STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435124	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society Miller	421 East 4th St Miller, SD 57362

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. 45683 Based on resident council meeting, observation, interview, record review, and policy review, the provider failed to ensure three of fifteen residents (1, 15, and 18) bathing preferences were followed. Findings include: 1. Resident council meeting held on 9/17/24 at 11:20 a.m. revealed: *The bathing schedule had changed recently. *Residents who wished to remain anonymous voiced their concerns they were not getting bathed on their scheduled bath days. *The lack of baths had been discussed during care plan meetings. 2. Observation and interview on 9/18/24 at 10:35 a.m. with resident 1 regarding her bathing schedule revealed: *She had been getting one bath a week after she was admitted . *The last two weeks her bath had not been completed on her scheduled day. *Her preference was three baths a week like she had received while she was an assisted living resident before she was admitted to the nursing home. Review of resident 1's electronic medical record (EMR) regarding her bathing preferences revealed: *Her 6/27/24 initial care plan was revised on 8/6/24 to include Resident requires whirlpool bath with 1 staff, preference is 2 weekly. *A progress note dated 7/30/24 from social services coordinator G: -Resident talked to this writer about wanting more baths due to her room being warm. -She was getting 3 baths a week at the AL where she was. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Her care plan had not been revised to indicate her preference of three baths a week. *Her bathing record documentation from 8/19/24 through 9/17/24 indicated she had a bath on 8/22/24, 8/28/24, and on 9/5/24. *There was no documentation that she had received a bath for 12 days. 3. Interview on 9/18/24 at 2:05 p.m. with resident 15 regarding his care revealed: *The day of his bath had recently been changed from Fridays to Mondays. -He was satisfied with bathing one time a week and had not minded the bath schedule change. *He did not get bathed on 9/16/24 before a funeral he planned to attend on 9/17/24. -He had specifically requested a bath from staff twice on 9/16/24, as he had wanted to be clean for the funeral. -The staff had not communicated with him that there was no hot water in the tub room where he bathed until late the evening of 9/16/24. -He was not offered a bath on the morning of 9/17/24 before the funeral. -He was not offered a sponge bath or to have a bath in the other facility bathing room and was not offered assistance with shaving. -He attended the funeral without having been bathed or shaved. Review of resident 15's medical record revealed: *His 7/10/24 Sit-Stand-Walk Data Collection Tool indicated he: -Preferred a Whirlpool bath during the day, two or more times per week. *His 9/18/23 care plan regarding bathing revealed: -There was an 8/6/24 focus area for bathing that included: -He required assistance of one staff person with bathing. -He preferred to have one whirlpool bath a week. *His bathing record from 8/19/24 through 9/18/24 indicated he had a bath on 8/23/24, 8/30/24, and 9/9/24. *There was no bathing documentation that he received a bath as he requested on 9/16/24. 4. Interview on 9/19/24 at 6:40 p.m. with resident 18 regarding bathing revealed: (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Staff helped her with bathing, and she was not able to bathe herself. *She thought her bath was scheduled for one time a week. *She missed her bath recently, and the staff told her something had broken down. *She did not know if she had not received bathing more often and stated her brain can't compute. Review of resident 18's medical record revealed: *Her 7/30/24 Sit-Stand-Walk Data Collection Tool indicated she preferred a tub bath, during the day, two or more times per week. *Her 9/18/24 care plan regarding bathing revealed: -There was a revised 8/6/24 focus area for bathing that included: --She required two staff members and a mechanical lift sling to transfer into a whirlpool chair. --She preferred one or two whirlpool baths a week. -Her bathing record from 8/19/24 through 9/18/24 indicated she had a bath on 8/23/24, 8/30/24, and on 9/15/24. --On 9/13/24 her bath was documented as not applicable. *There was no bathing documentation that she had received a bath for at least 15 days. 5. Interview on 9/19/24 at 11:07 a.m. with certified nursing assistant (CNA) K regarding resident bathing revealed: *The regular bath aide had changed to working part-time. *The administrative assistant had been scheduling the bath aides. *Different staff were scheduled to give baths when available. *Interview on 9/19/24 at 11:19 a.m. with interim director of nursing (IDON) B regarding resident bathing revealed: *She knew bathing was an issue. *There were recent changes in the bathing schedule due to staffing. *She had started tracking the residents' bathing to ensure they were being completed. *Her expectation was each resident would get two baths a week or according to the resident's preference documented on their care plan. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 9/19/24 at 4:00 p.m. with administrative assistant O regarding resident bathing revealed:*She was in charge of the nursing schedule. *The the full-time bath aide had recently quit working. *She scheduled whomever she could get to cover the bath schedule. *She agreed bathing was not being completed according to resident preferences. 6. Review of the provider's 11/1/23 Care Plan policy revealed: *Comprehensive care plan - Includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. *Person-centered care - A focus on the resident as the locus of control and supporting the resident in making his or her own choices and having control over their daily life. *Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables. *The plan of care will be modified to reflect the care currently required/provided for the resident. *The care plan will emphasize the care and development of the whole person ensuring that the resident will receive appropriate care and services. *The resident/family or legal representative will have the opportunity to participate in the planning of his or her care to the extent practicable. Review of the provider's 2022 Resident's Rights for Skilled Nursing Facilities booklet revealed: *The resident has the right to be informed of, and participate in, his or her treatment, including: .(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency and duration of care and any other factors related to the effectiveness of the plan of care. 43844

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 43844 Based on record review, interview, and policy review the provider failed to ensure one of one sampled resident's (27) physician was notified of the resident's suicidal ideation statements and safety concerns related to his staff-observed vehicle driving practices. Findings include: 1. Interview on 9/19/24 at 1:49 p.m. with interim director of nursing (IDON) B and registered nurse H regarding resident 27 revealed: *He had a car that was parked at the facility, and he drove that car at times. *They did not think that he was safe to drive. -They had notified the police; the police had told them they were not able to take his driver's license away from him. *There was no assessment completed for his cognitive abilities in relation to his driving a vehicle. *They had not notified his physician of their concerns about his driving. Review of resident 27's medical record revealed: *His nurse progress notes included: -On 7/17/24 he came in with a long piece of plastic with a rusty pointy end on it. When she asked what he was doing with it he told her since they took his scissors he was going to kill himself. Nurse told him that was not funny and we take those comments quite seriously. He told the nurse he was just kidding. The Social Services Coordinator asked him what he was doing with it and he told her the same thing. Administrator went to his room. [He] said he was not going to hurt himself or anyone else with it. -On 8/1/24 He stated that he was about in a wreck [with his car]. -On 8/2/24 Resident was insistent upon going for a drive in his car. Resident then got in his car, shut the door and drove off at a very fast speed, almost side-swiping the pick-up that was parked in front of his car. -On 9/15/24 He tightly squeezed a females buttock and stated, That's nice. *There was no documentation to support his physician had been notified of his statements of suicidal ideation or regarding his observed unsafe driving. Review of the provider's 12/4/23 Notification of Change policy revealed: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*A facility must immediately inform the resident, consult with the resident's physician and notify, consistent with his or her authority, the resident representative(s) when there is: -A significant change in the resident's physical, mental or psychosocial status.