PRINTED: 01/23/2024
FORM APPROVED
OMB NO. 0938-0391

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
	435074	A. BUILDING ______ B. WING ______	C 01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

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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 1/9/24 through 1/11/24. Good Samaritan Society De Smet was found not in compliance with the following requirements: F657, F684, and F812. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/9/24 through 1/11/24. The area surveyed was resident abuse and neglect. Good Samaritan Society De Smet was found not in compliance with the following requirement: F684	F 000	1. Immediate action taken by Administrator on 1/24/24: Resident identified: # 29 Care Plan was reviewed and updated to include elopement risk and Wanderguard necessity. Elopement drill was completed in facility. 2. All residents identified as an elopement risk have the potential to be affected by this deficient practice. Care plans for residents identified as at risk for elopement were reviewed to ensure current interventions. 3. All residents are evaluated upon admission/re-admission, significant change in cognition, identification of wandering behaviors, quarterly and annually MDS, and any significant change to assess for elopement risk.	2/1/24 MB
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657	A. Any identified Elopement risk Residents will have an order for a Wanderguard signed by the provider a BIMS will also be completed to determine the resident ability to understand and retain education about the Wanderguard system. Resident family/POA will also be notified/ educated of Wanderguard initiation. The resident's Care plan will be updated to reflect appropriate interventions including Wanderguard, if applicable. Wanderguard monitoring, wandering behavior identifications, as well as redirections and modifications of those behaviors, will be completed and documented per policy. B. A BIMS will be utilized to determine resident ability to exit building without supervision. Heat/ Cold weather policies will be followed by staff to ensure resident safety in times of extreme weather. Heat/Cold emergencies policy/ procedure, from our Emergency Management Manual, will be used by staff to ensure resident safety in times of extreme weather. An order for a Wanderguard will be requested from the physician for each resident "at risk" or with wandering behaviors.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marcus Bock
TITLE: Administrator
(X6) DATE: 2/8/24

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 657	Continued From page 1 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the care plan for one of one sampled resident (29) was revised to include interventions regarding risks of elopement. Findings include: 1. Observation on 1/10/24 at 3:10 p.m. of resident 29 revealed she was wearing a Wanderguard on her right ankle. 2. Interview on 1/10/24 at 3:21 p.m. with resident 29's family member revealed: *Resident 29 had been found outside of the building and staff would contact her when that happened. -The last incident happened about two weeks ago. 3. Interview on 1/11/24 at 8:14 a.m. with certified nursing assistant (CNA) H regarding elopement interventions for resident 29 revealed: *Resident 29 had a Wanderguard and the alarm would sound when the resident opened the door to go outside. *Staff would have to redirect her when they would see her attempting to go outside *The resident would go outside in the summer, during the warmer months, but when the weather was cold, she felt the resident would not have gone outside, and staff would have redirected her	F 657	C. All nursing staff will be educated in Care Planning and all staff will be educated on Elopements, heat/cold weather emergency policy and Wanderguard use and risks related to weather conditions. On 1/29/24 education was provided by DON. Anyone not in attendance will be educated remotely by February 1st, 2024, or educated prior to their next worked shift. Monitoring: DON or Designee will complete audits on updating the care plan to reflect interventions to prevent wandering and elopement. Audit to ensure that each "at risk" resident identified has a Care Plan (with behaviors and interventions to prevent wandering) initiated, Auditing: weekly x 4 weeks, then monthly x2 until the facility demonstrates the same compliance determined by the QAPI committee.	

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if she attempted to go outside.
*When asked about any recent incidents of resident 29's attempts to go outside, CNA H stated she was not aware of any incidents.
*When asked how staff would have known how to take care of the resident or how the staff were made aware of the resident's risk for elopement, she stated that they would use the Kardex and that would let new or traveling staff know and also through nursing report about the resident's risk of elopement.

