STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435075	A. BUILDING ____ B. WING ____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY HOWARD	**300 WEST HAZEL AVENUE HOWARD, SD 57349**

(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 1/27/25 through 1/30/25. Good Samaritan Society Howard was found not in compliance with the following requirement: F684 . A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/27/25 through 1/30/25. The area surveyed was Quality of Care/Treatment as it related to resident lift chairs. Good Samaritan Society Howard was found in compliance.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, call light report review, resident council meeting, and policy review the provider failed to ensure that two of seven sampled residents (1 and 5) had their call lights answered in a timely manner. Findings include: 1. Observation and interview on 1/27/25 at 2:56 p.m. with resident 1 while in her room revealed:	F 684	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclustions set forth in the statement of deficiences. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial complaince with federal require-ments of participation, this response and plan of correction constitutes the center's allegation of complaince in accord-ance with section 7305 of the state operations manual.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jody Becker	Administrator	2/14/25

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435075	A. BUILDING ______ B. WING ______	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY HOWARD	**300 WEST HAZEL AVENUE HOWARD, SD 57349**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 1 *She was in bed. *Her call light was attached to a blanket within her reach. *Staff used a total lift (a mechanical lift and sling used to lift a person's full body) to transfer her in and out of bed. *She had chronic pain. *Staff would come in her room and turn her call light off and tell her they needed to get another staff member to help with her transfer. *She stated she had waited over an hour for staff to answer her call light. Review of resident 1's call light report for January 2025 revealed: *There were 22 call light response times over 20 minutes. *Three of those call lights were on for over an hour. Review of resident 1's electronic medical record (EMR) revealed: *She had a brief interview for mental status (BIMS) assessment score of 15 which indicated she was cognitively intact. *She had diagnoses of: -Quadriplegia. -Major depressive disorder, recurrent severe without psychotic features. -Unspecified intracranial injury with loss of consciousness of unspecified duration. -Chronic pain due to trauma. *Her revised 11/1/24 care plan stated she had a history of not allowing staff to turn the call light to answered/off knowing that the call light system tracked times of cares and that was empowering to resident. 2. Observation and interview on 1/28/25 at 9:10	F 684	1. Corrective action for the affected residents and all other potential residents has been accomplished by providing education to all staff on 2/10/25 and 2/12/25 on facility call-light policy to promptly answer call lights, respond to request as soon as possible, turn call light off and inquire about resident's request. Education provided that any and all staff can answer a resdient's call light, if that staff member cannot provide assistance for the request, they are to put the call light back on and use the walkie talkie to let the staff that can help know the resident needs help. Education provided to the nursing staff that assignments and scheduled break times need to be followed. Onenursing staff member needs to be available for resident's needs before, during, and after all meal times. Staffing levels will continue to be adjusted based off of acuity and census to ensure all resident's needs are met timely. 2. To Identify other residents that have the potential to be affected the following audits will be performed: Call light time log audits will be done on resident 1 and resident 5,and all other wings where residents reside weekly x 4 weeks, monthly x 3 months, audits will include morning, evening and meal times audit findings will be taken to Qapi committee for review and determination if the calllight times are within complaince for being answered timely. Intentional rounding audits that ask the question if call lights are answered timely will be done by Administrator or designee on 2 random residents weekly x 4 weeks and monthly x 3 months with findings brought to the QAPI committee for review and determination if call light times are in complaince for being answered timely. 3. Systemic changes that have been put into place is education that anyone can promptly answer a resident's call light. And scheduling break times for nursing staff to ensure that their is a nursing staff member available at all times.	2/14/25

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	435075	A. BUILDING ______ B. WING ______	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY HOWARD	**300 WEST HAZEL AVENUE HOWARD, SD 57349**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 2 a.m. with resident 5 in her room regarding call light wait times revealed: *She was in bed. *Her call light was attached to a blanket within her reach. *She stated it took staff a long time to answer her call light at certain times of the day. *She had a BIMS assessment score of 15 which indicated she was cognitively intact. Review of resident 5's call light report for January 2025 revealed: *There were 13 call light response times over 20 minutes. *Two of those call lights were over an hour. Interview on 1/29/25 at 9:10 a.m. with administrator A and director of nursing (DON) B regarding call light times revealed: *They could review call light times by hallway, but not by individual resident room. *They were not able to print documentation for call light reports. *The DON reviewed and monitored call lights monthly, and it was very labor intensive. *Call light times were part of the quality assurance meetings. *They had created a performance improvement plan (PIP) in October for call lights *They had some high acuity residents that took a lot of time to care for. *They had increased staffing levels around mealtimes to try to meet the resident's needs. *Ancillary staff helped answer resident call lights, but they could not provide personal cares. *It was their expectation that resident call lights be answered in a timely manner. *They agreed call lights should be answered within 20 minutes.	F 684	4. Performance will be monitored through resident interviews, QA audits and observations of call light times. If any negative findings occur, re-education and if applicable corrective action will be given to the staff involved. Continued audits will be done until complaince is maintained	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY HOWARD	300 WEST HAZEL AVENUE HOWARD, SD 57349

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F 684	Continued From page 3	F 684		

Interview on 1/29/25 at 10:38 a.m. with agency certified nursing assistant (CNA) D regarding call lights revealed:
*They monitored call lights in the hallways and were to answer them when they come on.
*A white light meant a resident needed assistance.
*A green light meant staff were already helping a resident.
*A red light meant a resident needed assistance in the bathroom.
*She carried a walkie-talkie to communicate with other staff members about resident care needs, including call lights.

