clean the device weekly as described. Refer to the mask user guide for detailed instructions on cleaning your mask." -"Notes: Empty the humidifier daily and wipe it thoroughly with a clean, disposable cloth. Allow to dry out of direct sunlight and/or heat." *The "mask user guide" was not included on pages 8, 9, or 10. The provider only gave the surveyor that portion of the BiPAP machine user guide and had not provided a copy of the entire document as requested. 2. Observation and interview on 12/5/23 from 9:46 a.m. to 10:17 a.m. on the 300-hallway revealed: *At 9:46 a.m., CNA EE brought a mechanical stand aide lift into the hallway from resident 2's room. -CNA EE did not clean the machine. -There was a bag attached to the machine with a container of purple-top sanitizer wipes available. *At 9:53 a.m., resident 12 initiated his call light to request assistance with transferring from his wheelchair to his recliner. *At 10:06 a.m., CNA EE responded to resident 12's call light and brought the mechanical stand aide lift into his room without first sanitizing it. *She performed hand hygiene and put on a pair of clean gloves. *While resident 12 was standing with the help of the mechanical lift, CNA EE asked if she could	F 880		

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F 880	Continued From page 50 check his incontinence brief before helping him into his recliner. Resident 12 agreed. -CNA EE proceeded to pull at the brief to look inside to see if it was soiled or not. *She found that he did not need to be changed and proceeded to help resident 12 sit down in his recliner. *She removed the gloves and without performing hand hygiene, she assisted resident 12 with placing his nasal cannula back into his nostrils. Interview on 12/5/23 at 10:17 a.m. with CNA EE in the nurse's station revealed: *The mechanical lifts should have been cleaned in between each resident. *She confirmed that she had not cleaned the lift when she should have. *She was able to list the moments of hand hygiene and confirmed that she should have sanitized her hands before helping resident 12 with his nasal cannula. Interview on 12/5/34 at 4:15 p.m. with director of nursing C and infection preventionist P about the above observation revealed: *When training and retraining staff, they teach about "moments" of hand hygiene. *It was their expectation for staff to clean and sanitize the mechanical lifts in between each resident use, and to perform hand hygiene before putting on gloves and after removing gloves. *They agreed that CNA EE should have cleaned the lift in between using it for residents 2 and 12, and she should have sanitized her hands before assisting resident 12 with his nasal cannula. Review of the provider's undated "Safe Resident Handling Program Resource Packet" revealed: *Only page 8 of 43 was provided.	F 880		

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F 880	Continued From page 51 *Under the section "All Nursing Department employee's responsibilities include:" -"Follows infection control practice to clean lists after each use." Review of the provider's 3/29/22 "Hand Hygiene-Enterprise" policy revealed: *Under the "Policy" section: -"All employees are responsible for maintaining adequate hand hygiene by adhering to specific infection control practices." -"All employees in patient care areas ...will adhere to the 4 Moments of Hand Hygiene and 2 Zones of Hand Hygiene. 1. Entering Room 2. Before Clean Task 3. After Bodily Fluid/Glove Removal 4. Exiting Room 5. Zones: Patient zone and Health-care zone" -"Gloves are a protective barrier for the [healthcare worker] according to standard precautions. ...2. Hand hygiene should be performed after glove removal." *Under the "Procedure" section: -"[Healthcare worker] will use waterless alcohol-based hand sanitizer or soap and water to clean their hands: -- ...After removing gloves regardless of task completed -- ...When moving from contaminated body site to a clean body site during patient care --When entering healthcare zone (supply drawers, linen drawers or cupboards)" *"Lotion use, glove use, and fingernail care are important aspects of hand hygiene. - ...Glove use: Gloves should be utilized whenever contact with blood, body fluid or other potentially infectious matter is present, contact	F 880		

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F 880	Continued From page 52 with non-intact skin or as part of transmission based precautions, and when using chemicals during cleaning activities. Change gloves when moving from a dirty to a clean or sterile activity performing hand hygiene in between changing gloves ... Hand hygiene must be performed after removal regardless of task."	F 880		

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

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 12/4/23 through 12/7/23. Good Samaritan Society Sioux Falls Village was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Bullum
TITLE: Administrator
(X6) DATE: 01/03/2024

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

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	435045	A. BUILDING 01 - SIOUX FALLS GOOD SAMARITAN VILLAGE B. WING _____	12/05/2023

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 12/5/23. Good Samaritan Society Sioux Falls Village 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 and the Fire Safety Evaluation System (FSES) dated 12/7/23. Please mark an F in the completion date column for K 252 deficiencies identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K223, K321, and K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 223 SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and	K 223	K223 Door with Self-Closing Devices It is the policy of the facility to maintain self-closing doors in safe working order. Corrective Action will include: 1. The Manager of Ancillary Services and/or designee will conduct door	1/4/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Ballwin — TITLE: Administrator — (X6) DATE: 12/28/2023

