| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>Surveyor: 42477<br>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 1/18/22 through 1/20/22. Good Samaritan Society Corsica was found not in compliance with the following requirements: F684, F755, F849, F880, F881 and F886. | F 000 | Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. | |
| F 684<br>SS=G | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 42477<br>Based on observation, interview, and record review, the provider failed to ensure one of fourteen sampled residents (186) received the necessary care and services to:<br>*Ensure staff had been aware of non-weightbearing orders for a newly admitted resident 186.<br>*Ensure resident 186 had not experienced pain related to transfers and cares.<br>*Ensure staff had implemented an appropriate pain rating scale for resident 186.<br>*Ensure resident 186's care plan had been updated to inform staff how to care for her needs.<br>Findings include: | F 684 | On 01/31/2022, MDS Coordinator completed a pain evaluation for resident 186 and found current interventions adequately controlled resident's pain. On 02/10/2022, Director of Nursing updated the care plan to reflect using the PAINAD scale and ensured the care plan reflected proper weight bear status.<br><br>One additional resident admitted after 01/17/2022 had the potential to be affected by the deficient practice. On 02/09/2022, the MDS Coordinator interviewed resident to ensure they had adequate pain control and reviewed the admission orders to determine they were properly followed and needs accurately care planned.<br><br>To ensure the deficient practice does not recur, the Director of Nursing will provide training to all nursing personnel about their roles and responsibilities to ensure a smooth transition to the nursing home, whether from a hospital, assisted living, or private home. On 02/09/2022 all nursing personnel were trained on pain management, transfers, and following care plans appropriately. All new admissions will have a pain evaluation at time of adission and again 3 days later to ensure effectiveness of pain management program. Care plan will be updated with pain management plan and weight bear status on day of admission.<br><br>To monitor performance and ensure ongoing compliance, the Director of Nursing or designee will audit by chart review and resident interview to ensure pain evaluations were completed timely, care plan updated to reflect proper interventions, and effectiveness of the individuals pain management program.<br><br>Audits will occur weekly x 4, every other week x 2, and monthly x 1. Director of Nursing or designee will report findings to QAPI committee monthly. The QAPI committee will detrmine on-going interventions and monitoring. | 2-11-22 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Stephanie Macfarlane | Administrator | 02/15/2022 |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 1<br><br>1. Review of resident 186's medical record revealed:<br>*She had been admitted from the hospital on 1/17/22.<br>*Her diagnoses included displaced bimalleolar fracture of the left leg, with a subsequent encounter for a closed fracture with routine healing, Alzheimer's disease with late onset, Dementia without behavioral disturbances, other specified disorders of bone density and structure, bilateral primary osteoarthritis of the knee.<br>*The care plan initiated at that time did not include a plan for non-weight bearing status or effective pain management.<br>*Physician orders for Tylenol 325 milligram (mg) two tablets by mouth scheduled four times daily and "non-weightbearing. Medical predictability is to begin intense therapies on or around 1/24/22 to rehab bimalleolar fracture. Physical therapy and occupational therapy to evaluate and treat."<br><br>2. Observation and interview on 1/18/22 at 5:56 p.m. of resident 186 in the facility dining room revealed she:<br>*Was sitting in a wheelchair at a dining table alone facing a wall and crying.<br>*Stated she was unable to walk and had not wanted to eat because her leg hurt.<br>*Requested to go back to her room and wanted to call her son.<br>*Ate none of her meal and drank a small amount of her coffee.<br>-A facility staff member was obtained by this surveyor and asked to assist her.<br>-The staff member spoke to her briefly and then pushed her out of the dining room in her wheelchair. | F 684 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 2<br>Observation on 1/18/22 at 6:18 p.m. of resident 186 revealed:<br>*She was sitting in a recliner in her room with both of her legs elevated, no longer crying, and watching TV.<br>*There was a chair side table with a water mug and straw.<br>*A call light was clipped to the arm of the recliner.<br>*She had a pink cast to her lower left leg.<br><br>3. Observation and interview on 1/19/22 at 9:36 a.m. of resident 186 revealed she:<br>*Was dressed, her hair combed and was sitting in a recliner in her room with both of her legs elevated watching TV.<br>*Continued with complaints of left leg pain and rated her pain as "miserable."<br>*Reported she had fallen at home; her family took her to the hospital and a cast was put on her leg.<br>*Did not know about her pain management plan and stated "I don't know, I get very few pain pills. I can't even lift my leg up and, I don't know if I will be doing therapy."<br>*Was hungry and "I don't know if I went to breakfast or they brought it to me."<br><br>4. Observation and interview on 1/20/22 at 11:24 a.m. with registered nurse (RN) M, certified nursing assistant (CNA) P, and resident 186 revealed:<br>*RN M asked resident 186 how she transfers.<br>-Resident 186 shrugged her shoulders to indicated she had not known.<br>*RN M asked CNA P, who stated pivoting with one assist.<br>*RN M transferred resident 186 to her wheelchair:<br>-He stood in front of her, stood her up from her recliner, and pivoted her into her wheelchair.<br>-She was observed having weight on both legs. | F 684 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 3<br>-He had not used a walker, gait belt or any other kind of assistive device.