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43844 Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (15) who was blind had his food and drink free from flies in and on it, received timely care for his incontinence needs, and received a bath as scheduled prior to attending a funeral. Findings include: 1.Review of the provider's 9/11/24 SD DOH FRI revealed: *Interim director of nursing (IDON) B received an allegation of abuse from resident 15 on 9/11/24. *Allegations included he: -Had made requests for his care needs and had to wait up to three hours for staff to come back and perform them. -Had urinary incontinence and had not been provided no incontinent products. -Had visitors during a mealtime who told him flies were on his food and in his cup of hot chocolate. --Stated the visitors had told him they killed a total of 12 flies while seated at the table with him. Observation and interview on 9/17/24 at 9:30 a.m. with resident 15 revealed: *He was lying in bed with a book reading device next to him on the bed. -He was unshaven, with whiskers approximately one-fourth inch in length on his face. *His fingernails appeared dirty, with black residue underneath of them. *He stated he wished he was dead as this was the worst place he had been in all my life. *He said he had two [NAME] friends stop in and have dinner with him. -A problem arose with flies. -While eating dinner with his friends they told him that flies were on his food and in his hot chocolate. *The interview was then ended as his son arrived to him to a take to a funeral. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 9/19/24 at 1:45 p.m. with interim director of nursing (IDON) B regarding resident 15 revealed she: *Submitted a facility-reported incident (FRI) for resident 15 on 9/11/24 regarding suspected neglect. *Completed an interview with the resident but had not completed her final investigation. *Generally started an investigation when an issue was brought to her attention. *Interviewed the resident and included the interview in the FRI. -At the time of his interview, he expressed he was not provided incontinence care and had not used incontinence products. *Talked with and provided education to staff assigned to care for resident 15 regarding incontinence products, continued options, and incontinence care. *Stated staff were to have provided him incontinence care every two hours and as needed. -Was unsure if that had been added to his care plan. *Stated flies were horrible this time of year with the doors opened throughout the day. -Fly swatters were handed out, and the exterminator would came frequently to spray inside and outside the building. -Was not sure what else they could have done about the flies. Interview on 9/19/24 at 2:05 p.m. with resident 15 regarding his care revealed: *The day of his bath had recently been changed from Fridays to Mondays. -He was satisfied with bathing one time a week and had not minded the bath schedule change. *He did not get bathed on 9/16/24 before a funeral he planned to attend on 9/17/24. -He had specifically requested a bath from staff twice on 9/16/24, as he had wanted to be clean for the funeral. -The staff had not communicated with him that they had no hot water in the tub room where he bathed until late the evening of 9/16/24 and he was not offered a bath the morning of 9/17/24 before the funeral. -He was not offered a sponge bath or to have a bath in the other facility bathing room and was not offered assistance with shaving. -He attended the funeral without being bathed or shaved. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	*He had a bladder condition with incontinence and was told by his physician that he needed to be kept clean and dry and was to be checked for incontinence related needs) every two hours, but the staff did not consistently do that. *He would go to bed at 8:00 p.m. and staff would not check on him until 5:00 a.m. *He was not able to depend on his call light being answered and had waited for over an hour at times for staff to help him. -Had an episode of bowel incontinence within the past month and called his daughter with his talk telephone to get help. She called the main office number and told the person who answered the phone to have staff check on him, and that he had bowel incontinence when he waited for his light to be answered and needed help to get cleaned up. -Had another episode within two weeks, when he waited for over thirty minutes, and he couldn't hold it, so his roommate had helped him to the bathroom. Interview on 9/19/24 at 6:10 p.m. with resident 15's daughter regarding her father revealed: *She confirmed he called her within the last month asking for help and she called the office to have staff check on him. -He told her he waited for over an hour, couldn't hold it, and had a bowel incontinent episode, and had needed help to get cleaned up. *She visited later that day and he had not appeared to have been bathed or clean, his bedding was visibly dirty, and he had not appeared to have been changed. -Whenever she or her sisters visited, he asked them to change his bedding, and the staff had not changed his bedding unless he had an episode of bowel or bladder incontinence in the bed. *She and her siblings felt they couldn't say anything, or it would have made things worse for her father. Interview on 9/19/24 at 6:45 p.m. with business office manager C regarding resident 15 revealed: *She confirmed his daughter called the facility's main number within the past month during the mid-morning and she answered the phone. -His daughter reported her father called her for help and verbalized no one had answered his call light for an extended time. -His daughter requested staff go to his room to help him to the bathroom and clean him up, and that he reported to her he had a bowel incontinence episode while waiting for his call light to be answered. *She went to his room, saw the call light on in the hallway, but there was already a staff person in his room. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	*She had not asked staff if he had been incontinent. *She had not reported the call or episode to anyone. Review of the provider's 7/22/24 Abuse and Neglect policy revealed: *Purpose -To ensure that all identified incidents of alleged or suspected abuse/neglect, including injuries of unknown origin, are promptly reported and investigated. *The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Refer to F553 Finding 3, F657 Finding 5, and F925 Findings 5, 8, 9, and 10.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 50916 Based on interview, record review, and policy review, the provider failed to provide a copy of the transfer notice to the Office of the State Long-Term Care Ombudsman for one of one sampled residents (21) reviewed for facility-initiated transfer to the hospital. Findings include: 1. Interview on 9/17/24 at 9:00 a.m. with resident 21 revealed she did not think she had gone to the hospital recently. 2. Review of resident 21's electronic medical record (EMR) revealed: *She was transferred to the hospital on 5/15/24. -Her power of attorney (POA) was notified of her transfer. -There was no documentation the bed hold information was given to the resident or her POA. *She was transferred to the hospital on 6/18/24. -Her POA was notified. -There was no documentation the bed hold information was given to the resident or her POA. 3. Interview with the facility's local ombudsman on 9/18/24 at 2:51 p.m. regarding resident 21's transfers to the hospital revealed: *She said the facility normally filled out a report online about hospitalization s. *The facility has one month to notify them of the hospital transfer. *She stated that she had not received notifications for either of resident 21's hospital transfers above. 4. Interview on 9/19/24 at 11:12 a.m. with administrator A revealed: *The social services coordinator G was responsible for submitting hospital transfer reports to the ombudsman. *She was not aware that they had to report every hospital transfer to the ombudsman. *No documentation was provided to verify the ombudsman was notified of resident 21's hospital transfers. 