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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435134	A. BUILDING _____ B. WING _____	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST MARTIN VILLAGE	4825 JERICHO WAY RAPID CITY, SD 57702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 11/1/22 through 11/3//22. Good Samaritan Society - St. Martin Village was found not in compliance with the following requirements: F658, F692, and F812.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure: *One of one sampled resident's (45) physician order (PO) for daily weight monitoring and physician notification of weight gains greater than two pounds (lbs.) in a 48-hour timeframe had been followed. *One of one sampled resident's (36) PO for weight monitoring had been clarified for weight parameters and physician notification by nursing staff. Findings include: 1. Observation and interview on 11/1/22 at 10:30 a.m. and on 11/2/22 at 3:20 p.m. with resident 45 and his spouse revealed: *He was admitted on 8/25/22 from a local hospital following treatment for congestive heart failure (CHF). *They had not known if any specific interventions	F 658	Only fluid restriction residents were affected by this deficiency. The fluid restriction residents had their care plan, kardex, and information in the EMR updated to follow their weights and to clarify their daily weights that was set out by physician orders on 11-18-22. Re-education on the policy for daily weights and physician notification was completed on 11-21-22. This facility will follow the policy related to daily weights and physician notification. The weights will be completed by the nursing staff each morning.Nursing management will check to ensure that the weight was obtained and that the physician order of notification is in compliance. Daily weights will be care planned and attached to the kardex so all staff are aware. All documentation will be completed by the nursing staff to ensure that the facility is in compliance daily.	11/21/22

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

Kyle Richards | Senior Director | 11/22/2022

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

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F 658	Continued From page 1 such as fluid restriction or weight monitoring had been implemented relating to his CHF diagnosis. Review of resident 45's medical record revealed his diagnoses included: heart failure, chronic obstructive pulmonary disease, Parkinson's disease, ischemic cardiomyopathy, and arteriosclerotic heart disease. Review of resident 45's 11/2/22 Order Summary Report revealed: *The following POs had started on 9/28/22: -"Weights and Vitals: Assess lung sounds, peripheral edema, respiratory effort, and weight daily. -Call CHF Clinic provider/practitioner for weight gain greater than two lbs. in 48 hours or if five lbs. over admission weight every day shift." Review of resident 45's 9/28/22 through 11/2/22 Weights and Vitals Summary report revealed: *Daily weights had not been recorded on 10 days: 9/30/22, 10/10/22, 10/16/22, 10/17/22, 10/20/22, 10/22/22, 10/23/22, 10/29/22, 10/31/22, and 11/1/22. *Weight gains of greater than two lbs in a 48-hour timeframe were documented between: -10/1/22 (144 lbs) and 10/3/22 (151.8 lbs), a gain of 7.8 lbs. -10/4/22 (148.6 lbs) and 10/6/22 (150.8 lbs), a gain of 2.2 lbs. -10/15/22 (150.3 lbs) and 10/18/22 (152.4 lbs), a gain of 2.1 lbs. --No weight had been recorded on 10/17/22. -10/19/22 (152.4 lbs) and 10/21/22 (155 lbs), a gain of 2.6 lbs Review of resident 45's nurse progress notes between 9/28/22 and 11/2/22 revealed no	F 658	The Director of nursing or designee will audit daily weights to ensure they are in compliance. The audit will consist of auditing the residents with daily weights weekly for three weeks, then every other week for 3 times, and finally once a month for 3 times to ensure compliance. The Director of nursing or designee will report the audit findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendation for improvement. Monitoring results will be reported by the director of nursing or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	

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F 658	Continued From page 2 documentation the CHF Clinic provider/practitioner had been called regarding the weight gains referred to above. Interview on 11/3/22 at 1:45 p.m. with registered nurse J regarding resident 45's weight monitoring revealed: *His weights were expected to be recorded daily by a licensed nurse. *She used his previous day's weight to compare to the current day's weight to identify weight changes that might require physician notification. -She had not monitored his weight according to the physician's order, but should have been. Interview and review on 11/3/22 at 4:40 p.m. of the 9/28/22 through 11/2/22 Weights and Vitals Summary report for resident 45 with director of nursing B revealed: *There were 10 days his weight had not been documented per the PO. *There were four times he had weight gains greater than two lbs in a 48-hour timeframe without documentation to support a nurse had called the CHF Clinic provider/practitioner. *His weight had not been monitored per the PO, but should have been. -That had been the responsibility of the licensed nursing staff. 2. Observation and interview on 11/1/22 at 3:47 p.m. with resident 36 revealed he: *Was alert, hard of hearing, and able to understand and answer simple questions. *Denied any concerns and stated he did not want to talk long because he was going to an activity. *Was sitting in a wheelchair and wearing a shirt, basketball shorts, and slip on shoes. -Had white compression stockings on both legs	F 658		