<br>*Resident 186 was crying out in pain during the transfer and afterwards.<br>*Surveyor asked if RN M could look in her electronic medical record (EMR) to see how she was supposed to transfer.<br>*While looking in her EMR he:<br>-Was unable to identify her needs based on her care plan.<br>-Looked under orders and noted that she had an order for non-weight bearing status.<br>*Surveyor asked how they usually transfer residents who are of non weight bearing status and he stated:<br>-"With a lift."<br>-"CNA P told me she was a stand pivot transfer."<br><br>5. Phone interview on 1/20/22 at 2:07 p.m. with orthopedics surgery (RN) N regarding resident 186 and her weight bearing status revealed:<br>*Resident was seen by orthopedic provider on 1/12/22.<br>*The surgeon was performing surgery and unavailable for interview.<br>*A short leg cast was placed on the residents left lower leg.<br>*Non weight bearing of the left leg was ordered by the physician.<br>*No pain medications had been prescribed by the orthopedic surgeon.<br>-A two week follow up appointment was scheduled for 1/24/22 at 11:00 a.m.<br>*RN N verified that resident 186 should not be placing any weight on her left leg nor doing any pivot transfers.<br><br>6. Interview on 1/20/22 at 2:26 p.m. with RN O, a nurse from the hospital resident 186 was | F 684 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 4<br>discharged from revealed:<br>*On 1/7/22 after a fall, resident 186 had been brought from her assisted living facility to the emergency room.<br>*She was transferred to hospital acute status for pain management on 1/10/22.<br>-Hydrocodone/Acetaminophen one to two tablets every six hours as needed for pain was prescribed.<br>*She was discharged from the hospital acute status on 1/12/22 for an outside appointment and transported to the Orthopedic provider by family.<br>-She returned to the hospital following her orthopedic clinic appointment on 1/12/22 and was again, admitted as custodial care (care and services to assist her with her activities of daily living).<br>-An order for "transfer with walker and assist of two to wheelchair with pivot and front wheeled walker to maintain non-weight bearing to left extremity" was placed.<br>-The Hydrocodone/Acetaminophen 5/325 mg medication order was decreased to one tablet every four hours as needed for pain on 1/13/22, with the last dose received on 1/17/22 at 8:30 a.m.<br>*She was discharged from the hospital and admitted to the long-term care facility on 1/17/22.<br>-The hospital discharge orders did not include pain medication.<br><br>Interview on 1/20/22 at 2:55 p.m. with administrator A and RN M regarding resident 186 revealed:<br>*RN M agreed:<br>-The resident did not understand how to rate her pain using the number pain scale and the staff should have used the faces pain scale.<br>-The ratings of a two on her pain scale were likely | F 684 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 5<br>inaccurate.<br>-The pivot transfers had been causing her pain.<br>-The physician order for non-weight bearing was not included in her care plan.<br>-To notify the physician for new pain medication orders.<br>-The orthopedic physician should be notified that she had been transferred with pivoting and weight bearing of the left lower extremity.<br>*The administrator was not aware she was being pivot transferred with weight-bearing of the left extremity and agreed that would be contributing to her pain.<br><br>Interview on 1/20/22 at 3:50 p.m. with minimum data set coordinator (MDS) G regarding resident 186 revealed:<br>*The administrator and director of nursing had completed a screening process prior to accepting new facility admissions.<br>*The social worker had been responsible to obtain new admission orders.<br>-The administrator fulfilled the social worker role until a new social worker was hired and trained.<br>*The daytime charge nurse reviewed and entered new resident admission orders on the day of admission.<br>-The new resident admission orders were left on the nurse station computer keyboard for the night charge nurse to review.<br>*A request for Ibuprofen or Tylenol was faxed to the hospital discharging physician assistant and received back with a signed order for Tylenol 650 mg scheduled four times daily.<br>*The charge nurse was responsible to monitor for the effectiveness of pain medication and follow up with the provider for any needed adjustments.<br><br>Observation and interview on 1/20/22 at 4:12 | F 684 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 6<br>p.m. with resident 186 revealed she:<br>*Was sitting in a recliner in her room with both legs elevated.<br>-The call light clipped to the arm of the recliner.<br>*Stated "It hurts a lot, I can't walk on it."<br><br>Continued review of resident 186's pain ratings on her medication administration record revealed:<br>*While surveyor had observed her on 1/18/21 at 5:56 p.m. in the dining room crying with pain, her documented pain rating was a "2."<br><br>Review of the Sanford admission documentation policy reviewed/revised on 1/18/21 revealed:<br>*" Purpose<br>-To obtain appropriate initial information regarding the resident and family.<br>-To provide the initial documentation needed on admission."<br>*" Procedure"<br>- "13. The care plan is initiated through triggered UDAs as the Nursing Admit/Readmit Data Collection is completed. ADL and dietary information must be completed within the first 24 hours."<br><br>Review of the provider's december 2021 Pain Managemen policy revealed:<br>*" Purpose<br>-To provide residents assistance in pain management.<br>-To promote well-being by ensuring that residents are as comfortable as possible.<br>-To consistently collect data related to pain,<br>-To determine what pain relief interventions specific to the resident can be used to aid in maintaining a comfortable level of function and quality of life.<br>-To use non-pharmacological interventions for | F 684 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 7 | F 684 | | |

pain relief before starting any new medication.
-To use non-pharmacological interventions as identified by the resident to promote comfort.