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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K 223	Continued From page 1 * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain the required corridor separations in four locations (at smoke separations in the nursing home, at Cell's dining room, between the restorative unit and the nursing home, and by room 521. Findings include: 1. Observation on 12/5/23 at 9:15 a.m. revealed the cross-corridor smoke separation doors were not fully closing, and had a gap greater than 1/2-inch. Interview with the director of facilities at the time of the observation confirmed that condition. There was a current project with a contractor repairing the doors. 2. Observation on 12/5/23 at 10:12 a.m. revealed the Cell's dining room had a pair of doors equipped with a coordinator that was not functioning properly. The doors would not close. Interview with the director of facilities at the time of the observation confirmed that condition. 3. Observation on 12/5/23 at 11:40 a.m. revealed the pair of doors separating the restorative unit from the nursing unit did not close properly and had greater than 3/4-inch gap. Interview with the director of facilities at the time of the observation confirmed that condition. 4. Observation on 12/5/23 at 11:50 a.m. revealed the bottom latches of the pair of doors adjacent to room 521 had been removed. Interview with the director of facilities at the time of the observation	K 223	inspection performed per NFPA requirements. 2. All egress doors identified as not meeting this requirement will be repaired by listed dates below. a) The cross-corridor smoke separation doors will be replaced/repaired by 01/4/24. b) The Sells dining room will be repaired by 1/4/24. c) The pair of doors separating the rehab unit from the nursing unit will be repaired by 01/4/24. d) The doors adjacent to room 521 will be repaired by 1/4/2024. Assurance of On-Going Compliance 1. The Manager of Ancillary Services and/or designee will ensure doors with self-closing devices are inspected and maintained in accordance with NFPA Code. 2. The facility safety committee will review and oversee documentation that shows egress inspections are maintained and completed.	

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K 223	Continued From page 2 confirmed that condition. The deficiency had the potential to affect 100% of the smoke compartment occupants.	K 223		
K 252 SS=C	Number of Exits - Corridors CFR(s): NFPA 101 Number of Exits - Corridors Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4 This REQUIREMENT is not met as evidenced by: Based on observation and record review, the provider failed to maintain two conforming exits from the basement. Findings include: 1. Observation on 12/5/23 at 11:15 a.m. revealed the basement level was not provided with two conforming exits. One exit was through the boiler room (hazardous area), and the other discharged into the main level kitchen area. Review of previous survey data confirmed those conditions. This deficiency would affect a small number of maintenance staff. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K 252		F
K 321	Hazardous Areas - Enclosure	K 321	K321 NFPA 101 Hazardous Areas - Enclosures It is the policy of the facility to maintain hazardous areas smoke barriers within hazardous areas enclosures. Corrective Action will include: 1. The Manager of Ancillary Services and/or designee will routine inspect hazardous areas to meet requirements. 2. All area identified as not meeting this requirement will be repaired by listed dates below.	1/4/2024

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K 321 SS=E	Continued From page 3 CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain four separate hazardous areas (a new storage room created in the main dining room, housekeeping storage room, basement elevator opening, and rehabilitation unit boiler room) as required. Findings include:	K 321	a. The storage area in the main dining room has had combustible storage items removed and is no longer available for combustible item storage. Completed 01/04/2024. b. A door closer has been installed on the housekeeping storage room door. Completed 01/04/2024. c. The wooden board has been removed from the elevator shaft 12/21/2023. d. The rehab unit boiler room door will be replaced with a rated door by 4/7/2024 per extension approved by Jim Bailey, SD Department of Health. Assurance of On-Going Compliance 1. The Manager of Ancillary Services and/or designee will conduct inspections to ensure hazardous areas meet this requirement and as identified in our preventative maintenance program.	

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(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 321	Continued From page 4 1. Observation on 12/5/23 at 10:15 a.m. revealed a storage room had been created in the main dining room from cubicle partitions that were over 100 square feet, contained combustible items and did not maintain the hazardous area separation. a. The storage area started as a place for COVID protective equipment. b. The storage area now has a second section for kitchen equipment and paper goods storage. c. The storage area is also adjacent to three office areas, which were also created with cubicle partitions. 2. Observation on 12/5/23 at 10:45 a.m. revealed a housekeeping storage room was greater than 100 square feet, did not have a door closer functioning, had a 1.25-inch hole through the door, and contained flammable liquids. 3. Observation on 12/5/23 at 11:15 a.m. revealed the elevator shaft opening at the basement level was partially covered with flammable particle board. 4. Observation on 12/5/23 at 11:25 a.m. revealed the door to the rehabilitation unit boiler room was not a rated door. Interview with the facilities director at the time of the observations confirmed those findings. The deficiency affected four of numerous requirements for hazardous rooms.	K 321		
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING 01 - SIOUX FALLS GOOD SAMARITAN VILLAGE B. WING _____	12/05/2023

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GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

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K 918	Continued From page 5 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to document the generator battery conductivity monthly (no documentation for	K 918	K918 Electrical Systems – Essential Electrical Systems It is the policy of the facility to perform Weekly, Monthly and Annual Emergency Generators Inspections and Testing to assure Essential Electrical Systems "Emergency Generators" are tested in accordance with NFPA standards and requirements. Corrective action will include: 1. Durning monthly testing of the generator, conductivity testing will be performed and recorded on the generator batteries. Assurance of On-Going Compliance 1. The Manager of Ancillary Services and/or designee will conduct and assure emergency generator tests are performed to meet NFPA standards and requirements and that all testing is properly documented. 2. The facilities preventative maintenance program will be updated to include the required	1/4/2024

