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

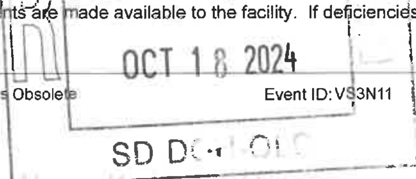
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435124	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER	421 EAST 4TH ST MILLER, SD 57362

(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 9/17/24 through 9/19/24. Good Samaritan Society Miller was found in not in compliance with the following requirements: F553, F580, F600, F623, F625, F657, F686, F689, F812, F865, F880, F882, and F925. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/17/24 through 9/19/24. Areas surveyed included quality of care related to lack of bathing, potential verbal and physical mistreatment of residents, resident neglect related to a resident being left on a bedpan for a prolonged time, not following the grievance process, lack of communication, and harassment of female staff by a male resident. Good Samaritan Society Miller was found not in compliance with the following requirements: F553, F600, F686, F865, and F925. On 9/18/24: *At 3:10 p.m., immediate jeopardy was identified related to the sanitation of dishware at F812. *At 4:25 p.m., a notice of immediate jeopardy was provided verbally and in writing to administrator A and business office manager/dietary manager C. An immediate jeopardy removal plan was requested at that time. The survey team exited the building at 5:00 p.m. On 9/19/24: *At 7:43 a.m. administrator A provided their final plan for the removal of the immediate jeopardy through an email submission.	F 000	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 conclusions set forth in the statement of deficiencies. 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 compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kimberly Sivertsen	Administrator	10/18/2024

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 000	Continued From page 1 *At 8:32 a.m. the provider's removal plan was reviewed and accepted by the survey team with guidance from the assistant administrator and long-term care advisor for the South Dakota Department of Health. *At 9:30 a.m. the survey team entered the facility to observe, interview, and review the provider's documentation related to their removal plan of the immediate jeopardy. *At 12:25 p.m. based on observations, interviews, and documentation review the survey team determined the immediacy was removed. The resident census was 40.	F 000		
F 553 SS=E	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.	F 553		

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F 553	Continued From page 2 §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on resident council meeting, observation, interview, record review, and policy review, the provider failed to ensure three of fifteen residents (1, 15, and 18) bathing preferences were followed. Findings include: 1. Resident council meeting held on 9/17/24 at 11:20 a.m. revealed: *The bathing schedule had changed recently. *Residents who wished to remain anonymous voiced their concerns they were not getting bathed on their scheduled bath days. *The lack of baths had been discussed during care plan meetings. 2. Observation and interview on 9/18/24 at 10:35 a.m. with resident 1 regarding her bathing schedule revealed: *She had been getting one bath a week after she was admitted. *The last two weeks her bath had not been completed on her scheduled day. *Her preference was three baths a week like she had received while she was an assisted living resident before she was admitted to the nursing home.	F 553	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? - Resident #1 - Bath schedule updated to ensure three baths are given a week. - Resident #15 -Bath schedule and care plan updated to ensure two baths are given a week. - Resident #18 - Quarterly Sit-Stand-Walk assessment were done on 10/3/24 indicating new bathing preference of once a week.	10/18/2024

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F 553

Continued From page 3

Review of resident 1's electronic medical record (EMR) regarding her bathing preferences revealed:
*Her 6/27/24 initial care plan was revised on 8/6/24 to include "Resident requires whirlpool bath with 1 staff, preference is 2 weekly."
*A progress note dated 7/30/24 from social services coordinator G:
-"Resident talked to this writer about wanting more baths due to her room being warm."
-"She was getting 3 baths a week at the AL where she was."
*Her care plan had not been revised to indicate her preference of three baths a week.
*Her bathing record documentation from 8/19/24 through 9/17/24 indicated she had a bath on 8/22/24, 8/28/24, and on 9/5/24.
*There was no documentation that she had received a bath for 12 days.

3. Interview on 9/18/24 at 2:05 p.m. with resident 15 regarding his care revealed:
*The day of his bath had recently been changed from Fridays to Mondays.
-He was satisfied with bathing one time a week and had not minded the bath schedule change.
*He did not get bathed on 9/16/24 before a funeral he planned to attend on 9/17/24.
-He had specifically requested a bath from staff twice on 9/16/24, as he had wanted to be clean for the funeral.
-The staff had not communicated with him that there was no hot water in the tub room where he bathed until late the evening of 9/16/24.
-He was not offered a bath on the morning of 9/17/24 before the funeral.
-He was not offered a sponge bath or to have a bath in the other facility bathing room and was not

F 553

Continued From page 3

2. How will other residents, having the potential to be affected by the same deficient practice, be identified?

- On 10/4/24 Sit-Stand-Walk assessments were audited to ensure they matched the bathing preference listed in residents' care plans and the bath schedule

- On 10/10/24 all residents were interviewed to determine their bath preferences were being honored.

3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur?

- Director of Nursing provided face-to-face education on 10/17/24 to nurse who completes Sit-Stand-Walk assessments on how to update care plans to ensure they match the assessment. Any additional nurse(s) assigned this task will be educated by DON/designee prior to assignment. DON signed off on completed education.

4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur?

- Director of Nursing or designee will complete audits of random residents baths to ensure residents are getting their baths as preferred by reviewing bath schedule, once a week for 4 weeks, then monthly for 2 months. All audits will be taken by Director of Nursing or designee to QAPI monthly until the facility demonstrates sustained compliance as determined by the committee.