*Responsible Staff
-RNs
-LPNs
*Policy
-All residents will receive interdisciplinary consultations on assistance in managing pain. Individualized approaches will be developed to address the resident ' s pain management needs in a holistic manner.
-The registered nurse will assess current pain levels and develop with the physician and interdisciplinary team interventions that may be non-pharmacological, as well as pharmacological. The registered nurse will review response to medication intervention and work closely with the physician to assist in the individualized pain management plan.
-The nurses working directly with residents must continually monitor and observe the resident for success of the pain management plan and report to the nurse manager and prescriber as necessary to keep the resident comfortable.
*Procedure"
- "2. Develop care plan including pain focus, goal, and interventions, including non-pharmacological interventions that allow documentation. Once these interventions are care planned, a pain management plan should be person centered and can include, but not be limited to, a medication regimen. The plan should help determine what other methods or alternatives to pain control/relief may be implemented prior to contacting a physician. The interdisciplinary team and nurses must have ongoing communication with the resident and monitor and evaluate the pain management plan, Include the resident ' s

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 8<br>goal for control of his or her pain. Update care plan as needed to reflect current effective interventions."<br>- "6. Pain documentation by the CNA is ideally entered using the interventions from the care plan. This is the most efficient and resident-specific way to allow documentation of pain and response to interventions. If a pain plan is not yet care planned, employees can use the Pain task (Numeric or PAINAD) and/or Vital Signs tasks in PCC[point click car]-POC[point of care]. Any time a resident is in pain, the nursing assistant should make the resident as comfortable as possible and verbally communicate with the nurse on duty, as well as send a New Alert from PCC-POC using the eINTERACT Stop and Watch Alert for pain."<br>Surveyor: 45095 | F 684 | | |
| F 755 SS=D | Pharmacy Srvcs/Procedures/Pharmacist/Records<br>CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed | F 755 | No resident was found to be impacted by the citation regarding the E-Kit. Any resident needing a medication from the E-Kit has the potential to be acffected if an expired medication was given accidentally or if treatment is delayed because a medication is not available.<br><br>To ensure the deficient practice does not recur on 02/08/2022 all nurses were educated by the Director of Nursing and Infection Preventionist about the procedure for removing medications from the E-Kit, notification to pharmacy of a new tamper proof tag number, and notification of expired medications.<br><br>On 02/04/2022, Infection Preventionist updated the Pharmacist Consultant monthly medication review audit to verify tamper proof tag numbers, audit E-Kit for expired medications, and audit the count of controlled medications. Pharmacist consultant will remove any medications that would expire prior to next visit to ensure all meds in the E-Kit are safe for use.<br><br>To monitor for continued compliance, QAPI Coordinator will audit for accuracy of the tamper proof tag, expired medications, and | 2-11-22 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 755 | Continued From page 9<br>pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 42477<br>Based on observation, interview, record review, and policy review, the provider failed to ensure accountability for controlled medications by ensuring emergency kits (e-kits) had been monitored and tracked for one of one facility e-kits. Findings include:<br><br>1. Observation and interview on 1/20/22 at 8:54 a.m. with licensed practical nurse (LPN) H in the facility's medication room revealed:<br>*They had an e-kit that contained the following medications:<br>-Lorazepam.<br>-Morphine.<br>-Tramadol.<br>-Hydrocodone.<br>*The form from the pharmacy stated there should have been 12 doses of Lorazepam, all with an expiration date of 6/2022.<br>-There were only seven Lorazepam doses in the e-kit.<br>*LPN H was not sure where the missing five | F 755 | Continued from page 9<br>Correct number controlled medications in the E-Kit. Audits will be completed weekly x4, every other week x2 and monthly x1. QAPI Coordinator or designee will report findings to QAPI committee monthly will determine ongoing monitoring and interventions. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 755 | Continued From page 10<br>Lorazepam doses could have been.<br>*They had not been writing down the e-kit tag numbers or documenting when they needed to access the medications inside of the e-kit.<br>*LPN H was going to call consultant pharmacist F regarding the missing Lorazepam doses.<br><br>Further interview on 1/20/22 at 9:40 a.m. with LPN H revealed she:<br>*Found five doses of Lorazepam in the secured box waiting to go back to pharmacy.<br>*Those doses were in the box because they were expired.<br>*Those five Lorazepam had a date of 7/2021.<br>*Agreed the pharmacy slip stated all 12 doses should have had an expiration date of 6/2022.<br><br>Phone interview on 1/20/22 at 11:54 a.m. with consultant pharmacist F revealed:<br>*He was the consultant pharmacist for the facility.<br>*LPN H had contacted him regarding the missing Lorazepam doses.<br>*He believed the missing five doses of Lorazepam had been in the secured box waiting for pharmacy return.<br>*Surveyor asked about the expiration date discrepancy regarding the date on pharmacy form and the date that was actual on the medications.<br>-He was unsure why the dates had not matched.<br>*He stated nurses are supposed to be filling out the form when they remove an e-kit tag and document which tag was removed and which tag was placed to secure the e-kit.<br>*He had not been aware that the nursing staff had not been following the process and completing the pharmacy form.<br><br>Review of the provider's September 2021 Emergency Drug Boxes policy revealed: | F 755 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 755 | Continued From page 11<br>*The emergency drug boxes were an extension of the providing pharmacist's store. They would be kept in the locked medication room, accessible only to licensed nurses and medication aides.<br>*If a drug was used from the box, the pharmacist or the pharmacist's agent will be notified according to the state's specific regulation.<br>*A list of emergency medications including the amounts, dosages/strengths will be posted on the outside of the box.<br>*The pharmacist would be responsible for monitoring the expiration dates.<br>*Record keeping would be completed in accordance with the state pharmacy system. | F 755 | | |