4. Interview on 1/11/24 at 9:44 a.m. with registered nurse (RN) J regarding resident 29's elopements revealed:
*Resident 29 would go outside when the weather was warm, and the staff would keep an eye on her while she was sitting outside.
*When the weather started getting colder and due to residents' dementia and impaired thought process, the interdisciplinary team decided to place a Wanderguard to ensure staff knew the resident attempted to go outside during the colder months.
*When asked what interventions were in place for resident 29's elopement risk, she stated that the staff would have kept an eye on her when she was outside and would have ensured the placement of the Wanderguard.

5. Interview on 1/11/24 at 11:00 a.m. with temporary agency CNA I revealed:
*Traveling staff were trained to use the resident's Kardex to ensure they knew how to care for each resident.
*CNAs would use a "cheat sheet" that would have the resident's names listed on it with space for the CNA to write down specific care needs for each resident from the Kardex or when they

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completed resident rounds with another CNA.

6. Review of resident 29's Kardex revealed:
*Resident showed significant poor safety awareness.
*There was no documentation regarding resident 29's exiting behaviors, Wanderguard, or any interventions that had been put into place regarding past elopements.

Review of resident 29's 11/28/23 care plan revealed no interventions were in place regarding her elopement attempts.

Review of resident 29's electronic medical record revealed:
*Resident had a Brief Interview for Mental Status (BIMS) of 6, which indicated severe cognitive impairment.
*There was no documentation in resident 29's 8/23/23 Minimum Data Set (MDS) that the resident exhibited any wandering behaviors.
*There was documentation in resident 29's 11/1/23 MDS that the resident had exhibited wandering behaviors and that they had occurred 1-3 days.
*A 10/10/23 social services progress note stated, "[resident's name] was outside in the parking lot coming back from approaching a parked car this morning at 8am. She was happily directed back into the building for breakfast"
*A 10/10/23 nursing services progress note stated, "Resident has had multiple attempts of exit seeking throughout the morning. Because the frequency is increasing, fax sent to provider to request a Wanderguard bracelet. Awaiting response at this time."
*A 10/10/23 physician's order for a Wanderguard at all times due to exit seeking. Nursing staff

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F 657	Continued From page 4 would check placement every day and at bedtime. *A 10/11/23 nursing services progress note that stated, "CP [Care plan] updated r/t [related to] elopement attempts." *A 10/11/23 nursing services progress note that stated, "ELOPEMENT: Elopement risk: Resident continues to self-propel w/c [wheelchair] in/out of front door multiple times throughout the day. Though resident has Wanderguard on that is checked and passes 'OK,' the auto alarm/lock doesn't always enact. Mostly resident simply sits near front door and observes what's going on. X [times]1 start propel self down side walk toward vehicles before staff re-directed resident back into facility." *A 10/20/23 nursing services progress note that stated, "Resident has been going in and out of the building frequently. Out this morning and sitting in the shade by the front door. Resident has a wander mate [Wanderguard] placed but resident still leaves the building when wander mate releases. Attempting to talk with resident about colder weather and not exiting building, but resident does not indicate that she understands. Resident also has hx [history] of attempting to get into vehicles in the parking lot." *A 10/29/23 nursing services progress note that stated, "Resident outside several times today, even with the temps [temperatures] below freezing. Resident out with wheelchair and sitting in the front area in the sunshine. Resident had sweat [sweater] in her lap, but needed assistance with getting it on. Spoke with resident that is getting too cold outside to sit out." *A 11/24/23 nursing services progress note that stated, "Resident sitting outside this morning near the front door. Resident's breath visible as about 15 degrees. Staff member approached resident	F 657		

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F 657	Continued From page 5 and resident did come into the building. Resident was given a lab [lap] blanket as well in case she did not want to come back into the building." *A 12/31/23 nursing services progress note that stated, "Resident went out the front door to sit in the sun. Resident sat outside about 10 minutes and did not attempt to come back into the building like she has in the past. Nurse went outside and asked if she was ready to come back into the building; resident stating yes. Got a blanket for resident to warm up. Resident shivering." *A 1/10/24 nursing services progress note stated, "Witnessed resident opening the front door. Had her light jacket with her, but when the cold air hit her face from the entry area, resident backed up and parked her wheelchair near the door but did not attempt to leave." 7. Interview on 1/11/24 at 2:00 p.m. with director of nursing services (DNS) B, administrator A, and regional clinical services coordinator G revealed: *The provider had not considered resident 29 to have been an elopement risk. *The resident had in the past exited the building but would only sit right outside the front door by the bench. *The resident had a Wanderguard placed that would sound an alarm to let staff know when the resident was attempting to go outside. *When asked about why the resident's exiting behaviors and interventions including the Wanderguard were not in the care plan, DON agreed that the Wanderguard and the resident's exiting behaviors should have been included in the care plan so staff were aware of those behaviors and interventions. Review of the 12/4/23 Comprehensive Care Plan and Care Conferences Policy revealed:	F 657		