5. Review of the provider's 12/6/23 Ombudsman policy revealed: (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*A website for more information regarding state-specific regulations. *The state-specific regulations on the website stated, Copies of notices for emergency transfers must also still be sent to the ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 50916 Based on interview, record review, and policy review, the provider failed to provide bed-hold notices to the resident and/or their representative regarding transfers to the hospital on two occasions for one of one sampled resident (21). Findings include: 1. Interview on 9/17/24 at 9:00 a.m. with resident 21 revealed she did not think she had gone to the hospital recently. 2. Review of resident 21's electronic medical record (EMR) revealed: *She was transferred to the hospital on 5/15/24. -Her power of attorney (POA) was notified of her transfer. -There was no documentation the bed hold information was given to the resident or her POA. *She was transferred to the hospital on 6/18/24. -Her POA was notified. -There was no documentation the bed hold information was given to the resident or her POA. 3. Interview on 9/18/24 at 2:23 p.m. with registered nurse H regarding resident 21's bed hold notice revealed: *She believed she had been the one to put the transfer in for her last hospital stay and didn't do a bed hold notice. *She could not find any bed hold notice pertaining to the last two hospital visits. 4. Interview on 9/18/24 at 2:25 p.m. with business office manager/dietary manager C revealed she did not find any bed hold notices for resident 21's recent hospital visits. 5. Interview on 9/18/24 at 3:15 with administrator A revealed they did not have bed hold notices signed for resident 21 for her hospital stays on 5/15/24 and 6/18/24. 6. 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: (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-1. The duration of the state bed-hold policy, if any, during which a resident is permitted to return and resume residence. -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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 43844 Based on observation, interview, review of the provider's facility reported incident (FRI) to the South Dakota Department of Health (SD DOH), and policy review the provider failed to ensure 4 of 5 sampled residents (1, 15, 18, and 27) had their care plans were followed, updated, and revised promptly to reflect their current status and care needs. Findings include: 1. Interview and observation on 9/17/24 at 4:01 p.m. with resident 27 revealed: *He had an electronic neuropathy machine [device] that he used daily for neuropathy pain on his feet. Review of resident 27's medical record revealed: *His nurse progress notes included: -On 7/17/24 he came in with a long piece of plastic with a rusty pointy end on it. When she asked what he was doing with it he told her since they took his scissors he was going to kill himself. Nurse told him that was not funny and we take those comments quite seriously. He told the nurse he was just kidding. The Social Services Coordinator asked him what he was doing with it and he told her the same thing. Administrator went to his room. [He] said he was not going to hurt himself or anyone else with it. -On 8/1/24 He stated that he was about in a wreck [with his car]. -On 8/2/24 Resident was insistent upon going for a drive in his car. Resident then got in his car, shut the door and drove off at a very fast speed, almost side-swiping the pick-up that was parked in front of his car. -On 9/15/24 He tightly squeezed a female staff's buttock and stated, That's nice. *His care plan had not included his use of the infra-red device, his suicidal ideations, use his inappropriate sexual touching of staff, or that he had a car and drove it. Interview on 9/19/24 at 1:49 p.m. with interim director of nursing (IDON) B and registered nurse H regarding resident 27 revealed: *He had a car that was parked at the facility, and he drove that car at times. *They did not think that he was safe to drive. -They had notified the police; the police had told them they were not able to take his driver's license away from him. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society Miller	421 East 4th St Miller, SD 57362

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*There was no assessment completed for his cognitive abilities in relation to his driving a vehicle. Follow-up interview on 9/19/24 at 2:40 p.m. with IDON B regarding resident 27's driving and his car revealed: *She had found out that he was recently picked up by police a couple of times while driving. -The police had taken his driver's license away from him. -He had sold the car to an employee. 2. Interview on 9/18/24 at 10:35 a.m. with resident 1 regarding her bathing schedule revealed: *She had been getting one bath a week after she was admitted . *Her preference was three baths a week like she had received while she was an assisted living (AL) resident before her admission to the nursing home. Review of resident 1's electronic medical record (EMR) regarding her bathing preferences revealed: *A progress note dated 7/30/24 from social services coordinator G: -Resident talked to this writer about wanting more baths due to her room being warm. -She was getting 3 baths a week at the AL where she was. *Her 6/27/24 initial care plan was revised on 8/6/24 to include Resident requires whirlpool bath with 1 staff, preference is 2 weekly. 3. Interview on 9/19/24 at 6:40 p.m. with resident 18 regarding bathing revealed: *Staff helped her with bathing, and she was not able to bathe herself. *She thought her bath was scheduled for one time a week. *She missed her bath recently, and the staff told her something had broken down. *She did not know if she had not received bathing more often and stated her brain can't compute. Review of resident 18's medical record revealed: *Her 7/30/24 Sit-Stand-Walk Data Collection Tool indicated she preferred a tub bath, during the day, two or more times per week. *Her 9/18/24 care plan indicated she preferred one or two whirlpool baths a week. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Observations of resident 18 revealed she was lying in her bed that was raised to its highest position: *On 9/17/24 at 2:39 p.m. *On 9.19.24 at 11:10 a.m. *On 9/19/24 at 2:12 p.m. Observation on 9/19/24 at 2:12 p.m. of resident 18 in her room revealed: *She was in her bed, eyes closed, bedside table positioned across the bed at waist area. *The bed was in the highest position. Interview on 9/19/24 at 2:08 p.m. with certified nursing assistant (CNA) K regarding resident 18's height of her bed: *Her bed should be in the lowest position possible to prevent her from falling. *She required the assistance of staff and a full body mechanical lift to get into bed. *CNA K had not assisted resident 18 on this day. Review of resident 18's medical record revealed: *Her admitted was 10/19/22 *Her Brief Interview of Mental Status score was a 10, indicating she had mild cognitive deficits. *Her care plan did not include the height her bed should be at when she was lying in it. *She required assistance of two staff members and a full-body mechanical lift for bed mobility. 5. Review of the provider's 9/11/24 SD DOH FRI revealed: *Interim director of nursing (IDON) B received an allegation of abuse from resident 15 on 9/11/24. *Allegations included he had urinary incontinence and no incontinent products were in place. Interview on 9/19/24 at 1:45 p.m. with IDON regarding resident 15 revealed: *She interviewed the resident and included the interview in the FRI. -At the time of that interview he expressed he was not provided incontinence care and had not used incontinence products. *She stated staff were to have provided incontinence care every two hours and as needed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She was unsure if his incontinence care needs had been added to his care plan. Interview on 9/19/24 at 2:05 with resident 15 regarding his care revealed he had a bladder condition with incontinence and was told by his physician that he needed to be kept clean and dry and was to be be provided incontinence care every two hours, but the staff had not consistently done this. Review of resident 15's medical record revealed: *His admitted was 10/12/23. *His diagnoses included: malignant neoplasm of bladder, legal blindness, macular degeneration, and unspecified dementia. *His care plan indicated: -On 2/28/24 Needs to be checked and changed approx. [approximately] q [every] 2-3 hours for incontinence. Uses an incontinent product. Voices that the urinal no longer works for him and he only uses the toilet for BM [bowel movement] purposes. -On 2/28/24 and revised on 5/18/24 ambulates with cane at times, otherwise hangs on to a staff members arm for guidance to get to destinations. May use wheelchair when feeling week. 6. Interview on 9/19/24 at 3:05 p.m. with minimum data set nurse D regarding resident care plans revealed: *The interdisciplinary