| F 849 SS=D | Hospice Services<br>CFR(s): 483.70(o)(1)-(4)<br><br>§483.70(o) Hospice services.<br>§483.70(o)(1) A long-term care (LTC) facility may do either of the following:<br>(i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.<br>(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.<br><br>§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:<br>(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and | F 849 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 849 | Continued From page 12<br>to the timeliness of the services.<br>(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:<br>(A) The services the hospice will provide.<br>(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.<br>(C) The services the LTC facility will continue to provide based on each resident's plan of care.<br>(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.<br>(E) A provision that the LTC facility immediately notifies the hospice about the following:<br>(1) A significant change in the resident's physical, mental, social, or emotional status.<br>(2) Clinical complications that suggest a need to alter the plan of care.<br>(3) A need to transfer the resident from the facility for any condition.<br>(4) The resident's death.<br>(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.<br>(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual | F 849 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 849 | Continued From page 13<br>resident's needs.<br>(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.<br>(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.<br>(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.<br>(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.<br><br>§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the | F 849 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 849 | Continued From page 14<br>LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.<br>The designated interdisciplinary team member is responsible for the following:<br>(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.<br>(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.<br>(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.<br>(iv) Obtaining the following information from the hospice:<br>(A) The most recent hospice plan of care specific to each patient.<br>(B) Hospice election form.<br>(C) Physician certification and recertification of the terminal illness specific to each patient.<br>(D) Names and contact information for hospice personnel involved in hospice care of each patient.<br>(E) Instructions on how to access the hospice's 24-hour on-call system.<br>(F) Hospice medication information specific to each patient. | F 849 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 849 | Continued From page 15<br>(G) Hospice physician and attending physician (if any) orders specific to each patient.<br>(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.<br><br>§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 45683<br>Based on interview, record review, and policy review, the provider failed to ensure integrated plans of care had been developed for one of two residents (3) receiving hospice services. Findings include:<br><br>1. Review of resident 3's medical record and care plan revealed:<br>*She had been admitted on 6/28/95.<br>*Her diagnoses included:<br>-Anticoagulant therapy.<br>-Tube feeding.<br>-Tardive dyskinesia.<br>-Schizophrenia.<br>-Depression.<br>*She had been receiving hospice services since 1/29/20.<br>*The only statement about hopsice in the comprehensive care plan was:<br>-"Family's wishes are for resident to remain in this | F 849 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 849 | Continued From page 16<br>facility under Hospice Care with [hospice provider's name]. She is on [Hospice provider's name] Receives AIDE, Social services, nursing, spiritual services from [hospice provider's name]."<br><br>2. Interview on 1/20/22 at 1:00 p.m.with hospice registered nurse (RN) R regarding resident 3's hospice care plan revealed:<br>*She believed the hospice care plan was kept at the nurse's station in a binder.<br>*The hospice care plan should have been integrated into the facility care plan.<br><br>Review of resident 3's 1/16/22 revised care and 12/9/21 hospice care plan revealed the following goals had not been integrated into her facility care plan:<br>-"She will report that her pain is at a minimal/comfortable level for her."<br>-"We want her to be as comfortable as possible."<br>-"She/staff will understand the specified care and services required to meet her end of life needs."<br>-"She/family/[provider name] will express faith and feelings within context of their faith traditions."<br>-"Her goal is to be able to enjoy nursing home activities and do her puzzles in her room."<br>-"Provide her/brother/[provider name] education about hospice services and external resources to assist with her life closure desires."<br>-"She/brother/[provider name] will have necessary information support, and direction and counsel to make her end of life decisions."<br><br>Interview on 1/20/22 at 1:55 p.m. with certified nursing assistant (CNA) Q regarding resident 3's hospice care plan revealed she thought it would be the same as her facility care plan. | F 849 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 849 | Continued From page 17<br>Interview on 1/20/22 at 2:00 p.m. with RN M regarding resident 3's hospice care plan revealed he believed it was same as her facility care plan.<br><br>Interview 1/20/22 2:01 p.m. with administrator A regarding resident 3's hospice care plan revealed:<br>*It was her understanding the hospice care plan was integrated with the facility care plan.<br>*She was not aware staff had not known how to access the hospice care plan.<br>*The hospice staff had a seperate binder for their care plans.<br>*It was updated by the hospice staff and then faxed to the facility.<br>*It was at the nurse's station.<br><br>3. Review of the provider's May 2021 Hospice-Provider Services in Skilled Nursing Facility(SNF), Assisted Living(AL), Therapy; Define Responsibility of Location/Hopsice Employee Rehab/Skilled policy revealed:<br>* A coordinated comprehensive plan of care shall be jointly developed by Long Term Care location and hospice.<br>*The hospice information/documentation should be integrated into the electronic medical record. | F 849 | | |