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F 657	Continued From page 6 *The MDS coordinator or care plan coordinator were responsible for the resident's care plans. *The care plan was driven by identifying the resident issues/conditions and their unique characteristics, strengths, and needs. *Care plans were reviewed with each MDS that was completed. *Care plans would be revised as the resident's needs/status change.	F 657		
F 684 SS=E	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: A. Based on electronic medical record (EMR) review, menu review, interview, and policy review the provider failed to ensure one of one sampled resident (42) was served an appropriate menu substitution. Findings include: Review of resident 42's EMR revealed: *On 10/27/23 the provider changed resident 42's diet to a regular diet level 5 mince moist. *On 12/19/23 while assisted by certified nursing assistant (CNA) E eating her noon meal she had begun coughing. *Thick foamy secretion with particles of rice had been identified. *She continued to cough and emit food particles	F 684	1. Immediate action taken by Administrator/ DON on 1/11/24: Resident Identified as #42 no longer resides in the facility. Resident #25 upon recognition of issue on 1/11/24 a physical bowel assessment was completed, and provider/family was notified - effective results of intervention on 1/11/24. Upon identification of improper menu substitution on #42, dietary Manager "C" educated Cook "D" on proper menu substitution on 1/11/24. 2. All residents have the ability to be affected by the deficient menu substitution practice and all residents with motility issues have the ability to be affected by the bowel monitoring. 3a. All residents identified with motility issues and without a documented bowel movement in 72 hours (about 3 days) will receive PRN bowel protocol. PRN bowel protocol: PRN medication/ treatment will be administered after a physical assessment or completion of Bowel UDA. If PRN medication is ineffective the physician will be notified for further instruction. Any individualized bowel protocol/program will be placed in the resident's care plan and communicated to staff via POC/PCC or during report.	2/1/24 MB

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F 684	Continued From page 7 while coughing. *She had been transferred to the hospital due to possible aspiration of rice. Review of the minced and moist menu served on 12/19/23 revealed it included the following: American Chop Suey, vegetable juice, 2% milk, black coffee and tea. Review of the menu substitution log for December 2023 revealed: on 12/19/23 vegetable juice had been substituted with white rice. 1. Interview on 1/10/24 at 3:15 p.m. with dietary manager (DM) C regarding the menus that were served to resident 42 revealed: *She had substituted resident 42's vegetables were served with the chop suey with rice. *She had paired rice with the chop suey which was ground chicken and Asian vegetables, and a barbecue sauce. *The chop suey had a sauce that had been served with it. -The sauce would have been thick enough for the minced moist diet requirements. 2. Interview on 1/10/24 at 4:00 p.m. with CNA E regarding the assistance of resident 42 at mealtime during the coughing event on 12/19/23 revealed: *He was assisting resident 42. *He stated the resident had begun coughing after eating some rice. *He then gave the resident some sips of water, but she continued to cough. *He then notified the nurse. 3. Interview on 1/11/24 at 10:00 a.m. with	F 684	3b. All residents will receive an appropriate menu substitution when substitutions are requested or required. A. A logbook is kept in the kitchen and will be filled out for any menu substitutions using dietary equivalents. B. Education was completed on Hand Hygiene, glove use, food service, and menu substitution equivalents by Registered Dietician in the facility on 1/25/24. All current staff in attendance. All nursing staff was educated on the PCC alert system and bowel management protocol on 1/29/24 by DON. 4. Monitoring: DON or Designee will audit PCC Alert notifications to identify any resident triggering a 3 day No bowel movement. Identified residents MAR/Resident Record will be checked to see if an intervention was completed and if effective/ineffective. If ineffective, a Progress note or UDA was completed, and physician was notified. Auditing: weekly x 4 weeks, then monthly x2 until the facility demonstrates the same compliance determined by the QAPI committee.	2/1/24 MB