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F 658	Continued From page 3 that went from his feet extending to his upper thighs. -There was a moderate amount of edema to both lower legs from his feet to above his knees. *Became short of breath while talking with this surveyor causing him to pause for air. Review of resident 36's medical record included the diagnoses of: generalized edema, cardiac murmur, bradycardia, atrial flutter, persistent atrial fibrillation, hypertension, endocarditis, hypo-osmolality (low electrolytes, protien, and nutrients) and hyponatremia (low blood sodium), abnormal weight loss, vascular dementia with behavioral disturbance, major depressive disorder, and anxiety disorder. Review of resident 36's Order Summary Report included: *A 9/24/20 order, "Daily weights-edema to lower legs-UNTIL stabilizes-in the morning for monitoring." *A 3/4/22 order, "Thigh High compression stockings ON in AM; OFF at HS (hour of sleep) in the morning and bedtime for edema prevention." *A 1/10/22 order, "Lasix 20 milligrams by mouth one time a day every Monday, Wednesday, and Friday for diuretic related to generalized edema." Review of resident 36's revised 10/6/22 care plan revealed: *"Focus:" -"The resident has potential fluid volume overload E/B [as evidenced by] generalized edema." *"Goal:" -"Resident will remain free of s/s [signs and symptoms] of fluid overload through review date, as evidenced by no pitting edema, weight WNL [within normal limits] as prescribed by doctor."	F 658		

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F 658	Continued From page 4 --There were no normal limits of weight identified and when to notify the doctor of weight gains. *"Interventions:" -"Weigh: daily" -"SUPPORT STOCKINGS: Apply and/or remove AM and HS-requires assistance from staff" Review of resident 36's 9/2/22 through 11/2/22 Daily Weights and Vitals Summary revealed: *Daily weights had not been recorded on nine days: 9/4, 9/5, 9/6, 9/11, 10/8, 10/12, 10/14, 10/15, and 10/16/22. *His weights had fluctuated between a low of 183.6 on 9/21/22 and a high of 196.0 on 11/2/22. -This was a 12.4 pound weight gain in two month's time. Review of resident 36's nursing progress notes from 9/2/22 through 11/2/22 revealed there was no documentation the provider had been notified of his weight fluctuations or to seek clarification of his normal weight limits. Interview on 11/3/22 at 1:50 p.m. with licensed practical nurse's (LPN's) H and I regarding resident 36's daily weights revealed: *They had been unable to clarify if it was his weight or his edema that was being monitored. *There had been no clarification on when to notify the provider. -LPN H stated she would normally monitor a resident's weight and notify the provider if there was a weight gain. *They were unable to recall if a provider had been notified about clarifying his weight orders. Interview on 11/3/22 at 4:47 p.m. with DON B regarding resident 36's daily weights revealed: *She would have expected the nurse to reach the	F 658		

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F 658	Continued From page 5 provider to get guidelines on weight limits. -"There should be a weight parameter set by the provider." *"We need to streamline a better process." 3. Review of the revised 12/02/21 Physician/Practitioner Orders policy revealed: *Purpose: "To provide a procedure that facilitates the timely and accurate processing of physician/practitioner orders." Review of the revised 4/26/22 Notification of Change policy revealed: *Policy: "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:" -"3. A need to alter treatment significantly-a need to discontinue or change an existing form of treatment or to commence a new form of treatment." Refer to F692.	F 658		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition	F 692	Only fluid restriction residents have the potential to be affected by this deficiency. One resident was taken off of their fluid restrictions per family conversation and MD order 11-4-22. The second resident had his fluid restrictions re-evaluated and all appropriate measures are in place. Re-education on the policy for fluid restrictions was completed on 11-21-22. The facility will follow the policy related to fluid restrictions. Notification to the dietary department and disbursement of which fluids over the day will be determined by the dietary and nursing department. Fluid restrictions will be care planned and attached to the kardex so all staff are aware of the fluid restrictions.	11/21/22