team, including nursing, dietary, activity, and social services were involved in the development of the care plan. -The resident's physician would review and sign the care plan. -Each member of the interdisciplinary team was responsible for completing their area of the care plan. *The care plan was updated whenever a resident had a change in the care they required and on a quarterly basis. -CNAs would provide her with information on each resident and she would then update their care plan with that information. --There had been lots of turnover with CNAs. *Regarding resident bathing: -Each resident's preference for bathing was obtained through interviews and documented on a Sit-Stand-Walk Data Collection Tool. --Their preference was then documented on their care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Regarding resident 27's care plan: -She had no knowledge of his suicidal ideation. --His physician should have been notified of this. --Social service designee G should have updated his care plan with this focus. -Was not certain if his driving a vehicle was on his care plan. -She was aware he had given a staff member an inappropriate written note asking her to meet him somewhere. *Regarding resident 18's bed positioning and care plan: -The head of the bed was to be elevated 30 degrees when she was in bed. -Resident 18 preferred the bed height to be maintained at a normal height. -Her bed was not to be in a low position as she was not a high fall risk. *Regarding resident 15's care plan and the use of incontinent products. -She was not aware he had not been using incontinent products. 7. Social service designee G was not available for an interview. 8. Review of the provider's 11/1/23 Care Plan policy revealed: *Comprehensive care plan - Includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. *Person-centered care - A focus on the resident as the locus of control and supporting the resident in making his or her own choices and having control over their daily life. *Policy -Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. -Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed towards achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. Any problems, needs and concerns identified will be addressed through the use of departmental assessments, the Resident Assessment Instrument (RAI) and review of the physician's orders. *The plan of care will be modified to reflect the care currently required/provided for the resident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The care plan will emphasize the care and development of the whole person ensuring that the resident will receive appropriate care and services, and other employees as determined by the resident needs. *The resident/family or legal representative will have the opportunity to participate in the planning of his or her care to the extent practicable. *The interdisciplinary team will review care plans at least quarterly.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49238 Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), observation, interview, and record review the provider failed to ensure one of one resident (17) who required staff assistance with care had not developed facility acquired pressure injuries when left on a bedpan for an extended time. Findings include: 1. Observation and interview on 9/17/24 at 9:02 a.m. with resident 17 revealed: *He was bedridden and dependent on staff for care due to a back injury and a history of a broken arm that did not heal correctly. *He had a mesh sling under him staff used for repositioning and for the lift. *he felt staff did a good job but this shift, but this shift, they don't want to help me. *He stated he pushed the call light button and, she just answered while you are in here, sometimes I am ornery and turn on the call light and wait for them and I have the door wide open so I can yell at them, you should see them run! They should check on me, what if I am on my last breath. 2. Interview on 9/18/24 at 9:49 a.m. with registered nurse (RN) H revealed: *Resident 17 is dependent on staff for all of his cares. *He would forget to use his call light at times, yell, call on his phone or he would call the police. *He has some dementia. *He used the bedpan because the lift was hard on him due to a history of back fractures. *He would use the toilet on his bath days. *He had a mesh sling under him they used to reposition him or to lift him up in the mechanical lift. 3. Interview and observation on 9/18/24 at 10:08 a.m. with RN H regarding resident 17 pressure ulcers revealed: *He had some wounds that were worse on admission but had improved. *She prepared for his wound care and stated it took three staff to reposition him. *She planned to be in his room for about one hour to complete his care. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	*CMA J and CMA T were in resident 17's room to assist RN H. *CMA J moved to the right side of his bed with CMA T and explained the care they would complete. *RN H placed a barrier down on a chair located on the left side of his bed for supplies. *She explained to resident 17 and the CM's they would clean him with wash cloths and then do his wound care. *She started at his face then his arms, and applied deodorant. *The CMAs rolled him to his right side with the mesh sling. *RN H removed his bandage from his coccyx (tailbone) wound. -That wound was open with pink and peeling skin on both of his outer buttocks. -RN H cleaned and irrigated the wound, applied collagen particles inside the wound and wound packing, she then covered the wound with a foam absorbent bandage. *The three staff repositioned him to his back for a break from wound care and continued to bathe him, then changed his gown. *The staff repositioned him back to his right side with the mesh sling. *RN H elevated his left heel on a pillow and his wound care was completed. *She put new elastic tubular bandage wraps on both of his lower legs. *Staff used the EZ way smart total body mechanical lift, attached his mesh sling to lift while CMA T stabilized his neck and head per RN H's direction. -He was lifted and suspended off the bed. -RN and H and CMA J changed his bedding placed a clean sling and an absorbent pad under, lowered him onto the bed, staff rolled him to his right and removed the dirty sling and replaced it with a clean one. -The three staff positioned him on his back with the head of the bed elevated. -The two CMAs then lifted and rolled resident 17 to his left as RN H pulled him toward her and the CMAs placed a wedge under his right side. -Resident 17 stated he did not want the wedge but RN H explained it was for pressure relief for his right buttock for a while and he stated he knew what it was for and agreed to use it for a while. *RN H placed pillows under each of his arms and under his left heel and a heel protector boot on his right foot. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	4. Interview on 9/18/24 at 4:00 p.m. with CMA J regarding resident 17 revealed: *She had heard resident 17 had been left on his bedpan from around 7:45 p.m. to 8:00 a.m. the next morning two weeks ago. *He had been on the bedpan when the day shift came on shift. * There was communication on the computer that stated when you put someone on the bedpan you are to take them off the bedpan. *There had been no education about bedpans since this incident that happened two weeks ago. 5. Interview on 9/18/24 at 4:32 p.m. with interim director of nursing (DON) B revealed: *Resident 17 was left on the bedpan from 9/4/24 at 8:00 p.m. until 9/5/24 at 8:00 a.m. *She stated she had been working and saw him still on the bedpan on 9/5/24 when he was repositioned. -She had seen areas on his buttocks that were red where he had sat on the bedpan all night. *She stated skin issues on his buttocks would have been noted on the Minimum Data Set (MDS). *She stated she had done education about bed pan use. *She did not have documentation of the education she provided. *She did not have an attendance sheet of staff that had attended the education. *She stated she had done the education when the incident occurred for those involved and had left resident 17 on the bedpan, and did not educate everyone. 