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K 918	Continued From page 6 2023). Findings include: 1. Record review on 12/5/23 at 2:15 p.m. revealed there was no documentation of the battery conductivity in the monthly maintenance logs for the generator for the calendar year 2023. Interview with the facility director at 4:15 p.m. on 12/5/23 revealed the generator had a maintenance-free battery installed and it could not be tested for specific gravity. He stated he had purchased a tester, and believed the maintenance staff were testing the batteries. The deficiency affected 100% of the building occupants.	K 918	field of battery conductivity testing. Completed 12/21/2023	

South Dakota Department of Health

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	10680	A. BUILDING: _____ B. WING _____	12/07/2023

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GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION ROAD SIOUX FALLS, SD 57106

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 12/4/23 through 12/7/23. Good Samaritan Society Sioux Falls Village was found not in compliance with the following requirement: S253.	S 000		
S 253	44:73:04:14 Memory Care Units Each facility with memory care units shall comply with the following provisions: (1) Each physician's, physician assistant's, or nurse practitioner's order for confinement that includes medical symptoms that warrant seclusion or placement shall be documented in the resident's chart and shall be reviewed periodically by the physician, physician assistant, or nurse practitioner; (2) Therapeutic programming shall be provided and shall be documented in the overall plan of care; (3) Confinement may not be used as a punishment or for the convenience of the staff; (4) Confinement and its necessity shall be based on a comprehensive assessment of the resident's physical and cognitive and psychosocial needs, and the risks and benefits of this confinement shall be communicated to the resident's family; (5) Locked doors shall conform to Sections: 18.2.2.2 and 19.2.2.2 of NFPA 101 Life Safety Code, 2012 edition; and (6) Staff assigned to the memory care unit shall have specific training regarding the unique needs of residents in that unit. At least one caregiver shall be on duty on the memory care unit at all times. This Administrative Rule of South Dakota is not	S 253	1. By 1/3/2024 resident 132 will no longer reside in special care unit. Residents 105 and 106 no longer reside in the facility. 2. By 1/3/2024 Director of Nursing or Designee will review all residents on secured unit and ensure we obtain orders for placement in the secured unit which includes medical diagnosis or symptoms that warrant admission to the secured unit. 3. To ensure the deficient practice does not recur, Director of Nursing or Designee will educate Social Services team on Admission criteria including diagnosis and symptoms warranting placement to special care unit per policy by 1/3/2024. Physician Order Policy includes requirements for admission into special care unit including order to admit with diagnosis for placement in special care unit.	01/03/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Ballou — TITLE: Administrator — (X6) DATE: 01/03/2024

STATE FORM 6899 — CNLD11 — If continuation sheet 1

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S 253	Continued From page 1 met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure three of three sampled residents (105, 106, and 132) residing in the special care unit (SCU) had physician's orders for placement in the secured unit that included the medical diagnosis or symptoms that warranted admission to the secured unit and was reviewed periodically by the resident's primary care provider. Findings include: 1. Observations on 12/4/23 from 2:30 p.m. through 6:00 p.m., 12/5/23 from 3:30 p.m. through 5:30 p.m., 12/6/23 from 10:00 a.m. through 11:30 a.m. and 12/7/23 from 9:00 a.m. through 10:30 a.m. revealed residents 105, 106, and 132 resided in the SCU. 2. Review of resident 105's 3/28/23 physician's orders for admission included "Okay to reside in a secure unit." 3. Review of resident 106's 9/30/21 physician's orders for admission included "Admit to Special Care Unit on 9/22/21 related to Dementia." 4. Review of resident 132's 2/20/23 physician's orders for admission included "Okay for resident to reside in a secured unit." Interview on 12/7/23 at 1:30 p.m. with clinical care leader R revealed she was not aware each resident in the SCU required the primary care physician to document the reason for their admission and to review the residents diagnosis and symptoms periodically to ensure the need for placement. Review of the provider's 1/31/23 Admission Criteria-Special Care Unit policy had no	S 253	4. To monitor performance and ensure ongoing compliance the Social Services Supervisor or designee will audit new admission orders to secured unit weekly x4, every other week x2, monthly x1 and quarterly x1. The results of those audit findings will be brought to the QAPI Committee meeting by the Director of Nursing or designee and continued until the facility demonstrates sustained compliance as determined by the committee.	

South Dakota Department of Health

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S 253	Continued From page 2 information on what the physician's orders should have included for admission to the special care unit. Review of the provider's 1/31/23 Pre-Admission, Admission, and Discharge - Special Care Unit policy revealed: *If required by state regulation, a physician's order would have been obtained before a resident admission to the special care unit or the discharge of a resident from the special care unit. *Each quarter at the resident care plan meeting, residents should have been reassessed for the appropriateness of placement on the unit.	S 253		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 12/4/23 through 12/7/23. Good Samaritan Society Sioux Falls Village was found in compliance.	S 000		