STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435087	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society Canistota	700 West Main St Canistota, SD 57012

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 45683 Based on interview, record review, and policy review the provider failed to provide bed-hod notices to residents and/or their representatives regarding transfers to the hospital on two of three occasions for two of two sampled residents (9 and 46). Findings include: 1. Interview on 12/3/24 at 8:59 a.m. with resident 9 revealed she: *Had gone to the hospital. *Was there for a long time. *Could not remember why she was in the hospital. Review of resident 9's electronic medical record (EMR) revealed: *She was transported to the emergency department (ED) on 7/23/24 and was admitted to the hospital. *Her power of attorney (POA) was notified by phone of her transfer. *She returned to the facility from the hospital on 7/29/24 with diagnoses of urinary tract infection (UTI) and pneumonia. *Resident 9's POA called the provider on 7/31/24 to inform them he was notified resident 9 was being taken to the ED for an evaluation, but he was not notified she had been admitted . *There was no documentation in her EMR that indicated bed-hold information was given to her or her POA. 2. Interview on 12/3/24 at 9:25 a.m. with resident 46 revealed she did not think she had gone to the hospital recently. Review of resident 46's EMR revealed: *She was transferred to the hospital on 4/21/24. (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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Her POA was notified by phone of her transfer. -There was no documentation in her EMR that indicated the bed-hold information was given to her or her POA. *She was transferred to the hospital on 6/7/24. -Her POA was notified by phone of her transfer. -A bed-hold was signed by resident 46's POA on 6/10/24. 3. Interview on 12/4/24 at 3:22 p.m. with social worker C regarding the bed-hold notifications revealed: *She was responsible for issuing the bed-hold notifications. *The hospitalization for resident 46 happened on a Sunday and it did not get communicated to her. *She thought it was the nurse's responsibility to issue a bed-hold notification if it was at night or on a weekend. *She would have issued a bed-hold notice on Monday morning. *She agreed the bed-hold notifications were not given to the above residents or their POA. 4. Interview with administrator A at 4:02 p.m. regarding bed-hold notifications revealed: *She knew a resident/responsible party must be notified of the bed-hold when residents transferred to the hospital. *They had a checklist that staff were to follow for transfers. *Her expectation was the social worker would issue the bed-hold notifications during normal business hours and the charge nurse would issue it during nights and weekends. *She agreed bed-hold notifications were not being issued appropriately. 5. Review of the provider's 12/7/23 Bed-Hold policy revealed: *Purpose: To ensure that the resident/resident representative is made aware of the facility's bed hold and reserve bed payment policy before and upon transfer to a hospital or when taking a therapeutic leave of absence from the facility. *Policy: At the time of admission, transfer or therapeutic leave, the location will provide written information to the resident or resident representative that specifies: -1. The duration of the state bed-hold policy, if any, during which a resident is permitted to return and resume residence. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-2. The reserve bed payment policy in the state plan. -3. The location's policy regarding bed-hold periods permitting a resident to return. *In Case of Emergency Transfer. -1. b. The charge nurse is responsible for completion of notification procedures if the transfer occurs at a time the social worker is not at the location. -2. The social worker or designated individual will contact the resident/resident representative to inquire regarding their decision for holding a bed. -3. In cases where the facility was unable to notify the resident representative, the social worker or designated individual will document multiple attempts to reach the resident's representative.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50916 Based on record review, interview, and policy review the provider failed to ensure one of one sampled resident (42) had reviewed and was provided a summary of her baseline care plan within forty eight hours of admission. Findings include: 1. Review of resident 42's electronic medical record (EMR) revealed: *She had been admitted on [DATE]. *She was admitted from an inpatient psychiatric facility. *She was diagnosed with unspecified mood [affective] disorder, mild neurocognitive disorder due to known physiological condition with behavioral disturbance, liver cell carcinoma, and long term use of anticoagulants. *Her Brief Interview for Mental Status (BIMS) assessment score was 12 which indicated moderate cognitive impairment. *There was no documentation of a power of attorney (POA) until 9/18/24. *Her baseline care plan was not signed as completed until 11/4/24. *There was no documentation in her EMR that a baseline care plan summary had been reviewed with the resident. 