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F 684	Continued From page 8 registered dietitian (RD) F regarding the resident's menu substitutions revealed: *If a substitution was for a vegetable a different kind of vegetable should have been served instead of rice. *She felt that the barbecue sauce that had been served with the rice would not have been thick enough to meet the requirements for a minced moist diet. 4. Interview 1/11/24 at 2:24 p.m. with director of nursing services (DNS) B regarding resident 42's coughing episode on 12/19/23 during mealtime revealed: *She was aware that her diet had changed twice in the past year. *She was not able to locate a rational for the diet changes. *She was not aware that rice was not on the menus to be served that day, and it was a substitution for a vegetable juice. *She agreed that if the rice had been substituted for vegetable juice, that would not have been an appropriate substitution. Review of the provider's December 2023 Substitutions-food and Nutrition Services policy revealed: *"To provide employees policy and procedure for appropriate menu substitutions when planned menu item or ingredient is unavailable." *"Temporary changes to the pre-planned menu cycle are documented. As often as possible, the menu is served as posted/planned." *"All substitutions are documented and kept on file with original posted menu." *"When possible, the cook will check with the director of food and nutrition services/dietary manager before making the substitutions."	F 684		

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F 684	Continued From page 9 *"Menu changes are to be kept to a minimum." *"Vegetable Food Amount Equivalent to 1/2 cup include:" -"1 small baked potato may be substituted with 3/4 cup vegetable juice." Review of the provider's November 2023 Diet Manual and Nutrition Services policy revealed: *"The diet manual will be approved by the dietitian annually." *"The diet manual will meet the established national standards." *"The diet manual will be used to write the therapeutic and texture-modified diet extensions in conjunction with established national standards," *The National Care Manual includes information on International Dysphasia Diet Standardization Initiative (DDS) diets. A diet manual addendum will be created if the diet manual used at a location had not been updated to include the DDS diets. The addendum will be in writing and posted/stored with diet manual." B. Based on observation, family interview, EMR review, staff interview, and policy review, the provider failed to monitor and follow up on signs and symptoms of constipation for one of one sampled resident (25) with a history of a small bowel obstruction. Findings include: 1. Observation and family interview on 1/10/24 at 1:00 p.m. with resident 25 and her daughter revealed: *Resident 25 was sitting in her wheelchair in her room.	F 684		

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*Her daughter was visiting her and agreed to be interviewed regarding her mother's care.
*The daughter stated:
-Her mother had dementia and was non-verbal most of the time.
-She was very happy with her mother's care.
-Her mother had issues with constipation.
-Her mother was hospitalized a month ago for a small bowel obstruction.

Review of resident 25's EMR revealed:
*She had a Brief Interview for Mental Status (BIMS) of two that indicated severe cognitive impairment.
*Her diagnoses included constipation.
*She was on two medications for her constipation.
*She was admitted to the hospital on 11/27/23.
*She returned from the hospital on 12/1/23.
*Her hospital diagnosis was a small bowel obstruction with urinary tract infection (UTI).
*Her 12/7/23 physician's orders included the following:
-Dulcolax suppository 10 milligrams (mg) give daily as needed for constipation.
-Contact provider/practitioner if there were three days without a significant bowel movement (BM).
*The activities of daily living (ADL) charting indicated she had no documented BM from 1/3/24 through 1/9/24.