| F 880 SS=F | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control | F 880 | Directed Plan of Correction<br>Good Samaritan Society Corsica F880<br>Corrective Action:<br>1. For the identification of lack of:<br>*Appropriate use of barriers while door of isolation room is open.<br>*Appropriate putting on and taking off PPE when transitioning within an isolation area caring for multiple residents. -Hand hygiene and glove use. *Appropriate precautions and knowledge of required cleaning and disinfection products when cleaning in room(s) of resident with CRE. | 2-11-22 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 18<br>program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct | F 880 | Do look at general knowledge related to any cleaning that is not the norm.<br><br>The administrator, DON, and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas.<br>All facility staff who provide or are responsible for the above cares and services will be educated/re-educated on 02/08/2022 by Director of Nursing and Infection Preventionist.<br>Identification of Others:<br>2. ALL residents and staff have the potential to be affected by lack *Appropriate use of barriers while door of isolation room is open.<br>*Appropriate putting on and taking off PPE when transitioning within an isolation area caring for multiple residents.<br>-Hand hygiene and glove use not followed.<br>*Appropriate precautions and knowledge of required cleaning and disinfection products when cleaning in rooms(s) of resident with CRE or cleaning an area that is not the norm.<br>Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by date by Infection Preventionist.<br>System Changes:<br>Root cause analysis conducted answered the 5 Whys:<br>- Identified why doors were open was due to safety risk of residen and resident request. The care plans did not reflect this information due to not enough individuals are trained on updating care plans and the two individuals who do update care plans were out ill. Staff are usually specialized to particular tasks and not enough are trained on updating care plans.<br>-Identified why employee did not remove gloves after coming out of red room and into a yellow zone. Employee stated they were in a hurry and were not prioritizing tasks. Staff was working in different zones and was trying to get to the other zones quickly. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 19<br>contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 42477<br>Based on observation, interview, policy review, and national guidelines review, the provider failed to ensure:<br>*Seven of sixteen residents (3, 9, 11, 12, 16, 27, and 34) who had been on quarantine due to exposure to COVID-19 had a barrier in place or kept their doors closed.<br>*One of one observed certified nursing assistants (CNA) (L) had followed appropriate infection control guidelines when exiting a two of two COVID-19 positive resident's (35 and 187) shared room.<br>*One of one observed environmental services technician (J) had been aware of the appropriate precautions and measures to take with a resident on contact precautions for carbapenem-resistant Enterobacteriaceae (CRE).<br>Findings include:<br><br>1. Observation on 1/18/22 at 4:45 p.m. of the | F 880 | Continued from page 19<br><br>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.<br>Administrator contacted the South Dakota Quality Improvement Organization (QIN) on 02/03/2022 and discussed that we understand quality improvement methodologies, are aware of the QIO and its website and resources. GPQIN also worked with us on a six week quality improvement plan related to CMS's referral as a COVID HotSpot in September 2021 and used the GPQIN's performance audit tracker.<br><br>Monitoring:<br>4. Administrator, DON, and/or designee will conduct auditing and monitoring 2 to 3 times weekly over all shifts to ensure identified and assigned tasks are being done as educated and trained.<br>Monitoring for determined approaches to ensure effective implementation and ongoing sustainment.<br>*Staff compliance in the above identified area.<br>*Any other areas identified through the Root Cause Analysis. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month.<br>Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by administrator, DON, and/or a designee to the QAPI committee monthly and continued until the facility demonstrates sustained compliance as determined by committee. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 20<br>facility's 100-wing revealed:<br>*There were 18 residents on the 100-wing.<br>-Two of those 18 residents (35 and 187) were positive for COVID-19, and were in a shared room.<br>-The remaining 16 residents (3, 6, 8, 9, 10, 11, 12, 15, 16, 18, 23, 24, 27, 29, 31 and 34) were on quarantine precautions due to exposure to COVID-19.<br>-Seven of the 16 residents (3, 9, 11, 12, 16, 27, 34) were in four rooms and their doors were open.<br>--Those rooms had signs adjacent to their door that stated their doors must remain closed.<br><br>2. Observation on 1/18/22 at 5:14 p.m. CNA L on the 100-wing hallway revealed:<br>*She had been in resident 35 and 187's shared room.<br>*When she exited the room and with the same soiled gloves she:<br>-Reached into the clean supply drawer to grabbed wipes.<br><br>Further observation on 1/18/22 at 5:38 p.m. of CNA L revealed she:<br>*Was exiting resident 35 and 187's room.<br>*Had not removed her soiled gloves prior to exiting the room.<br>*Preformed the following while still wearing her soiled gloves:<br>-Disinfected her faceshield and hung it on the clean hook to dry.<br>-Removed her N95 mask.<br>*Heard something from inside of resident 35 and 187's door, she:<br>-Opened the COVID-19 barrier and stated "Hold on [resident 35's name]."<br>-Was only wearing a surgical mask when she | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 21<br>peaked the residents' room.<br>*Wearing the same surgical mask, she walked down the hallway, past the double doors to grab a gown.<br><br>Interview on 1/19/22 at 9:00 a.m. with administrator A regarding quarantined resident's opened doors and CNA L infection control observations revealed:<br>*Any resident who is on quarantine should have their door closed.<br>*Some residents have their doors opened for safety reasons and that will be located on their care plans to do so.<br><br>Review of selected resident's 3, 9, 12, 16, and 27 January 2022 care plans revealed there had not been any mention of having their doors remain open for safety reasons.