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F 692	Continued From page 6 demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to: *Implement a process that ensured an accurate accounting of daily fluid intake for two of two sampled residents (45 and 36) with physician ordered fluid restrictions. *Ensure two of two sampled residents' (45 and 36) care plans had been revised to reflect a fluid maintenance goal and interventions to meet their individualized needs. Findings include: 1. Observation and interview on 11/1/22 at 10:30 a.m. with resident 45 and his spouse revealed: *He was admitted on 8/25/22 from a local hospital following treatment for congestive heart failure (CHF). *They had not known if any specific interventions such as restricting his daily fluid intake were being implemented related to that diagnosis. Observations on 11/2/22 at 7:45 a.m. and 11/3/22 at 8:30 a.m. of resident 45 eating breakfast in the north dining room revealed: *On 11/2/22 he had a cup (240 milliliter [ml]) of water, a cup (240 ml) of chocolate supplement drink, and a beverage mug (360 ml) in front of him.	F 692	All documentation will be completed by the nursing staff to ensure that we are within the fluid restriction daily. The Director of Nursing or designee will audit fluid restrictions to ensure they are in compliance. The audit will consist of auditing the residents with fluid restrictions weekly for three weeks, then every other week for 3 times, and finally once a month for 3 times to ensure compliance. The Director of nursing or her designee will report the audit findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendation for improvement. Monitoring results will be reported by the director of nursing or her designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	

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F 692	Continued From page 7 *On 11/3/22 he had two cartons (240 ml each) of chocolate supplement, a cup (240 ml) of water, and a covered beverage mug (360 ml) in front of him. Observation on 11/2/22 at 2:15 p.m. of resident 45 in his room revealed: *There were three covered beverage mugs (360 ml each) on his over bed table, one bottled water (240 ml), and another covered beverage mug (360 ml) on his nightstand. Review of resident 45's medical record revealed his diagnoses included: heart failure, chronic obstructive pulmonary disease, Parkinson's disease, ischemic cardiomyopathy, and arteriosclerotic heart disease. Review of resident 45's 11/2/22 Order Summary Report revealed: *A physician order dated 10/18/22: "2000 ml fluid restriction. 480 ml/meal for dietary, 560 ml/day for nursing every shift for CHF." *No orders for the use of a diuretic medication. Review of resident 45's October 2022 Treatment Record that included daily fluid intake amounts between 10/18/22 and 10/31/22 revealed: *A daily fluid intake entry for the day shift and a daily fluid intake entry for the night shift. -Resident 45 had exceeded his 2000 ml fluid intake on one day (10/28/22) during that timeframe. Review of resident 45's care plan revised on 10/24/22 revealed: *An incorrect goal related to his risk for and history of dehydration and potential fluid deficit related to use of a diuretic.	F 692		

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F 692	Continued From page 8 *Interventions included: "Offer drinks of choice during resident interactions. Explain importance of adequate nutritional intake. Praise resident's progress or efforts. Observe for s/s [signs and symptoms] of dehydration: sunken eyes, dry mouth, changes in mental status, fever, etc. Report to nurse." *There was not a goal or interventions related to: -His risk for potential fluid overload related to his heart related diagnoses. -The amount of his daily fluid restrictions, how his fluids were expected to be allocated throughout the day, and who was responsible for providing those fluids per physician order. -Monitoring, assessment, and physician notification of pre-determined weight increases by licensed nursing staff per physician order. -His 10/12/22 physician order for compression stockings to be placed on resident 45 during the day and removed at night related to his CHF diagnosis. Interview on 11/2/22 at 7:50 a.m. with lead food service assistant K regarding residents requiring fluid restrictions revealed: *Each day food services was provided an updated Diet Type Report. -It identified any resident with a fluid restriction and their specific fluid restriction order. *Resident 45 had no fluid restrictions listed on the 11/2/22 Diet Type Report. -If he had, food service staff would have provided fluids, including supplements, according to the amount food service had been ordered to provide per the Diet Type Report. *Nursing staff calculated the total amounts of fluids consumed by residents with fluid restrictions at the end of each meal.	F 692		