2. Interview on 1/11/24 at 11:59 a.m. with registered nurse (RN) J regarding resident 25's constipation revealed she:
*Knew resident 25 had not had a BM since 1/2/24.
*Stated resident 25 was not eating or drinking very well so it was hard to get results.
*Thought the hospice nurse tried some things but

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(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 11 was not sure. *Would start giving laxatives if a resident had not had a BM for three days. 3. Interview on 1/11/24 at 1:39 p.m. with DNS B regarding resident 25's constipation and physician follow-up orders revealed: *She agreed there was no documentation resident 25 had a BM for seven days. *She knew the physician's order was to notify the physician after three days without a BM. *Her expectation was nurses would monitor and document in the resident's chart and follow the physician's orders. Review of the provider's revised 4/26/23 Bowel & Bladder Evaluation, Assessment, Toileting Program policy revealed: *"Constipation: If the resident has two or fewer bowel movements during the seven-day look-back period or if for most bowel movements the stool is hard and difficult to pass (no matter what the frequency of bowel movements)." *"Abdominal assessment is complex because of the multiple organs in the abdominal cavity. To perform an effective abdominal assessment, you must know the location of those organs. Prevention of constipation and fecal impaction is critical. Failure to accurately assess the abdomen has led to unnecessary death of residents. 1. During a 72-hour period, document bowel function in PCC (Point Click Care)-POC (Plan of Care)."	F 684		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		

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
	435074	A. BUILDING ______ B. WING ______	C 01/11/2024

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GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

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F 812	Continued From page 12 §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 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, and policy review, the provider failed to ensure proper glove use and hand hygiene was performed during two of two observed meal services by one of one dietary cook (D) in the dining room. Findings include: 1. Observation and interview on 1/9/24 from 5:03 p.m. through 5:36 p.m. with cook D revealed he: *Washed his hands and put on a pair of gloves before serving the evening meal, stating when asked about their use, that he wore gloves anytime he was serving food. With those same gloves on: *He proceeded to pick up the scoop for the main entrée to stir the gravy. *He picked up a stack of nine plates and moved them to the serving bar in front of the steam table. *He picked up the resident's individualized paper	F 812	1. Immediate action taken by Administrator: A. Individual identified "D" cook was educated by Dietary Manager "C" on 1/11/24 B. Education was set up on 1/19/24 with Registered Dietician - , to come to the facility on 1/25/24 to conduct in-service training. C. A new Diet Nutrition Care Manual was ordered on 1/25/25 (will be signed by RD when she is in the building). 2. All residents have the potential to be affected by this deficient practice. 3. Education: Education on Hand Hygiene and glove use / food Procurement and preparation/Service and Sanitation was completed by - RD on 1/25/24 in the facility. 4. Monitoring: DON or Designee will audit hand hygiene and glove use in food service; randomly across all meals 3x weekly for 4 weeks then 1x weekly for 4 weeks and then 1x monthly x2 months until the facility demonstrates the same compliance determined by the QAPI committee.	2/1/24 MB

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	435074	A. BUILDING ______ B. WING ______	C 01/11/2024

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F 812	Continued From page 13 meal slip. *With those same gloved hands he: -Touched a ready-to-eat sandwich. -Placed the sandwich on a plate. -Cut the sandwich in half while holding the sandwich on the plate with his left hand. *Took the scoops and ladles for the next resident's plate with those same gloved hands. *Continued to serve more resident meals with those same gloved hands, touching meal slips, plates, scoops, and ladles to serve the resident's food. *Requested a green scoop for the turkey salad and took the scoop when it was given to him by an unidentified ungloved staff person. *With those same gloved hands he continued to serve resident meals throughout the meal service touching multiple times. *Touched the back pocket of his pants to silence his phone. *Handled a bag of bread and removed two slices of bread by touching them with those same gloved hands and continued to touch multiple food items with those same gloved hands. *Picked up a pen to write a note on a meal slip. *Handled a stack of five plates. *Rested both of his hands on the serving counter before preparing the five-room trays. 2. Observation on 1/10/24 from 12:03 p.m. through 12:38 p.m. with cook D revealed he: *Was wearing gloves while serving the noon meal from the steam table in the dining room. *Handled a piece of garlic toast with the same gloved hands and placed it on a resident's plate. -There was a pair of tongs available in the garlic toast bin on steam table. -Prepared three plates for room trays handling the noodles that were hanging over the edge of	F 812		

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F 812	Continued From page 14	F 812		

the plate with the same gloved hands and placed the noodles back on the plate.
-Handled three pieces of garlic toast from the bin on the steam table with his gloved hand and placed each garlic toast on three separate plates.