<br><br>3. Observations made on the following dates and times revealed the quarantine room doors had been opened:<br>*On 1/18/22 from 4:45 p.m. through 6:14 p.m.<br>*On 1/19/22 at 9:15 a.m and 12:17 p.m.<br>*On 1/20/22 at 8:44 a.m. and 11:45 a.m.<br><br>Surveyor: 44928<br>4. Observation and interview on 1/20/22 at 11:41 a.m. with environmental services technician J revealed she:<br>*Was cleaning resident 22's room, who was positive for CRE.<br>-There was a sign adjacent to her door that stated "Contact Precautions."<br>*Cleaned room with bottle of pink spray, the same spray she used in every room.<br>*Was unable to state what was in the pink bottle.<br>*Cleaned the toilet and with the same soiled | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 22<br>gloves opened the paper towel dispenser to check the remaining quantity.<br>*Had not known if there was any special precautions she needed to take while in resident 22's room.<br>*Had been unaware if there were any different cleaning steps she needed to preform for the room.<br>*Stated she cleaned all the rooms the same.<br><br>5. Interview on 1/20/22 at 3:07 p.m. with food, nutrition, and housekeeping manager C revealed:<br>The pink bottle contained Disinfecting 73 Acid Bathroom Cleaner, used in every bathroom.<br>*No special cleaning instructions for resident room with CRE<br><br>Interview on 1/20/22 at 3:15 p.m. with administrator A revealed:<br>Disinfecting 73 Acid bathroom cleaner is not effective against CRE.<br>*Internet search of CRE revealed bleach is effective against CRE<br>*Administrator was unable to find policy for room cleaning with CRE.<br><br>Interview on 1/20/22 at 3:52 p.m. with infection preventionist E and administrator A revealed they:<br>*Agreed resident's doors should have remained closed.<br>*Had not thought about implementing clear plastic dividers for residents with safety concerns.<br>*Agreed soiled gloves should be removed prior to exiting a COVID-19 positive resident's room.<br><br>6. Review of the providers December 2019 Infection Prevention and Control policy revealed:<br>*"Each society location will maintain an infection prevention and control program to provide a safe, | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 23<br>sanitary and comfortable environment for residents, patients, children, families, visitors and employees to help prevent the development and transmission of communicable diseases and infections."<br>*"The infection prevention an control progame will attempt to meet federal and state regulations for infection control..."<br><br>Review of centers for disease control and prevention (CDC) September 2021 guidance. <cdc.gov/coronavirus/2019-ncov/long-term-care.html> revealed:<br>*"Place a patient with suspected or confirmed SARS-CoV-2 [COVID-19] infection in a single-person room. The door should be kept closed..."<br>*"Regularly review CDC's Interim Infection Control Recommendations for Healthcare Personnel During the COVID-19 Pandemic for current information and ensure staff and residents are updated when this guidance changes."<br>*"In general, it is recommended that the door to the room remain closed to reduce transmission of SARS-CoV-2. This is especially important for residents with suspected or confirmed SARS-CoV-2 infection being cared for outside of the COVID-19 care unit. However, in some circumstances (e.g., memory care unites), keeping the door closed may pose resident safety risks and the door might need to remain open. If doors must remain open, work with facility engineers to implement strategies to minimize are flow into the hallway." | F 880 | | |
| F 881 SS=D | Antibiotic Stewardship Program<br>CFR(s): 483.80(a)(3) | F 881 | No resident was found to be impacted directly by this deficient practices | 2-11-22 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 881 | Continued From page 24<br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 42477<br>Based on interview, policy review, and record review, the provider failed to implement an effective antibiotic stewardship program. Findings include:<br><br>1. Interview on 1/20/21 at 3:52 p.m. with infection preventionist E and administrator A regarding the antibiotic stewardship program revealed they:<br>*The pharmacy consultant was not involved in their antibiotic stewardship program.<br>*Agreed he could provide expertise into antibiotic usage.<br>*Revealed they did not have criteria to look closely at residents who were having repeated urinary tract infections in a certain period of time and the antibiotics that they were on.<br><br>Review of the provider's December 2019 Infection Prevention and Control Program policy revealed:<br>*"The system of identifying, reporting, investigating, and controlling infections and communicable disease for all residents will be tracked where possible on the Infection and Antimicrobal Tracking Tool and reviewed by the QAPI [quality assurance process improvement] committee who will keep a record of any | F 881 | Continued from page 24<br><br>All residents have the potential to be impacted by lack of antibiotic stewardship.<br>On February 3rd, 2022, Infection Preventionists sent antibiotic stewardship commitment and expectation to pharmacist consultant.<br>Pharmacist consultant will provide expertise in trends of antibiotic use and recommendations for residents with repeat UTIs and provide additional data monthly to QAPI committee.<br>Pharmacist consultant will attend quarterly Antibiotic Stewardship meetings beginning February 28th, 2022. Education was provided to Infection Preventionists, Medical Director, and Pharmacist Consultant by Director of Nursing on February 3rd, 2022 about the Antibiotic Stewardship Program and pharmacy involvement in the program on a monthly basis.<br><br>To ensure continued compliance, the Infection Preventionsist or designee will audit QAPI minutes to ensure pharmacist consultant participation and antibiotic tracking and completion of quarterly Antibiodic Stewardship meetings. Audits will occur monthly x3.<br>Infection Preventionists or designee will report findings to the QAPI committee monthly and QAPI committee will determine onging monitoring and interventions. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 881 | Continued From page 25<br>corrective action taken." | F 881 | | |