Interviews on 1/29/25 at 1:28 p.m. with residents in a group setting regarding call lights revealed:
*They waited longer before and after meals for call lights to be answered.
*Some staff would answer the call lights but they had to get another staff member to help them, which increased their wait times.

Interview on 1/30/25 at 10:08 a.m. with business office manager/quality assurance performance improvement (QAPI) C regarding resident call lights revealed"
*The QAPI team met monthly.
*Call light times were reviewed at the meeting by DON B for specific trends.
*They had been completing call light audits since October.
*The call lights were on longer around mealtimes and during morning and evening cares for residents.
*They had added staffing hours to try to address the longer resident call light times.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435075	A. BUILDING ______ B. WING ______	C 01/30/2025

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GOOD SAMARITAN SOCIETY HOWARD	**300 WEST HAZEL AVENUE HOWARD, SD 57349**

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F 684	Continued From page 4 Review of the provider's 7/29/24 revised call light policy revealed: *"Purpose: To ensure resident always has a method of calling for assistance." *"To promptly answer resident's call light." *"Procedure: 1. New admission- explain and demonstrate the use of call light system." *"2. When resident's call light is observed/heard, go to resident's room promptly." *"3. Respond to request as soon as possible. Turn call light off and inquire about resident's request."	F 684		

PRINTED: 02/07/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435075	A. BUILDING ______ B. WING ______	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY HOWARD	**300 WEST HAZEL AVENUE HOWARD, SD 57349**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments 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 on 1/28/25. Good Samaritan Society Howard was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jody Becker	Administrator	2/14/25

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435075	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**01/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY HOWARD	**300 WEST HAZEL AVENUE** **HOWARD, SD 57349**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey was conducted on 1/28/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Good Samaritan Society Howard was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 1/29/25. Please mark an F in the completion date column for K233 and K241 deficiencies identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K233 and K241 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 233 SS=C	Clear Width of Exit and Exit Access Doors CFR(s): NFPA 101 Clear Width of Exit and Exit Access Doors 2012 EXISTING Exit access doors and exit doors are of the swinging type and are at least 32 inches in clear width. Exceptions are provided for existing 34-inch doors and for existing 28-inch doors where the fire plan does not require evacuation by bed, gurney, or wheelchair. 19.2.3.6, 19.2.3.7 This REQUIREMENT is not met as evidenced by: Based on measurement and document review, the provider failed to maintain proper exit access	K 233		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jody Becker
TITLE: Administrator
(X6) DATE: 2/14/25

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	435075	A. BUILDING **01 - MAIN BUILDING 01** B. WING	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY HOWARD	**300 WEST HAZEL AVENUE** **HOWARD, SD 57349**

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K 233	Continued From page 1 door widths for two of two randomly observed sets of cross-corridor doors (north and east of the nurses' station). Findings include: 1. Measurement on 1/28/25 at 10:30 a.m. revealed each leaf in the pair of one-hour fire-rated cross-corridor doors to the north of the nurses station measured 30 inches in clear width. That clear opening width did not provide the minimum requirement of 32 inches. Review of the previous survey report confirmed the condition was part of the original construction. 2. Measurement on 1/28/25 at 10:40 a.m. revealed each leaf in the pair of one-hour fire-rated cross-corridor doors east of the nurses station measured 31.5 inches in width. That clear opening width did not provide the minimum requirement of 32 inches. Review of the previous survey report confirmed the condition was part of the original construction. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K 233		F
K 241 SS=C	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4	K 241		

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	435075	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**01/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY HOWARD	**300 WEST HAZEL AVENUE** **HOWARD, SD 57349**

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K 241	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation and document review, the provider failed to ensure at least two conforming exits existed from each floor of the building (basement has only one conforming exit). Findings include: 1. Observation on 1/28/25 at 10:51 a.m. revealed the basement did not have a conforming exit. The primary exit was the basement stairway that discharged onto the main level corridor system. The second basement exit was through a window to an area well-equipped with a fixed ladder. Review of the previous survey report confirmed the condition existed since the original construction. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct the deficiencies identified in K000.	K 241		

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
	10631	A. BUILDING: ______ B. WING ______	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY HOWARD	**300 W HAZEL AVE HOWARD, SD 57349**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 1/27/25 through 1/30/25. Good Samaritian Society Howard was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jody Becker	Administrator	2/14/25