| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435046 | A. Building<br>B. Wing | 09/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Good Samaritan Society Sioux Falls Center | 401 West Second Street<br>Sioux Falls, SD 57104 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(continued on next page) |

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.

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

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on South Dakota Department of Health (SD DOH) complaint review, record review, interview, and policy review, the provider failed to protect the resident's right to be free from neglect and abuse for one of one sampled resident (4) who complained of prolonged wait times for his call light to be answered by staff and felt that had caused him to be incontinent of urine or bowel at times. The resident expressed that those instances caused him to feel less than human. Findings include:1. Review of the 2/7/25 SD DOH complaint intake report regarding resident 4 revealed:*Resident 4 had slept so long that he was incontinent of urine.*He turned on his call light, and after 30 minutes no one answered so he called the front desk.*He waited an additional 30 minutes before someone came to assist him.*He sat in urine for over an hour. 2. Review of resident 4's electronic medical record (EMR) revealed:*His Brief Interview for Mental Status (BIMS) assessment score on 12/5/24 was 15 which indicated his cognition was intact.*His Braden score on 12/2/24 was 16 which indicated he had a mild risk for skin breakdown.*He had diagnoses of:-Mixed incontinence (a condition of stress and urge voiding).-Open wound to right buttock (skin breakdown).-Spinal stenosis (narrowing of spaces between spinal bones).-Adjustment disorder (inability to adapt to situations in society). -Hypertensive heart disease with heart failure (high blood pressure which damages the heart over time). -Morbid Obesity (excessive weight that significantly impacts health and well-being).-Major depressive disorder, single episode, severe (feeling of sadness and loss of interest that interfere with daily living). -Generalized anxiety disorder (persistent worry and fear about everyday situations).*His right buttock wound discovered on 1/15/25 and was due to incontinence.-He had orders to receive Triad Hydrophilic wound dressing paste (wound healing product) to the wound and to cover the wound with Mepilex dressing once daily and as needed.*Numerous documentations in his progress notes indicated his refusal of activities of daily living, repositioning, medications and treatments.*Resident 4's care plan indicated he was bedfast all or most of the time and he preferred bed baths. That was initiated on 9/19/24.-His bathing preference was updated on 2/7/25 that indicated his preferred a shower weekly on Thursday morning. 3. Review of resident 4's call light log from 1/19/25 to 2/7/25 revealed these times that were over 20 minutes in length:*On 1/20/25 at 12:57 a.m. his call light was on for 23 minutes.*On 1/20/25 at 8:20 a.m. his call light was on for 43 minutes. *On 1/22/25 at 5:11 a.m. his call light was on for one hour and seven minutes.*On 1/26/25 at 12:16 p.m. his call light was on for 25 minutes.*On 2/3/25 at 5:10 a.m. his call light was on for 22 minutes.*On 2/3/25 at 8:52 p.m. his call light was on for 39 minutes.*On 2/6/25 at 9:54 p.m. his call light was on for 24 minutes. 4. Interview on 9/3/25 at 8:08 a.m. with resident 4 revealed:*He had some depression and anxiety.*He showered once a week on Thursday morning.*He had been left lying in urine and bowel movement several times in his bed after turning his call light on and waiting for assistance.*He required a treatment to his right buttock open area daily.*His call light could be on for 20 minutes to two hours before it was answered at times.*He stated, He felt disgusting and less then human when they do not answer his call light, how can another person do that to another person. Interview on 9/3/25 at 10:55 a.m. with certified nursing assistant (CNA) K revealed:*She has worked at facility for about three years.*Resident 4 did not exhibit negative behaviors toward her.*She had at times observed resident 4 screaming at other staff and throwing things in his room.*Resident 4 had periods when he would cry and bang on things.*Resident 4 had refused cares such as toileting, and bathing at times.*The expected time for staff to answer a resident's call light was two minutes. Interview on 9/3/25 at 5:00 p.m. with certified medication aide (CMA) L revealed:*Resident 4 had episodes when he will yell and scream at staff at times.*She felt resident 4 had a hot temper and could go from being calm to hot in a short period of time.*Resident 4 was able to use his call light.*If resident 4 had an incontinent episode it could set him off and he will get upset. Interview on 9/4/25 at 2:28 p.m. with director of nursing (DON) B revealed:*Resident 4's preference for bathing prior to 2/7/25 was to take a bed bath to allow for his smoking time preference.-He changed to a weekly shower on 2/7/25.*Resident 4 would at times refuse staff assistance with toileting, bathing, showering, repositioning, and wound care.*Resident 4 does attend care conferences.*She thought the staff answering a call light was within 20 to 30 minutes of it being turned on would be a prompt response and that was her expectation. Interview on 9/4/25 at 3:10 p.m. with administrator A revealed:*His expectation regarding the staff answering a resident call light, was it would be answered in an appropriate time, and that would depend on the resident and the resident's needs.*When asked if an hour was too long to wait, he stated that would depend on what the resident's needs would be. 5. Review of the provider's revised 7/8/25 Call light Policy revealed:*Purpose to ensure residents always have a |