| F 886 SS=F | COVID-19 Testing-Residents & Staff<br>CFR(s): 483.80 (h)(1)-(6)<br><br>§483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must:<br><br>§483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not<br>limited to:<br>(i) Testing frequency;<br>(ii) The identification of any individual specified in this paragraph diagnosed with<br>COVID-19 in the facility;<br>(iii) The identification of any individual specified in this paragraph with symptoms<br>consistent with COVID-19 or with known or suspected exposure to COVID-19;<br>(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;<br>(v) The response time for test results; and<br>(vi) Other factors specified by the Secretary that help identify and prevent the<br>transmission of COVID-19.<br><br>§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;<br><br>§483.80 (h)((3) For each instance of testing: | F 886 | Residents are found to not be affected by the deficient practice. On 02/03/22 the 8 unvaccinated employees not in the 90 day window were notified via OnShift messaging to test before their shift and put their test results in Health Information Manager's mailbox to be entered into Excel spreadsheet for tracking purposes.<br>All residents have the potential to be affect by the deficient practice<br>To ensure the deficient practice does not recur, an excel spreadsheet was created on 01/31/2022 to track unvaccinated staff that need to be tested with frequency determined by county transmission level. HIM Coordinator will complete data entry and notify Infection Preventionist weekly of any missed tests.<br>Each week, IP or designee will notify staff with a missed test that a negative test must be obtained prior to next scheduled shift. On 01/31/2022 Administrator educated HIM and IP the importance of tracking COVID-19 data on a weekly basis and monitoring the data on a weekly basis.<br>To ensure compliance, Infection Preventionist or designee will audit 10 staff to ensure staff who are not fully vaccinated are testing at the frequency determined by the community transmission level. Audits will occur weekly x4, every other week x2, and monthly x1. Infection Preventionist or designee will report findings to the QAPI committee monthly and QAPI committee will determine ongoing monitoring and interventions. | 2-11-22 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 886 | Continued From page 26<br>(i) Document that testing was completed and the results of each staff test; and<br>(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.<br><br>§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.<br><br>§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.<br><br>§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 42477<br>Based on interview, record review, and policy review the provider failed to ensure all of their unvaccinated staff had been routinely tested per current recommendations and guidance for COVID-19, during an outbreak. Findings include:<br><br>1. Review of the provider's current employee COVID-19 testing documentation revealed:<br>*The information was disorganized and difficult to determine when staff had been tested.<br>*Review of 15 unvaccinated staff members | F 886 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 886 | Continued From page 27<br>testing records determined:<br>-There was missing documentation that showed some staff had not been tested every three to seven days while in outbreak.<br><br>Interview on 1/20/22 at 3:52 p.m. with infection preventionist E and administrator A revealed:<br>*The facility had been in outbreak since 12/27/21.<br>*They agreed the system they had in place was disorganized and difficult to track who had been tested and when.<br>*They stated the four department heads were in charge of ensuring their staff had been tested.<br>*There was no one ensuring the department heads had the testing completed.<br><br>Review of the provider's August 2021 COVID Testing Employee policy revealed:<br>*"[Provider name] recognizes the importance of preventing the transmission of COVID-19, a serious and, in some cases, deadly illness. Robust COVID-19 testing can protect vulnerable patient and resident populations, clients, employees, licensed independent medical practitioners (MDs [medical doctors], DOs [doctor of osteopathic medicine] and advanced practice providers, contingent workers, students, volunteers, and visitors from exposure to COVID-19..."<br>*"All [provider name] employees, providers, contigent workers, student and volunteers are required to submit to COVID-19 testing were job-related and consistent with business necessity, as well as consistent with applicable federal, state, or municipal order or department of health guidance..." | F 886 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>Surveyor: 42477<br>A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 1/18/22 through 1/20/22. Good Samaritan Society Corsica was found not in compliance with the following requirement: E0001. | E 000 | Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitues the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. | |
| E 001 SS=D | Establishment of the Emergency Program (EP) CFR(s): 483.73<br><br>§403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12<br><br>The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements:<br><br>* (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.)<br><br>*[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and | E 001 | The Administrator added a policy and procedure for sewage and waste disposal to the emergency management plan and written agreement with a map/directions to another facility in case of a total evacuation on 2/10/22.<br><br>All resident have the potential to be impacted by lack of emergency preparedness.<br><br>To ensure continued compliance Administrator will review the Emergency Preparedness Plan on an annual basis and make updates as needed and the emergency management plan will be reviewed by the Safety Committee on a monthly basis.<br><br>To ensure that this deficiency does not occur again the Administrator will review the Emergency Preparedness Plan on an annual basis and include strategies for addressing sewage and water resources and emergency evacuation routes. The Administrator will educate the Safety Committee members about the new waste disposal process and emergency evacuation route on 2/14/22. QAPI coordinator or designee will report findings to the QAPI committee monthly and QAPI committee will determine ongoing monitoring and interventions. | 2/14/2022 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stephanie Macfarlane | TITLE: Administrator | (X6) DATE: 2/15/2022