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F 692	Continued From page 9 Interview on 11/3/22 at 10:45 a.m. and 1:15 p.m. with food and nutrition supervisor (FNS) C revealed she: *Was notified of dietary order changes including fluid restrictions by e-mail from nursing services when a new diet was ordered. *Posted that e-mail in the kitchen for food service staff to see, updated and redistributed the daily Diet Type Report to each dining room. *Had not known resident 45 had a current physician order for fluid restriction. -Knew he had a fluid restriction in the past that was stopped, but it had been restarted. *Had not notified food service staff that restriction was restarted. -That was her responsibility. *Confirmed resident 45's mealtime fluid restrictions had not been followed by food service staff. Interviews on 11/2/22 at 3:00 p.m. with certified nurse assistant (CNA) L and on 11/3/22 at 1:30 p.m. with CNA M revealed: *Resident 45 had no fluid restrictions. *He was offered fluids daily in his room during afternoon and evening snack pass in addition to what he received at mealtimes and with his medications. Interview on 11/3/22 at 1:45 p.m. with registered nurse J regarding resident 45 revealed: *She thought he was on fluid restrictions in the past, but that had been discontinued. -Verified he was still on fluid restrictions by checking his current physician orders. *CNAs were not allowed to offer or provide fluids to residents on fluid restrictions. -That was the responsibility of licensed nurses. *Food service staff were suppose to track	F 692		

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F 692	Continued From page 10 mealtime fluid intakes, but they did not document or communicate that information to nursing staff. *She referred to the amount of fluid food service staff were suppose to give resident 45 at each meal (480 ml) and used that number in her daily fluid intake total whether she knew if he had consumed that amount or not. *His daily fluid consumption was not accurately accounted for and his fluid restriction order had not been followed. Interview on 11/3/22 at 5:20 p.m. with director of nursing (DON) B revealed: *Resident 45's care plan had not been revised to reflect his current physician ordered fluid restrictions or any individualized approaches related to that problem. -It was the responsibility of all interdisciplinary team members care plans during care conferences and whenever new physician orders occurred to review and revise those plans as needed. *The GSS #195 form was not currently used. -That form required communication between nursing staff and food and nutrition services regarding decisions about when and who would have provided resident 45's fluids, completion and monitoring of his daily fluid intake. *The current process had failed to accomplish those things. 2. Observation and interview on 11/1/22 at 3:47 p.m. with resident 36 revealed he: *Was alert, hard of hearing, and able to understand and answer simple questions. *Denied any concerns and stated he did not want to talk long because he was going to an activity. *Was sitting in a wheelchair and wearing a shirt, basketball shorts, and slip on shoes.	F 692		

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F 692	Continued From page 11 *Had white bilateral compression stockings on both legs that went from his feet extending to his upper thighs. *Had a moderate amount of edema to both lower legs from his feet to above his knees. *Became short of breath while talking with this surveyor causing him to pause for air. *Had not known if he was on any type of restricted fluids. Review of resident 36's medical record included diagnoses of: generalized edema, cardiac murmur, bradycardia, atrial flutter, persistent atrial fibrillation, hypertension, endocarditis, hypo-osmolality (low electrolytes, protien, and nutrients) and hyponatremia (low blood sodium), abnormal weight loss, vascular dementia with behavioral disturbance, major depressive disorder, and anxiety disorder. Review of resident 36's Order Summary Report included: *A 4/6/22 order, "fluid RESTRICTIONS: 1)*Dietary* 240 ml/meal (720 ml/day) 2) *Nursing* 480 ml/day every day and night shift." *A 7/28/22 order, "Based on lab report, CNP [certified nurse practioner] G Landers wrote order for: "Fluid restriction 1,200 ml.- every shift for edema." *A 9/24/20 order, "Daily weights-edema to lower legs-UNTIL stabilizes-in the morning for monitoring." *A 3/4/22 order, "Thigh High compression stockings ON in AM; OFF at HS [hour of sleep] in the morning and bedtime for edema prevention." *A 1/10/22 order for Lasix 20 milligrams by mouth one time a day every Monday, Wednesday, and Friday for diuretic related to generalized edema.	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435134	A. BUILDING _____ B. WING _____	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST MARTIN VILLAGE	4825 JERICHO WAY RAPID CITY, SD 57702