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| F 0678<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, record review, and interview, the provider failed to withhold cardiopulmonary resuscitation (CPR) for one of one resident (100) who had a do not resuscitate (DNR) code status (specifies the type of emergent treatment a person wishes to receive if their heart or breathing would stop) and was found unresponsive.Findings include:1. Review of the provider's [DATE] SD DOH FRI revealed:*On [DATE], resident 100 was found unresponsive by restorative nursing aide (RNA) V.*Director of nursing (DON) B initiated the provider's code blue process. *CPR [cardiopulmonary resuscitation] was initiated [by a facility staff member] and EMS [Emergency medical services] [was] called prior to the [resident's] DNR order being brought to the resident room. Code status was found via the advanced directive binder on the crash cart (a cart that stores medication and equipment for use during a medical emergency) per policy/procedure.*Upon EMS's arrival at the facility, the resident's code status was confirmed to be DNR.*[The provider's] Policy was followed. 2. Review of resident 100's electronic medical record (EMR) revealed:*She was admitted to the facility on [DATE].*An [DATE] physician's order for ADVANCE DIRECTIVE: Do Not Resuscitate (DNR). 3. Interview on [DATE] at 11:20 a.m. with DON B, who worked on [DATE], revealed:*On [DATE], RNA V found resident 100 unresponsive during the morning water pass.*DON B's office was in the area of resident 100's room. She entered that room, assessed resident 100, and determined she was not breathing.*DON B asked certified nursing assistant (CNA) K resident 100's code status, and was told by CNA K that the resident's code status was a full code (all life-sustaining measures, including CPR, should be used during a medical emergency to attempt to restart a patient's heart and lungs).*Registered nurse (RN) W brought the crash cart to resident 100's room, and gave a second verbal confirmation that resident 100 was a full code.*DON B initiated CPR on resident 100, requested the automated external defibrillator (AED), and requested 911 to be called.*DON B provided CPR to resident 100 until emergency medical technicians (EMTs) arrived and assumed resident 100's emergency treatment. *DON B looked at the advanced directives binder and read that resident 100 had a DNR code status.*That written DNR code status was provided to the EMTs, and CPR was stopped.*DON B stated if she had known that resident 100 had a DNR code status, she would not have started CPR on resident 100. There had been a miscommunication. 4. Interview on [DATE] at 9:31 am with CNA K, who worked on [DATE], revealed:*She had responded to resident 100's room after resident 100 was found unresponsive.*CNA K told DON B that resident 100 was a full code.*CNA K had not looked at the advanced directives binder when she told DON B that. She thought that resident 100 was a full code. 5. Interview on [DATE] at 10:43 p.m. with clinical learning development specialist (CLDS) F revealed:*She was a CPR instructor and conducted the nursing staff skills fair and competencies.*When a resident was found unresponsive, staff were trained to check the resident's vitals (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate), obtain the crash cart and the advance directives binder to confirm the resident's code status before initiating CPR.*The advance directives binder and the residents' EMR identified each resident's physician-ordered code status.*She expected that CPR would not be initiated if a resident had a DNR code status. *She stated that it was the facility's policy for the nurse to check the resident's code status before starting CPR. *Review of the provider's [DATE] Advance Directive including Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator (AED) policy, revealed:*If cardiac arrest occurs, CPR must be initiated unless the resident has: a. A valid DNR order on file that includes the medical order issued by a physician. |