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 001 | Continued From page 1<br>local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:<br><br>*[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 45683<br>Based on interview and record review, the provider failed to establish a complete emergency preparedness program that included policies, procedures, communication plan, and transfer agreement. Findings include:<br><br>1. Interview and review of the provider's emergency preparedness program documentation on 1/20/22 at 3:35 p.m. with administrator A revealed:<br>*They did not have a complete emergency preparedness program.<br>*They had not:<br>-Addressed policies and procedures for sewage and waste disposal.<br>*There was not a communication plan that had:<br>-A written agreement to transfer residents to another facility in case of total evacuation.<br>-A map/directions to get to another facility, in case of emergency. | E 001 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | | | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **01/19/2022** |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>Surveyor: 27198<br>A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 1/19/22. Good Samaritan Society Corsica was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities.<br><br>The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K100 and K351 in conjunction with the provider's commitment to continued compliance with the fire safety standards. | K 000 | Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. | |
| K 100 SS=E | General Requirements - Other<br>CFR(s): NFPA 101<br><br>General Requirements - Other<br>List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by:<br>Surveyor: 27198<br>Based on observation and interview, the provider failed to maintain noncombustible construction at one randomly observed location (outside the kitchen exit). Findings include:<br><br>1. Observation and interview on 1/19/22 at 12:12 p.m. revealed the underside of the attached overhang outside of the kitchen exit had been constructed of noncombustible framing but the underside of the roof was covered with one | K 100 | On 1/31/2022, the 2 Maintenance Technicians removed plywood from the attached overhang outside of the kitchen exit.<br><br>All residents have the potential to be impacted by the deficient practice.<br><br>The Maintenance department will contact Environmental Services Consultant for questions about what they could use to prevent birds from building nests in the noncombustible construction of the building and for any other questions relating to noncombustible buildings.<br><br>Maintenance Director will provide education to maintenance personnel to utilize their resources such as coordinating with Construction and Design Consultants. Bi-weekly rounds will be conducted to ensure nests are not being built in overhang areas.<br><br>Substantial compliance will be achieved by 02/11/2022. | 02/11/2022 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| *Stephanie Macfarlane* | Administrator | 02/10/2022 |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **01/19/2022** |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 100 | Continued From page 1<br>quarter inch plywood. That combustible plywood ceiling is not allowed with the noncombustible construction of the building.<br><br>Interview with the maintenance mechanic at the time of the observation confirmed that finding. He stated they had placed the plywood there to prevent birds from building their nests in that location.<br><br>The deficiency could affect 100% of the smoke compartment occupants. | K 100 | | |
| K 351 SS=D | Sprinkler System - Installation<br>CFR(s): NFPA 101<br><br>Spinkler System - Installation<br>2012 EXISTING<br>Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.<br>In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers.<br>In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.<br>19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 27198<br>Based on observation and interview, the provider | K 351 | On 02/01/2022 Midwest Sprinkler was contacted for a quote on sprinkler installation in the wheelchair washer area and to schedule a date for completion. Midwest Sprinkler came on 02/07/22 to install a new sprinkler in the wheelchair washer room.<br><br>The deficient practice has the potential to affect 11 rooms in 300 wing where the wheelchair washroom is located. On 02/03/22, Environmental Services Technician conducted a walkthrough of the facility to locate any other potential closed areas without a sprinkler head and no other findings were noted at that time.<br><br>To ensure the deficient practice does not recur maintenance team will contact Midwest Sprinkler to install a sprinkler whenever a new room is added to the facility.<br><br>The Maintenance Director or other designee will be responsible to contact Midwest Sprinkler if an additional room is added to the facility. At this time no additional rooms are\ being added. Fire sprinkler systems are being inspected on a weekly basis per our preventative maintenance program – should the need for additional fire sprinkler system be discovered will notify administration to have installed.<br><br>Substantial compliance will be achieved by 02/11/2022. | 02/11/2022 |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435089 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **01/19/2022** |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 351 | Continued From page 2<br>failed to furnish sprinkler protection throughout the facility as required. The wheelchair washing area was not covered by the automatic fire sprinkler system. Findings include:<br><br>1. Observation on 1/19/22 at 2:15 p.m. revealed the wheelchair washing room was not covered by the building's automatic sprinkler system. Interview with the maintenance mechanic at that same time confirmed that finding. He stated he was unaware that room did not have a sprinkler installed in it.<br><br>The deficiency could affect 100% of the smoke compartment occupants. | K 351 | | |

South Dakota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 10609 | A. BUILDING: _____ B. WING _____ | 01/20/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S 000 | Compliance/Noncompliance Statement<br><br>Surveyor: 27198<br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 1/18/22 through 1/20/22. Good Samaritan Society Corsica was found in compliance. | S 000 | | |
| S 000 | Compliance/Noncompliance Statement<br><br>Surveyor: 42477<br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 1/18/22 through 1/20/22. Good Samaritan Society Corsica was found in compliance. | S 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Stephanie Macfarlane

TITLE
Administrator

(X6) DATE
02/10/2022

STATE FORM 6899 O2Z611 If continuation sheet 1 of 1

FEB 10 2022