6. Interview on 9/19/24 at 11:39 am with CNA K revealed: *She was not trained on how to work with challenging residents, but she would leave the room and return later if a resident was being difficult. *She was not involved in the incident when resident 17 was left on the bedpan but found out about it the next morning. *She had no training about bedpans since that incident had happened. *She had heard from other people that administrator A had said if it happened again people would be written up. 7. Interview on 9/19/24 at 12:48 p.m. with certified medication aid (CMA) Q revealed: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	*She was aware resident 17 had been left on the bed pan from 7:00 p.m. or 8:00 p.m. to 7:00 a.m. or 8:00 a. m. but she could not remember the date. *She had been called by RN R and DON B to his room to help get him off the bedpan. *Resident 17 needed three people to move him for cares and repositioning. *She saw a red mark on his right buttock she thought the red mark on his left upper buttock was a bruise from the bedpan. *She stated there was a mass text that went to her personal phone and was put in computer communication system whoever put a resident on a bedpan were to take them off. *She was not aware of any other education or meeting about bedpan use. 8. Interview on 9/19/24 at 1:15 p.m. with RN R regarding resident 17 being left on the bedpan revealed: *She had gotten report the morning of 9/5/24, walked down the hallway and looked in on resident 17 from the hall and he was asleep. -She was not aware he was still on the bedpan at this time. *She had been providing care on the other hall and the business office manager C had come out of her office and stated resident 17 had called 911. -They both went to resident 17's room and he was crying and stated he had been left on the bedpan all night. *She stated they lifted the cover and could not see the bedpan and they lifted him with the sling and rolled him to his side and could then see the bedpan was still under him. *She stated they had not done this in front of the police officer due resident 17's privacy. *He is very difficult to move due to his size. *He had had his medications the night before and had fallen asleep on the bed pan and didn't feel it. *Staff should have known to get him off the bedpan. *He had a red ring on his buttocks from being on the bedpan all night but the ring was gone now. *She was not aware of any education provided to staff in reference to him being left on the bedpan. 9. Review of resident 17's Minimum data set (MDS) quarterly assessment dated [DATE] for skin conditions revealed: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	*He was at risk of developing pressure ulcers/injuries. *He did not have any stage 2 pressure ulcers. *He did have a Stage 4 pressure ulcer that was present on admission. *He was not on a turning/repositioning program. 10. Review of resident 17's wound assessments revealed: *On 8/29/24 signed by RN H, Left heel 1. Progress toward healing 1. Wound name -left heel deep tissue injury (DTI), 2. Type of wound a. Pressure ulcer, 2a. No, was this pressure ulcer present on admission/re-admission? 2b. Staging e) Unstageable 3. Healing process-evidenced by: Area is 60% dark pink, pink beefy granulated tissue with 40 percent white slough at the center. 4. Deterioration of wound - evidenced by: [NAME] purulent drainage. Peri-wound border now has dark purple non-blanching tissue. *On 8/29/24 signed by RN H, Left lower leg 1. Progress toward healing 1. Wound name, DTI with epidermal avulsion at center to posterior aspect of left lower leg. 2. Type of wound a. pressure ulcer 2a. No, was this pressure ulcer present on admission/re-admission? 2b. Staging k) Not staged 3. Healing process- evidenced by: Superficial, scant serosanguineous drainage, no erythema. 4. Deterioration of wound - evidenced by: Non-blanching dark purple intact tissue. *On 9/11/24 signed by RN R, Left buttock 1. Progress toward healing 1. Wound name, none 2. Type of wound a. Pressure ulcer, 2a. No, was this pressure ulcer present on admission/re-admission? 2b. Staging b)Stage 2, 3. Healing process- evidenced by: none, 4. Deterioration of wound - evidence by: Skin is sloughing off. *On 9/11/24 signed by RN R, Right buttock 1. Progress toward healing 1. Wound name, none 2. Type of wound a. Pressure ulcer 2b Staging b) Stage 2 3. Healing process- evidence by, none 4. Deterioration of wound - evidenced by: Maceration. 11. Review of resident 17's skin observations revealed: On 8/20/24 signed by RN R, 1. Skin check b. All other skin observations noted (e.g., bruising, abrasion, skin tears, rash, location of closed pressure injury) 2. Location -identify the site of the skin observation. In the description field, include the following: Type of skin condition, size/measurements, other information that further identifies the skin condition. Site 23) coccyx Description stage 4, site 44) Left lower leg (rear) Description stage 2, site 50) Left heel, description unstageable wound. *On 9/10/24 signed by Interim DON B, 1. Skin check 1. B. a1. Skin check b. All other skin observations noted (e.g., bruising, abrasion, skin tears, rash, location of closed pressure injury) 2. Location -identify the site of the skin observation. In the description field, include the following: Type of skin condition, size/measurements, other information that further identifies the skin condition. Site 31) Right buttock, Description Redness noted with skin hardening noted. Continue to monitor. Site 32) Left buttock Description Redness with skin hardening noted. Provider aware. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	12. Review of resident 17's diagnosis revealed: *Pressure ulcer of sacral regional, stage 4, Dementia, Pressure ulcer of left heel, unstageable, Spinal stenosis, lumbar region without neurogenic claudication, Morbid obesity, Muscle weakness, Abnormalities of gait and mobility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43844 Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (27) who used an infra-red device for neuropathy pain in his feet had a current physician order for its use and had been assessed for safety of its use. Findings include: 1. Interview and observation on 9/17/24 at 4:01 p.m. with resident 27 revealed: *He had an electronic neuropathy machine [device] that he used daily for neuropathy pain on his feet. *He stated, I had to go through a lot to get it approved to have in his room. -The device would shut off automatically after twenty minutes of use. *He pointed toward the device that was located on a folding chair, next to the window, and stated he used it every day. *The device had uncleanable surfaces, with areas of carpet taped to it electrical tape. -There was a piece of paper taped to the device with Scotch tape that had instructions to shut it off in 20 minutes. Review of resident 27's medical record revealed: *His admitted was 11/8/23. *His diagnoses included: dementia, chronic atrial fibrillation, chronic kidney disease, and heart failure. -He did not have a diagnosis for neuropathy. *His 7/9/24 Brief Interview of Mental Status (BIMS) score was a 14, which indicated his cognition was intact. *His physician orders included: *An 11/8/23 order to use a personal infra-red device for no more than 20 minutes every other day as needed for pain to his waistline or feet. *A 1/15/24 order to discontinue that order for use of the infra-red device. *His treatment administration record from 11/8/23 through 1/5/24 revealed there was no documented use of the infrared device. (continued on next page)

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Good Samaritan Society Miller	421 East 4th St Miller, SD 57362

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*There was no current order for use of the infra-red device. *His care plan did not include the use of the infra-red device. *On 9/18/24 a Communication/Visit with Physician that indicated [resident 27] previously had an order to use the infrared device he privately purchased years ago to treat his foot neuropathy. Order had been discontinued in Jan. of 2024 as DON [director of nursing] at that time didn't realize he was still using it. Faxed a request to [clinic name] for a new order as he is in fact using it. Safety assessment will need to be done prior to his next use of it. Device should be stored in the med room when not in use. Interview on 9/19/24 at 1:45 p.m. with interim director of nursing [IDON] B and registered nurse (RN) H regarding resident 27's use of the infra-red device revealed: *RN H confirmed resident 27 did not have a diagnosis of neuropathy. *RN H was first aware of the infrared machine on 9/19/24 in the morning. *RN H confirmed there was no safety assessment for his use of the infra-red device. -She confirmed the infrared device was in resident 27's room and stated it should have been in the medication room and the use of it should have been documented on resident 27's treatement administration record (TAR). -She indicated it needed to come out of his room. *IDON B was not certain who was to remove the infra-red device from his room. -On 09/19/24 at 3:14 p.m. the infra-red device was again observed in resident 27's room. A policy was requested regarding electronic medical equipment from the provider and there was none provided.