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F 692	Continued From page 12 Review of resident 36's revised 10/6/22 care plan revealed: *"Focus:" -"The resident has potential fluid volume overload E/B [as evidenced by] generalized edema." *"Goal:" -"Resident will remain free of s/s [signs and symptoms] of fluid overload through review date, as evidenced by no pitting edema, weight WNL [within normal limits] as prescribed by doctor." *"Interventions:" -"Weigh: daily" -"SUPPORT STOCKINGS: Apply and/or remove AM and HS-requires assistance from staff" *There were no fluid restrictions or fluid intake monitoring listed on his care plan. Interview on 11/3/22 at 1:20 p.m. with lead food service assistant E revealed she: *Had been employed as lead food service assistant for six months. *Had been able to identify resident 36 as having fluid restrictions. -Was unable to state how many ml's daily fluid restriction he was to receive. -Thought he was to receive three ounces of water, two ounces of juice, and four ounces of coffee at each meal. --Had not known how many ml's this equaled (270 ml) and stated she was not good with numbers and was still learning. -Had not been aware of having any training on fluid restrictions. *Provided this surveyor with three different sheets of laminated paper she used as reference on resident 36's fluids to be given at meals. -One sheet stated resident 36 received "OJ" at meals. -The next sheet stated, "Coffee and OJ".	F 692		

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F 692	Continued From page 13 -The final sheet stated, "Regular diet, coffee, juice all meals." *Agreed the laminated sheets did not state the amounts of the fluids that were to be provided to resident 36. Interview on 11/3/22 at 2:30 p.m. with FNS C revealed: *She had resident 36 listed as being on an 1,800 ml/day [milliliter per day] fluid restriction. -Had not been aware he was on a 1,200 ml/day fluid restriction. *It was her responsibility to ensure fluid restrictions and exact ml amounts were listed in the resident care plan. *Resident 36 was to receive eight ounces of coffee and four ounces of juice per meal (360 ml). *She tried to make reference material as simple as possible for the staff. -"Like 1 cup of coffee, 1 cup of juice." *"Fluid amounts need tightened up with all new staff." *Confirmed the fluid amounts referenced above by herself and staff were not accurate for resident 36. Interview on 11/3/22 at 1:50 p.m. of LPN H regarding resident 36's fluid restrictions revealed: *His fluid restrictions were documented by the nurse on the resident's treatment administration record. *The certified nurse assistants (CNA's) also documented fluid intakes in their daily task charting. -The totals were broken down by shift and there were no daily totals. -The nurse would then look at the resident's daily fluid intake and add the totals to determine if fluid	F 692		

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F 692	Continued From page 14 restrictions were being followed. *The residents on fluid restriction were not provided fluids in their rooms beyond what was given at meals. Review of resident 36's October through November 2022 treatment administration record revealed: *Fluid restrictions were acknowledged by the nurse with a yes or no checkmark in a box. -There were no documented fluid intake totals for the day. Review of resident 36's 14-day fluid intakes documented in the CNA's task charting revealed there were no daily totals and no documentation on any fluid intakes outside of meals. Observation on 11/3/22 at 2:12 p.m. with LPN H of resident 36's room revealed: *Two 12 ounce (360 ml) beverage containers containing fluid on his night stand. *The beverage containers were not supposed to be in his room. Interview on 11/3/22 at 4:37 p.m. with DON B regarding resident 36's fluid restrictions revealed it was her expectation nursing and kitchen staff were to document the actual fluid amounts that were being consumed. 3. Review of the revised 5/26/22 Residents at Risk for Dehydration, Fluid Maintenance policy revealed: *"7. DFN [director of food and nutrition], dietician, or designee will write the problem/goal for dehydration/fluid maintenance in the care plan. The approaches may include a variety of disciplines depending on the resident's individual	F 692		