2. Interview on 12/4/24 at 2:25 p.m. with director of nursing (DON) B regarding residents' baseline care plans revealed: *The Minimum Data Set (MDS) nurse F completed the baseline care plans. *She guessed resident 42's baseline care plan had been signed as completed on 11/4/24 at her care conference. 3. Interview on 12/4/24 at 3:11 p.m. with resident 42 about her baseline care plan revealed: *She did not remember reviewing her baseline care plan when she was admitted to the facility. *She did not remember signing a baseline care plan when she was admitted to the facility. 4. Interview on 12/4/24 at 3:46 p.m. with MDS nurse F revealed: *She completed the nursing portion of the baseline care plans. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*She did not have any documentation if they had reviewed or given a summary of resident 42's baseline care plan with her at the time of her admission. 5. Review of the provider's revised December 2, 2024 Care Plan policy revealed: *A baseline care plan includes instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. *A baseline care plan will be developed upon admission according to federal and state regulations. The location must provide the resident and resident representative with a written summary of the baseline care plan. Use the PN-Care Conference Note/or Matrix equivalent to document that the meeting occurred with the resident and representative and any significant discussion that occurred.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45683 Based on observation, interview, record review, and policy review the provider failed to ensure: *Necessary food safety guidelines were followed for appropriate storage of resident food items. *Proper cleaning procedures were followed for dishes used to store, prepare, and serve residents' food in one of one main kitchen. Findings include: 1. Observation on 12/2/24 at 3:06 p.m. during the initial tour of the main kitchen revealed: *Three uncovered bowls of breakfast cereal stacked on top of each other inside the cupboard above the steam table. *Three soup bowls and three soup cups inside another cupboard with food residue on them. Interview on 12/2/24 at 3:25 p.m. with cook E regarding the items in the above cupboards revealed: *The bowls of breakfast cereal had been put in the cupboard after breakfast. *The booster heater had gone out of the commercial dishwasher and had not been working for two weeks. *The staff were washing the dishes by hand. *The staff were checking water temperatures and sanitizer levels while doing dishes by hand. *The new booster heater was scheduled to be delivered on 12/3/24. Interview and record review on 12/2/24 at 5:03 p.m. with nutrition and food services supervisor D regarding the items in the cupboard and the commercial dishwasher revealed: *She did not know why the bowls of cereal were in the cupboard. *Her expectation was no food items would be stacked on top of each other or uncovered. *She confirmed the booster heater for the commercial dishwasher had gone out two weeks ago. *The soup bowls and cups observed above had been rewashed to ensure they were clean before being used. *The staff were monitoring water temperatures and sanitizer levels while washing dishes by hand. *Review of the documented water temperatures and sanitizer level logs confirmed the levels were in compliance. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 12/4//24 at 3:45 p.m. of the commercial dishwasher in the main kitchen revealed the booster heater was being replaced by a service technician. Review of the provider's 5/7/24 Food-Supply Storage-Food and Nutrition Services policy revealed: *7. Foods that have been opened or prepared are placed in an enclosed container, dated, labeled and stored properly. *8. Items being prepared for the next meal do not have to be dated and labeled but must be covered. Once meal service is over, cover, date and label trays of individually-portioned items such as desserts, salads, glasses of juice, milk and supplements. Review of the provider's 3/25/24 Warewashing-Mechanical and Manual-Food and Nutrition policy revealed: *Food and nutrition employees ensure that food preparation equipment, dishes and utensils are effectively cleaned, sanitized to destroy potential disease carrying organisms and stored in a protective manner. *Manual Ware Washing. Pots, pans and any other utensils or wares will be scraped, washed, rinsed and sanitized.