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43021 Based on observation, interview, record review, and policy review, the provider failed to ensure that staff were able to verify the chemical sanitation level required to sanitize the dishes used for preparation and serving residents' food. Failure of that increased the potential risk of foodborne illnesses for the entire resident population who received meals prepared in the kitchen and served to the residents. Findings include: 1. IMMEDIATE JEOPARDY Interviews with dietary staff throughout the survey indicated that the dishwasher's chemical sanitation was not functioning. Staff were not aware of any process to follow when the dishwasher's chemical sanitation was not functioning. Staff could not accurately verify the chemical sanitation level of the dishwasher to ensure proper sanitation due to the expired test strips. IMMEDIATE JEOPARDY NOTICE Notice of immediate jeopardy was given verbally and in writing on [DATE] at 4:25 p.m. to administrator A and business office manager (BOM)/dietary manager (DM) C. An immediate removal plan was requested. IMMEDIATE JEOPARDY REMOVAL PLAN On [DATE] at 7:43 a.m., administrator A provided the survey team with a final written immediate jeopardy removal plan. The removal plan had been approved by the survey team on [DATE] at 8:32 a.m. with guidance from the assistant administrator and long-term care advisor for the South Dakota Department of Health. The provider gave the following acceptable immediate jeopardy removal plan on [DATE] at 7:43 a.m.: 1. Provided to surveyors the requested dishwasher manufacturer manual and disinfectant information to support the instructions are being followed and appropriate sanitation is occurring and documentation from Ecolab's [DATE] visit. 2. Use disposable paper plates, cups, and silverware until dishwasher is up and running appropriately. 3. Placed new non expired strips in, for the 3 comp sink. 4. Removed all expired strips in kitchen. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. All dishes to be washed in the 3-comp sink until dishwasher is fixed to verify levels. 6. On [DATE] implemented the use of a Monitoring Use of Ecolab disinfectant Test Strips form for staff to sign off on what the expiration date is of a cartridge when they replace it and the label in the cartridge holder on the wall. 7. On [DATE] completed immediate education with all dietary staff. Food service assistant M and [NAME] V were trained onsite at 6:30 p.m. At 10:12 p.m. all dietary staff were texted education and informed prior to their next shift they will receive in person training on proper procedure for non-working dishwasher and education on non-expired test strips with return demonstration. 8. On [DATE] at 7:06 p.m. all staff were educated via PCC Communications with the following message Kitchen staff must ensure all chemical test strips are NOT EXPIRED. This goes for the dishwasher and the 3 comp sink. See BOM/DM C for education before start of your next shift. 9. By [DATE] will add to the TELS Service Provider a task for Director of Environmental Services to monitor weekly if a cartridge is near expiration and needs to be replaced. 10. On [DATE] left messages for EcoLab to come fix dishwasher ASAP. In the meantime BOM/DM C, who holds the dietary manager license, tried a new bucket of Ultra San Ecolab 5 gallon liquid sanitizer in the dishwasher. Retested and the low-temp dishwasher disinfectant tested properly at 50 ppm. Unsure why the initial bucket tested at 0 ppm. It was promptly disposed of. The immediate jeopardy was removed on [DATE] at 12:25 p.m. after verification that the provider had implemented their removal plan. After the removal of the immediate jeopardy, the scope and severity of the citation level was lowered to an F. 2. Observation on [DATE] at 10:05 a.m. of the kitchen revealed the sanitizing testing strips located by the three compartment sink had an expiration date of [DATE]. 3. Interview on [DATE] at 10:06 a.m. with food service assistant (FSA) M revealed: *She used those same sanitizing testing strips located by the three-compartment sink to test the red bucket of water and sanitizing solution to ensure the parts per million (PPM) was correct for effective sanitization. *That red bucket would be dumped out and new water and sanitizing solution would be put into it and tested . -That process was done in the morning, at noon, supper time, and whenever it was terrible. *The sanitizing solution used was Oasis 146 Multi-Quat Sanitizer. 4. Observation on [DATE] at 10:07 a.m. of the testing documentation of the red sanitizing bucket revealed it was completed at 10:00 a.m. that day. 5. Observation and interview on [DATE] at 10:10 a.m. with cook L revealed: (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*She tested the sanitizing bucket at the 3-compartment sink and it tested at 10 ppm with the expired testing strips. -She confirmed the test strips were expired. -She emptied the bucket of sanitizing solution. -She then ran new water and sanitizer into the bucket, while priming the sanitizer to add more. -The bucket of sanitizing solution then tested and read at 400 ppm using the outdated testing strips. 6. Interview and observation on [DATE] at 10:12 a.m. with Nutrition and Food Services Supervisor (NFSS) F regarding testing the sanitizing solutions revealed: *She stated the red bucket of sanitizing solution should test at 400 ppm. -That solution should be changed first thing in the morning, at 9:00 a.m., 1:00 p.m., 3:00 p.m., 4:30 p.m., 6:00 p.m., and as needed. -She confirmed the test strips used to test the red bucket of sanitizer were outdated. -She opened a drawer and pulled out a different box of test strips. -She confirmed those expired on [DATE]. -There were no other test strips available for use. *She stated the dishwasher temperature for washing and rinsing of dishes should be at 120 degrees Fahrenheit. -It tested at 120 degrees. -The disinfectant should be at 50 ppm. -She then tested the dishwasher sanitizer and it tested at 10 ppm. -She confirmed that was not a sufficient sanitizing solution to prevent food-borne illness. -The chemical used for sanitation in the dishwasher was Ulta San. *The dishwasher had been leaking water when used and repairs were completed on [DATE]. 7. Observation on [DATE] at 12:05 p.m. revealed the noon meal was served with Styrofoam plates, the drinks and desserts were served in multi-use dishware. 8. Interview and observation on [DATE] at 1:35 p.m. with ancillary services supervisor E revealed: (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*He was attempting to repair the dishwasher. *There was a rack of trays on the clean side of the dishwasher that appeared to have been run through the dishwasher. *There was a rack of used pitchers on the dirty side of the dishwasher. *Numerous dirty cups and bowls from the noon meal were sitting on the counter. 9. Interview and observation on [DATE] at 1:45 p.m. with cook L revealed: *The dishwasher was being tested for correct sanitizing chemical amount after each dishwashing cycle. -The sanitizer was correct for two cycles of dishwashing. *She then tested the dishwasher sanitizer and it tested at 0 ppm. *She stated it was not working and they would have to rewash or hand wash the dishes. 