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F 692	Continued From page 15 needs. 8. Nursing, food and nutrition services, or other discipline will adjust the plan of care as necessary to meet goals." *Reference to an Instruction Sheet for completing a Fluid Restriction Worksheet (GSS [Good Samaritan Society] #195): -"Use: Recommended when there is a diet order with a fluid restriction." -"Purpose: To facilitate communication between nursing and food and nutrition services when planning how to provide a fluid-restricted diet order for a resident." *The Fluid Restriction Worksheet (GSS #195) included two sections: one for food and nutrition services and one for nursing services. -A table for each service area to document the types and amounts of fluids provided at mealtimes, during medication passes, and between meals as well as the total amount of daily fluids that could not be exceeded based on the resident's fluid restriction order. -A place for each service area to record the date, their signature, and their respective daily total fluid intakes for a resident.	F 692		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812	All residents have the potential to be affected by this deficiency. All dietary staff have been educated on cleaning procedures for the kitchens.This included how to clean all areas, inspecting all areas to clean, and when to clean and what to clean during the scheduled times. The entire kitchen was deep cleaned by the dietary department on 11-2-22. The gas stoves, the ovens, and ice dispensers were all thoroughly cleaned by the dietary staff to ensure proper sanitary conditions for the kitchen. There is a new cleaning schedule that was implemented for the kitchen that have elements of deep cleaning on a weekly basis and on	11/21/22

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F 812	Continued From page 16 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure kitchen cleanliness was maintained for: *One of one main kitchen, located in a separate building from the long term care facility. *One of one serving kitchen, located in between the facility's north and south dining rooms. *One of two ice dispensers located in the north dining room serving area. Findings include: 1. Initial walk through observation and interview of the main kitchen on 11/1/22 from 9:07 a.m. to 9:30 a.m. with food and nutrition supervisor (FNS) C revealed: *The main kitchen produced 600 meals a day, providing meals to the independent living, assisted living, and long term care residents. -These meals were placed into stainless steel holding pans and taken by rolling carts from the main kitchen to the serving kitchen located in the long term care facility. *The warming oven contained a large amount of burned and dried food particles covering the entire inside bottom, walls, and door of the oven. *The gas stove cast iron cooking grates were coated in dried grease and burned on blackened food particles.	F 812	a continuous basis for all kitchen areas. The certified dietary manager or her designee will conduct audits on the cleanliness of the kitchen areas including the stoves, ovens, and ice dispensing machine. In addition, the dietary manager or her designee will conduct audits on the rest of the kitchen to ensure cleanliness of all areas of the kitchen in the facility. Audits will be conducted once a week for 3 weeks, every other week x 3 times, and once a month x 3 months. The dietary manager or her designee will report to the QAPI committee on a monthly bases the results for the cleanliness of the kitchen including those areas needing specific attention of the gas stoves, ovens, and ice dispensing machine. The results will be reported by the dietary manager for the QAPI committee and if necessary make any recommendations for improvement. It will be continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	

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F 812	Continued From page 17 *The oven and stove were on a daily cleaning checklist that staff were to follow and initial. 2. Initial walk through observation and interview of the serving kitchen on 11/1/22 at 9:30 a.m. with FNS C revealed: *The holding pans would be removed from the rolling carts and placed into two separate steam tables. -These tables would then be pushed into the two adjacent dining room serving areas for meal service. *The gas stove in this kitchen was used only to fry eggs. -Observed the stove's cast iron cooking grates were coated in dried grease and burned on blackened food particles. *The stove was on a daily cleaning checklist that staff were to follow and inital. Further observation and interview on 11/1/22 at 9:35 a.m. of the north dining room serving area with FNS C revealed: *The ice dispenser had a large amount of white crusty build-up, resembling lime scale, around one of the two ice dispensing outlets. *This same white crusty build-up was also noted along the back splash of the dispenser where ice is placed into cups. *Maintenance was to clean and de-scale the ice machines once a month. Interview on 11/2/22 at 8:15 a.m. with maintenance worker D revealed: *They had a once monthly maintenance schedule to flush all ice machines and internal cleaning of the machines and dispensers. *He thought the kitchen staff were responsible for cleaning the exteriors of the ice dispensers.	F 812		

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F 812	Continued From page 18 *There was white crusty build-up resembling lime scale on the exterior of the north ice dispenser. Further interview on 11/2/22 at 3:15 p.m. with FNS C confirmed: *The oven and stove grates in both kitchens were coated with dried food and grease. *The expectation was for all surfaces, including the ovens and stoves, to be cleaned on a weekly basis. *The main kitchen ovens were supposed to be sprayed and cleaned weekly on Sunday. -They were gas ovens and were shut off daily after seven p.m. -There was no kitchen staff scheduled past seven p.m. to perform the oven cleaning task. *Kitchen staff had cleaning schedules, but she was having difficulty getting staff to complete the tasks. -"They are signing they are doing it, but obviously it is not getting done. I am so upset with them." -She had depended on lead cook's F and G to be following up on the completion of the cleaning tasks. -"Staff had let it fall off when staffing was low and never picked it back up. That will change." *Maintenance had always cleaned the exterior of the ice dispensers in the past. -"Maintenance should be responsible for cleaning all inside and outside of ice machines and dispensers as chemicals are used." -She had not wanted her kitchen staff to be using strong chemicals to clean the exterior of the ice dispensers while they were working with food handling. -The policy had not stated who was responsible for this task. *There was a system failure on cleaning of the exterior of the ice dispensers.	F 812		

