PRINTED: 07/20/2023 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 435124 07/13/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 421 EAST 4TH ST GOOD SAMARITAN SOCIETY MILLER **MILLER, SD 57362** SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION DATE (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 000 **INITIAL COMMENTS** F 000 None needed. In compliance. A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/10/23 through 7/13/23. Good Samaritan Society Miller was found in compliance. None needed. In compliance. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/10/23 through 7/13/23. Areas surveyed included quality of care and resident treatment. Good Samaritan Society Miller was found in compliance.

LABORATORY DIRECT DR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Administrator

7/23/2023

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 of nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not explan of correction is provided. For our singly 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.

FORM CMS-2567(02-99) Previous Versions Obse

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Facility ID: 0018

If continuation sheet Page 1 of 1

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

PRINTED: 07/20/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		435124	B. WING		07/13/2023			
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY MILLER				STREET ADDRESS, CITY, STATE, ZIP CODE 421 EAST 4TH ST MILLER, SD 57362				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION			
E 000	CFR Part 482, Subpa Emergency Prepared Term Care facilities v	ey for compliance with 42 art B, Subsection 483.73, lness, requirements for Long vas conducted from 7/10/23 ad Samaritan Society Miller ance.	E 000	None needed. In compliance				
V	DIRECTOR'S DR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE Administrator	(X6) DATE 7/23/2023			

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 fleriplencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete JUL 2 3 2023 Event ID-SKPS11

SD DOH-OLC

Facility ID: 0018

If continuation sheet Page 1 of 1

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
10651		B. WING			07/13/2023	
NAME OF PROVIDER OR SUPPLIER		ADDRESS, CITY, ST	FATE, ZIP CODE			
GOOD SAMARITAN SOCIETY	MILLER	TH STREET , SD 57362				
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETE DATE	
S 000 Compliance/Nonc	Compliance/Noncompliance Statement			- Telescope 1		
Administrative Ru 44:73, Nursing Fa 7/10/23 through 7	of for compliance with the les of South Dakota, Article cilities, was conducted from 1/13/23. Good Samaritan Society tot in compliance with S157.			A		
provided in all soil rooms, and storag may also be ventil air from the buildir This Administrative met as evidenced Based on observa provider failed to none randomly obsesouth wing. Findin 1. Observation on room 16 had been restroom and had located in the room maintenance super observation reveal washing wheelchate grille in the restroom the exhaust was not linterview with the room that room was red.	ed exhaust ventilation shall be ed areas, wet areas, toilet e rooms. Clean storage rooms ated by supplying and returning ag's air-handling system. e Rule of South Dakota is not by: tion, testing, and interview, the naintain exhaust ventilation in erved room (room 16) in the gs include: 7/11/23 at 11:15 a.m. revealed a resident room with a a wheelchair washing machine in. Interview with the rvisor at the time of the ed room 16 was being used for irs. Testing of the exhaust fan im with tissue paper revealed	S 157	The maintenance supervimotor in the exhaust van restroom in room #16. Exhaust vans are checker maintenance supervisor in check was completed on	of the d by the	7/18/2023	

JUL 2 4 2023

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Administrator

07/24/2023

WISI11

If continuation sheet 1 of 2

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
10651			B. WING	07/13/2023		
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	ATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY MILL	ER	SD 57362		F 1	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
S 000	Continued From page 1		S 000	1 1 2 1 1		
S 000	Compliance/Noncompliance Statement		S 000			
	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 7/10/23 through 7/13/23. Good Samaritan Society Miller					
	was found in compliar	nce.				
				Annual Manager		
				a la		
				the contract of the contract o		
				38 1 ° 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		