10. Interview on [DATE] at 1:51 p.m. with NFSS F revealed testing of the dishwasher had been done all day and has not changed (the chemical sanitizing remained at 0 ppm). 11. Observation on [DATE] at 1:52 p.m. of cook L revealed she filled the third compartment of the three compartment sink with water and sanitizer. Interview on [DATE] at 2:00 p.m. with cook L revealed: *The dishwasher sanitizer normally needed to be changed about every three weeks. -She was usually the person to change it. *She had recently been on vacation and was not sure the last time it was changed. 12. Interview on [DATE] at 2:50 p.m. with NFSS F revealed: *Anyone was able to change the sanitizer bucket. *She had placed an order for more sanitizer and it would be delivered on [DATE]. *She had changed the test strips by the three compartment sink. -She was not aware they had an expiration date. -She stated she thought if the test strips expired, they should have turned a different color. 13. Review of the provider's [DATE], [DATE], and [DATE] monthly cleaning log revealed:-*There was an area labeled Chemical Dispensers. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*That area was left blank. Review of the provider's documented Ultra San five-gallon bucket supply revealed: *On [DATE] the local school district had donated five buckets to the nursing home. *One bucket of Ultra San was delivered from the provider's chemical supplier on [DATE], [DATE], [DATE], and on [DATE]. *The Safety Data Sheet for Ultra San revealed the ingredients were sodium hypochlorite and chlorine. Review of the provider's [DATE] Consultant Dietitian's Report revealed: *On the Sanitation and Safety area there was a hand written note that indicated, Reviewed audit (business office manager/dietary manager) Conducted. See her report. Many issues identified that need correction. *Attached to that report was a document that included: -Sanitizing strips were expired and given to NFSS F. -The Summarize potential cause. And Summarize action taken areas were left blank. Review of the provider's dishwasher operation manual revealed: *A handwritten note that indicated the dishwasher was installed on [DATE]. *Sanitizer in original concentration is caustic and may cause damage to wash tank and or sump without dilution. *The manual did not indicate the appropriate concentration to be used. Review of the contractor's service record on [DATE] revealed the dishwasher sanitizing solution was to be between ,d+[DATE] ppm, it was at 75 ppm. Review of the Oasis 146 Multi-Quat Sanitizer guidelines revealed: *The solution's broad efficacy range of ,d+[DATE] ppm stays within proper longer. *It was EPA-registered (Environmental Protection Agency) for third sink sanitizing and on hard non-porous food-contact surfaces and ware. *It prevented cross-contamination of food contact surfaces. Review of the provider's Supervisor, Nutrition and Food Services job description revealed: *Assists in the training of new staff members and the development of existing staff members. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*Ensure department meets all regulatory requirements. *Advises on the . and sanitation of food. Review of the provider's Manager, Nutrition and Food Services job description revealed: *Assists in the training of new staff members and the development of existing staff members. *Trains others on main considerations and issues related to laws and regulations in the implementation of healthcare and nutritional practices. Review of the provider's [DATE] General Sanitation - Food and Nutrition policy revealed: *Appropriate sanitizers and test strips can be ordered through (provider's supplier name). *Director of food and nutrition services (DFN) or senior living dining director maintains a supply of appropriate test strips and thermometers to monitor sanitizing products in use. *Cleaning and sanitizing equipment surfaces is a two-step process. Surfaces are cleaned and rinsed before being sanitized. All food contact surfaces will be washed, rinsed and sanitized: Review of the provider's [DATE] Sanitizing Food Contact Services - Food and Nutrition Services policy revealed: *Food-contact surfaces - The surface of equipment, worktables, dining tables dishware or utensils were food normally comes into contact, or from which food may drain, drip, or splash onto food or a surface that may come in contact with food. *Employees are trained during orientation on proper handling of all cleaning, disinfecting and sanitizing agents in use as well as the difference between disinfecting and sanitizing. *Monitor to ensure all products are correctly labeled and dated when opened. *Sanitizing solution: Mix sanitizing chemicals I the recommended concentration levels for proper concentrations measure in parts per million (ppm). High concentrations can be unsafe and may leave an odor or bad taste on the objects and corrode metals. *Check solution concentrations frequently with an appropriate test kit since they may become depleted when they kill microorganisms and bind with food. *Change the sanitizing solution when it becomes depleted or when the water is visibly dirty. Review of the provider's [DATE] Warewashing-Mechanical and Manual policy revealed: *To promote good practice during ware washing regarding prevention of foodborne illness. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*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., *Temperature information found below refers to temperatures listed in the FDA (Food and Drug Administration) Food Code and can be used for additional guidance as needed. -Low Temp [temperature] - 120 degrees Fahrenheit + [plus] 50 parts per million (ppm) of sodium hypochlorite (or according to manufacturer's guidelines). If temperature/chemicals are outside acceptable parameters, employees notify the DFN, . before proceeding with ware washing., *Manual Ware Washing *Sanitize -c. Chemical Treatment --1) The third compartment of the three compartment sink will be filled with hot water (75 degrees Fahrenheit or per manufacturer's instructions.) Sanitizing solution will be measured and dispensed according to manufacturer's instructions. --2) A high concentration of sanitation solution may be potentially hazardous and can contaminate food. --3) Use proper test strips to ensure accurate results for the chemical use. -7. Temperature and chemical concentration --a. Proper test strips and thermometers are available. 43844