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F 812	Continued From page 19 3. Review of the provider's August through October 2022 cleaning logs revealed: *All a.m., p.m., and prep cook, daily cleaning schedules were completed and initialed by staff. -The logs had contained a check-off item stating "All equipment used-cleaned and sanitized-grill, fryer, ect...". Review of the provider's 2/15/22 policy "Cleaning schedule-Food and Nutrition Services" revealed: *"Cleaning schedule" -"1. The director of food and nutrition services (DFN), senior living dining director or designee is to post written daily, weekly and monthly cleaning assignments in the kitchen areas." -"5. The DFN, food and nutrition supervisor, senior living dining director, senior living manager or person in charge is responsible for monitoring employees to ensure that cleaning duties are completed in a satisfactory and timely manner." *The policy had listed multiple items to be cleaned but had not included ovens or stove grates. Review of the provider's 3/28/22 policy "Ice Machines Use and Maintenance-Food and Nutrition Services" revealed it had not stated which department was to perform external ice machine and dispenser maintenance.	F 812		

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

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 11/1/22 through 11/3/22. Good Samaritan Society - St. Martin Village was found in compliance.	E 000		

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

Kyle Richards | Senior Director | 11/22/2022

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435134	A. BUILDING **01 - SERENITY PLACE** B. WING _____	**11/01/2022**

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GOOD SAMARITAN SOCIETY - ST MARTIN VILLAGE	**4825 JERICHO WAY RAPID CITY, SD 57702**

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 11/1/22. Good Samaritan Society - St. Martin Village was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiency identified at K355 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to perform monthly checks of fire extinguishers in accordance with NFPA 10. Monthly checks had not been performed on four randomly checked fire extinguishers (Serenity Place north boiler room, Serenity Place south boiler room, the kitchen, and in the mechanical room located above the laundry room) for October 2022. Findings include: 1. Observation on 11/1/22 beginning at 9:03 a.m. and ending at 11:30 a.m. revealed four randomly observed fire extinguishers (Serenity Place north	K 355	All residents have the potential to be affected by this deficiency. The fire extinguishers that were not inspected in October were inspected on 11-1-22 and signed off on by the Ancillary Manager of the facility. An inspection numbering/location system was created for all fire extinguishers and entered on an inspection sheet to ensure all extinguishers are checked monthly. Education was completed with all maintenance team on how to uses the inspection sheet when completing monthly checks. Ancillary Manager or designee will audit monthly extinguisher checks for 4 months to ensure all extinguishers are inspected monthly.	11/21/22

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

Kyle Richards | Senior Director | 11/22/2022

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

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	435134	A. BUILDING **01 - SERENITY PLACE** B. WING _____	**11/01/2022**

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K 355	Continued From page 1 boiler room, Serenity Place south boiler room, the kitchen, and in the mechanical room located above the laundry room) did not have the monthly maintenance check written on the fire extinguisher tag for October 2022. Interview with the manager of ancillary services at the time of the observation confirmed that finding. He indicated he was unaware of that issue. He further stated the extinguishers which had not been inspected were only the ones found in the maintenance areas and that all of the extinguishers in the resident areas had been completed.	K 355	Ancillary Manager or designee will report to the QAPI committee on a monthly basis the audits of the monthly fire extinguisher checks. The QAPI committee will review the audit and if necessary make any recommendations for improvement. It will be continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68237	A. BUILDING: _____ B. WING _____	11/03/2022

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 11/1/22 through 11/3/22. Good Samaritan Society - St. Martin Village was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 11/1/22 through 11/3/22. Good Samaritan Society - St. Martin Village was found in compliance.	S 000		

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

Kyle Richards

TITLE

Senior Director

(X6) DATE

11/22/2022

STATE FORM 6899 0LKQ11 If continuation sheet 1 of 1