Interview on 1/11/24 at 10:34 a.m. with cook D and dietary manager (DM) C regarding glove use and hand hygiene revealed:
*Both were temporary staff from an agency.
-Cook D had been working at the facility the past one and a half months.
-DM C had been working at the facility since October 2023.
*Cook D revealed he:
-Stated "I've done food service for 20-30 years."
-Had "always been taught if I'm the only one in the area and stayed in the area I didn't have to change gloves."
*DM C revealed she:
-Agreed with the observations noted above.
-Agreed there was a potential for cross-contamination when wearing the same pair of gloves for multiple tasks.

Interview on 1/11/24 at 11:07 a.m. with interim director of nursing services K, regional clinical services coordinator (RCSC) G and administrator A revealed:
*They all agreed the above observations created risks for potential cross-contamination during both observed resident meal services.
*They all agreed that wearing one pair of gloves for multiple tasks during meal service was a problem.

Review of the provider's 6/14/23 Food Nutrition Services policy on "Hand Washing and Glove Use" revealed:

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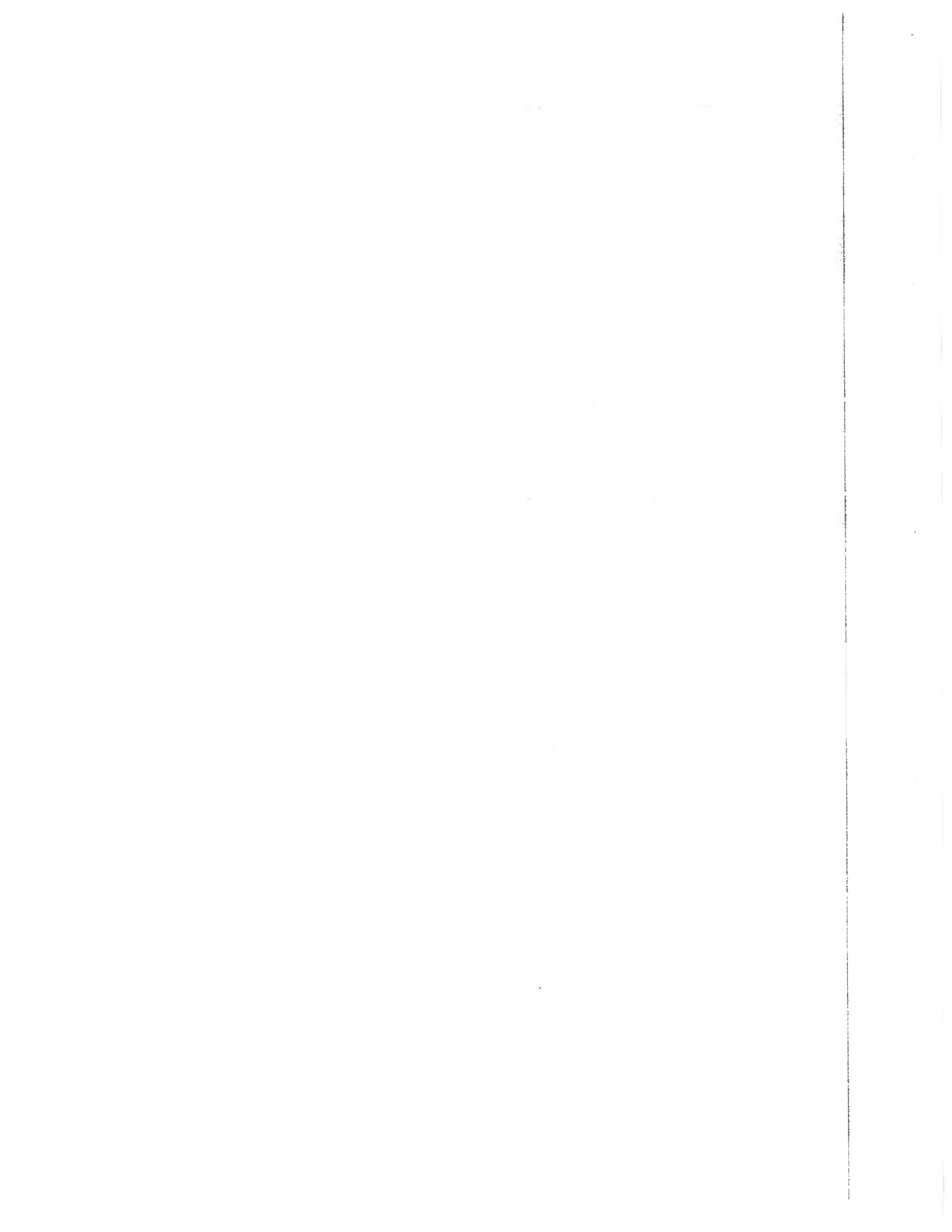
F 812	Continued From page 15 *Purpose: "...to reduce risk of cross-contamination when serving highly susceptible populations." *Policy: "Proper utensils such as tissue, spatula, tongs, and single-use gloves should be used for food handling to reduce the risk of cross-contamination." *Procedure: "Proper Use of Gloves": -"Gloves are worn when the employee:" --"Is handling ready-to-eat foods and completing a single task." -"Gloves are changed as follows:" --"Before handling ready-to-eat foods." --"When coming in contact with something that may be contaminated, such as handling pots/pans/tray/utensils..." --"After touching hair, skin or clothing." *"Food and Nutrition Competency Checklist Hand Washing and Glove Use" -"Proper Use of Gloves" --"Use utensils and single service deli papers whenever possible instead of gloves when touching any food; ready to eat or otherwise." --"Gloves are worn when the employee is handling ready-to-eat foods and completing a single task." --"Gloves are not worn routinely when serving food, during food preparation or when completing more than one task. Utensils are used when completing multiple tasks." Review of cook D's orientation paperwork revealed: *A "Hand Hygiene and Handwashing Clinical Skill Checklist". -"During Service of Meals" --"Do not wear gloves routinely during meal delivery or setup. Gloves can only be used if limited to a single task (e.g., buttering bread).	F 812		