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 43021 Based on interview, record review, quality assurance and performance improvement (QAPI) program review, and job description review, the provider failed to ensure an effective, ongoing, and comprehensive QAPI program was in place to track and measure performance; systematically analyze underlying causes of systemic quality deficiencies; develop and implement corrective action or performance improvement activities; and monitor or evaluate the effectiveness of the corrective action/performance improvement activities, and revise the actions, as needed. Findings include: 1. Interview on 9/19/24 at 5:28 p.m. with quality assurance (QA) specialist/certified medication assistant (CMA) I regarding the QAPI Program revealed: *She had been the QAPI coordinator for the past three years. *The committee met monthly. *The provider's medical director attended monthly. *They had developed and completed a performance improvement plan (PIP) for pressure ulcer prevention and treatment from 12/18/23 through 6/11/24. *There was not a current PIP in place. Continued interview with QA specialist/CMA I regarding areas of non-compliance identified by the survey team and recent facility-reported incidents (FRI) were reviewed and QA specialist/CMA I revealed: *She was aware that there were problems with resident baths not being completed as scheduled and honoring resident preferences and was going to propose a bathing PIP at next week's QAPI meeting on 9/26/24. *She was not aware of any facility-reported incidents through the SD DOH's online reporting system and only tracked adverse events through the provider's electronic medical record (EMR) system. -She was aware of the adverse event regarding a resident (17) who had been left on a bedpan for an extended period of time as administrator A had sent a message to the nursing staff through their online scheduling system and EMR communication system regarding the incident. -She was aware of abuse concerns, both verbal and sexually inappropriate behavior from specific male residents (27 and 37) towards staff members as they had been brought up at the staff stand-up meetings, but those abuse concerns had not been addressed through their QAPI committee. *The dietary department's outdated chemical sanitation test strips had not been identified through the QAPI process. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 49238 Based on interview the provider failed to ensure they had not established and maintained an infection prevention and control program. Findings include: 1. Interview on 9/19/24 at 3:16 p.m. with interim director of nursing B revealed: *She stated she had not done anything with the infection control program in the month she had been there except make two binders. *She did not have updated policies and procedures for the program. *She was not doing any infection surveillance. *She stated she did not have a process in place for antibiotic stewardship and she did not have someone monitoring antibiotic use or orders. 2. Interview on 9/19/24 at 4:30 p.m. with administrator A revealed she agreed they did not did not have an active infection prevention and control program. 3. Interview on 9/19/24 at 5:28 p.m. with quality assurance specialist/certified medication assistant I revealed: *The former director of nursing had been the provider's infection preventionist but she had resigned from her position effective at the beginning of August 2024. *The provider had no current qualified infection preventionist.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435124	A. Building B. Wing	09/19/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49238 Based on interview the provider failed to ensure that they had an infection preventionist (IP). 1. Interview on [DATE] at 3:16 p.m. with interim director of nursing (DON) B revealed: *She was told she would be the IP. *She stated she did not have her certificate for infection preventionist as it had expired. *She was not currently enrolled to regain her certification and was not going to enroll since she was an interim DON. 2. Interview on [DATE] at 4:30 p.m. with administrator A revealed she agreed they did not did not have an infection preventionist. 3. Interview on [DATE] at 5:28 p.m. with quality assurance specialist/certified medication assistant I revealed: *The former director of nursing had been the provider's infection preventionist but she had resigned from her position effective at the beginning of [DATE]. *The provider had no qualified infection preventionist.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435124	A. Building B. Wing	09/19/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43844 Based on observation, interview, and policy review the provider failed to ensure pest control for flies was effective. Findings include: 1. Observation on 9/17/24 at 8:15 a.m. in the conference room revealed a live beetle crawling on the floor. 2. Observation on 9/18/24 at 8:40 a.m. in the dining room revealed a live fly on a clean clothing protector. 3. Observation on 9/18/24 from 8:41 a.m. through 8:45 a.m. revealed: *Ten dead crickets in the hallway by rooms 24 through 38. *Five dead crickets in the side entrance by the nurses station. 4. Observation on 9/17/24 at 9:15 a.m. of resident 22 revealed: *He was in his room, seated in a recliner, and had a blanket covering him. -There were five live flies on the blanket that was covering him. 5. Observation and interview on 9/17/24 at 9:30 a.m. with resident 15 revealed: *He stated he had two [NAME] friends stop and have dinner with him. -A problem arose with flies. --While eating dinner with his friends they told him that there were flies on his food and in his hot chocolate. -He stated he would not have known there were flies in his food if his friends had not told him as he was blind. 6. Observation on 9/17/24 at 2:08 p.m. of resident 37 revealed: *An unknown number of dead flies on the floor. *A live fly was flying around a surveyor's head. 7. Observation on 9/18/24 at 10:27 a.m. of resident 1 in her room revealed three live flies, one had been flying around her head, one on her shirt, and one on her shoe. 8. Interview on 9/19/24 at 12:30 p.m. with ancillary services supervisor E regarding pest control revealed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435124	A. Building B. Wing	09/19/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*A professional pest control company came once a month to the facility. *The North and South hallways had an automatic spray system for killing flies. *The kitchen had a device that looked like a light but had sticky tape in it for catching flies. *The dining room did not have any fly control. -He was not aware there had been a concern with flies in the dining room. *He had knowledge of quite a few crickets. *He stated the facility is close to a bird seed plant and the city sewer lagoon. -He thought these might contribute to the flies in the facility. 9. Interview on 9/19/24 at 1:45 p.m. with interim director of nursing B regarding resident 15 and his concern of flies in his food revealed: *She stated flies were horrible this time of year with the doors opened throughout the day. -Fly swatters were handed out, and the exterminator came frequently to spray inside and outside the building. -She was not sure what else they could have done about the flies. 10. Review of the provider's 8/2/24 Pest Control policy revealed: *All . locations will comply with any federal, state, or local laws concerning pest infestations. *Applicable pest threats will be identified in the plan along with mitigation steps. *Sanitary conditions will be maintained on the grounds and all common areas. The location will have properly fitting exterior doors and will dispose of garbage in a manner so as not to promote insect or rodent infestations. Resident and patient rooms and units should be monitored by staff members performing assigned tasks in the rooms and units for signs of insect or rodent infestations.