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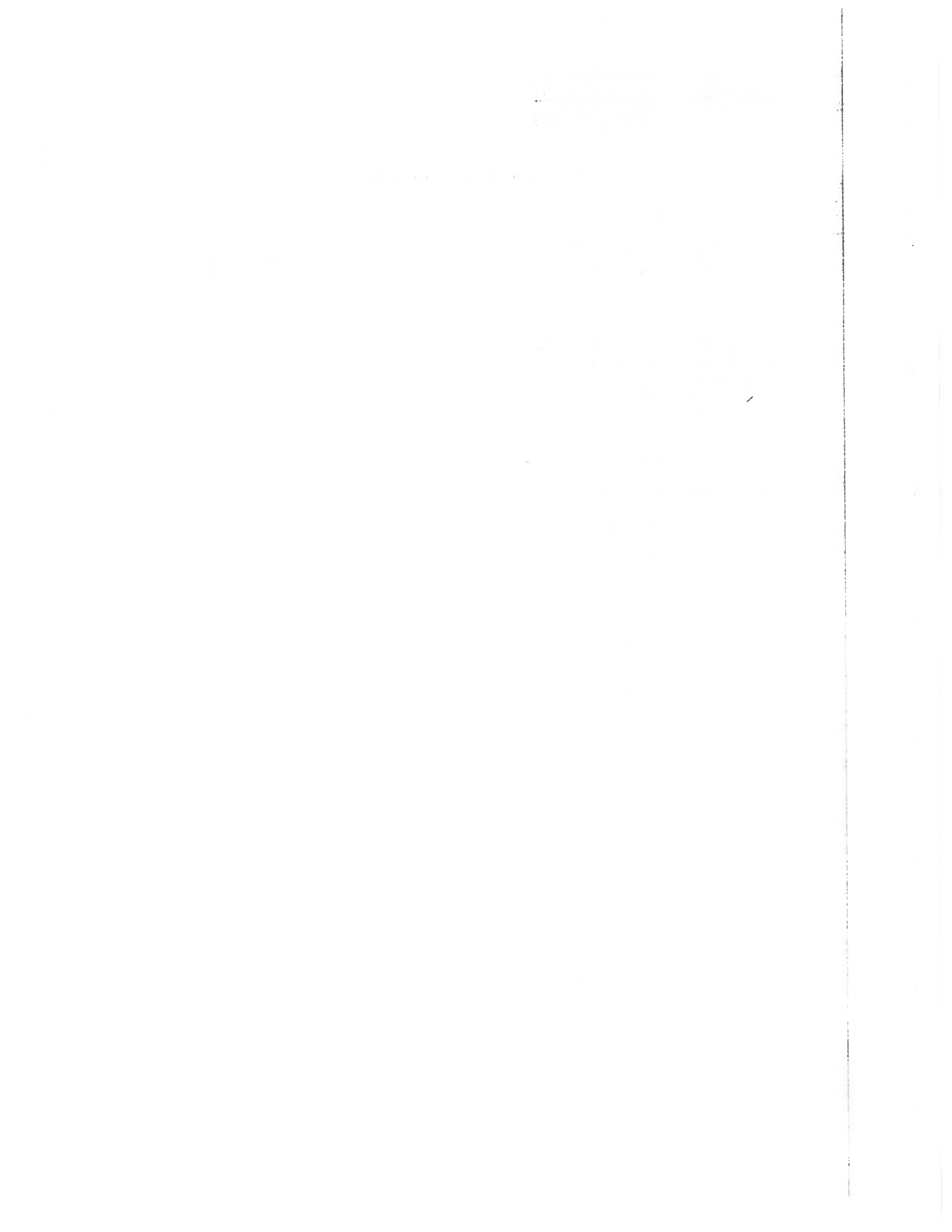
F 812	Continued From page 16 Gloves require handwashing when donned and doffed." was rated as "skilled and able to work independently" on 11/27/23. -The checklist was signed by: --Cook D on 11/27/23. --Director of nursing services B on 11/27/23. Interview on 1/11/24 at 4:05 p.m. with director of nursing services B revealed: *She had completed orientation with cook D on 11/27/23. *She had completed the "Hand Hygiene and Handwashing Clinical Skill Checklist" with him. *She recalled reviewing the portion that stated "Do not wear gloves routinely during meal delivery or setup. Gloves can only be used if limited to a single task (e.g. buttering bread). Gloves require handwashing when donned and doffed" and rated him as "skilled and able to work independently." -She agreed that correlated directly with the meal observations of cook D the past two days.	F 812		



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435074	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 01/11/2024

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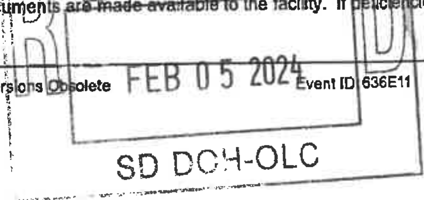
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 1/9/24 through 1/11/24. Good Samaritan Society De Smet was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marcus Blake
TITLE: Administrator
(X6) DATE: 2/1/24

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.



PRINTED: 01/23/2024
FORM APPROVED
OMB NO. 0938-0391

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
	435074	A. BUILDING 01 - MAIN BUILDING 01 B. WING	01/10/2024

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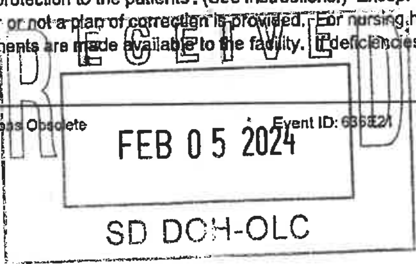
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 1/10/24. Good Samaritan Society De Smet was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marcus Block	Administrator	2/1/24

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.



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
	10614	A. BUILDING: ______ B. WING ______	01/11/2024

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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 1/9/24 through 1/11/24. Good Samaritan Society De Smet was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marcus Block

TITLE: Administrator

(X6) DATE: 2/1/24