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F 553	Continued From page 4 offered assistance with shaving. -He attended the funeral without having been bathed or shaved. Review of resident 15's medical record revealed: *His 7/10/24 Sit-Stand-Walk Data Collection Tool indicated he: -Preferred a Whirlpool bath during the day, two or more times per week. *His 9/18/23 care plan regarding bathing revealed: -There was an 8/6/24 focus area for bathing that included: -He required assistance of one staff person with bathing. -He preferred to have one whirlpool bath a week. *His bathing record from 8/19/24 through 9/18/24 indicated he had a bath on 8/23/24, 8/30/24, and 9/9/24. *There was no bathing documentation that he received a bath as he requested on 9/16/24. 4. Interview on 9/19/24 at 6:40 p.m. with resident 18 regarding bathing revealed: *Staff helped her with bathing, and she was not able to bathe herself. *She thought her bath was scheduled for one time a week. *She missed her bath recently, and the staff told her something had broken down. *She did not know if she had not received bathing more often and stated her "brain can't compute". Review of resident 18's medical record revealed: *Her 7/30/24 Sit-Stand-Walk Data Collection Tool indicated she preferred a tub bath, during the day, two or more times per week. *Her 9/18/24 care plan regarding bathing revealed:	F 553	Continued From page 4 - Starting 10/14/24 as part of the weekly Interdisciplinary Team meetings, the bath schedule will be reviewed to ensure residents baths have been given as scheduled	

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F 553	Continued From page 5	F 553		

-There was a revised 8/6/24 focus area for bathing that included:
--She required two staff members and a mechanical lift sling to transfer into a whirlpool chair.
--She preferred one or two whirlpool baths a week.
-Her bathing record from 8/19/24 through 9/18/24 indicated she had a bath on 8/23/24, 8/30/24, and on 9/15/24.
--On 9/13/24 her bath was documented as not applicable.
*There was no bathing documentation that she had received a bath for at least 15 days.

5. Interview on 9/19/24 at 11:07 a.m. with certified nursing assistant (CNA) K regarding resident bathing revealed:
*The regular bath aide had changed to working part-time.
*The administrative assistant had been scheduling the bath aides.
*Different staff were scheduled to give baths when available.

*Interview on 9/19/24 at 11:19 a.m. with interim director of nursing (IDON) B regarding resident bathing revealed:
*She knew bathing was an issue.
*There were recent changes in the bathing schedule due to staffing.
*She had started tracking the residents' bathing to ensure they were being completed.
*Her expectation was each resident would get two baths a week or according to the resident's preference documented on their care plan.

Interview on 9/19/24 at 4:00 p.m. with administrative assistant O regarding resident

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F 553	Continued From page 6	F 553		

bathing revealed:
*She was in charge of the nursing schedule.
*The the full-time bath aide had recently quit working.
*She scheduled whomever she could get to cover the bath schedule.
*She agreed bathing was not being completed according to resident preferences.

6. Review of the provider's 11/1/23 Care Plan policy revealed:
*"Comprehensive care plan - Includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment."
*"Person-centered care - A focus on the resident as the locus of control and supporting the resident in making his or her own choices and having control over their daily life."
*Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables."
*"The plan of care will be modified to reflect the care currently required/provided for the resident."
*"The care plan will emphasize the care and development of the whole person ensuring that the resident will receive appropriate care and services."
*The resident/family or legal representative will have the opportunity to participate in the planning of his or her care to the extent practicable.

Review of the provider's 2022 Resident's Rights for Skilled Nursing Facilities booklet revealed:
*"The resident has the right to be informed of, and participate in, his or her treatment, including: ...(ii) The right to participate in establishing the

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F 553	Continued From page 7 expected goals and outcomes of care, the type, amount, frequency and duration of care and any other factors related to the effectiveness of the plan of care."	F 553		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or	F 580	1. Corrective action to residents affected: - Resident #27 On 8/1/24 the physician's office alerted the facility to the concerns for residents safety related to his driving based on an incident they had witnessed when he was at the clinic. The Social Services Coordinator (SSC) called the Miller Police Department and they said there is a form on the SD Department of Motor Vehicles (DMV) website for a driver's evaluation request. This form was completed by the SSC and sent to the state. On 7/9/24 the resident had received a BIMS score of 14, indicating he was cognitively intact. -Resident sold his car on 9/2/24 after receiving a certified letter from the SD DMV questioning his ability to drive safely. Resident informed DMV at that time that he would no longer be driving. - 10/1/24 updated PHQ9 is 2 and BIMS 12 - Care plan updated for behaviors and interventions. - Behavior tracking updated in POC for staff to document. - On 9/23/24 counseling was offered to resident and he declined. - Will update physician by 10/18/24 on the resident's past suicidal ideation.	10/18/2024

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F 580 Continued From page 8

State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on record review, interview, and policy review the provider failed to ensure one of one sampled resident's (27) physician was notified of the resident's suicidal ideation statements and safety concerns related to his staff-observed vehicle driving practices. Findings include:

1. Interview on 9/19/24 at 1:49 p.m. with interim director of nursing (IDON) B and registered nurse H regarding resident 27 revealed:
*He had a car that was parked at the facility, and he drove that car at times.
*They did not think that he was safe to drive.
-They had notified the police; the police had told them they were not able to take his driver's license away from him.
*There was no assessment completed for his cognitive abilities in relation to his driving a vehicle.
*They had not notified his physician of their concerns about his driving.

F 580 Continued From page 8

2. Identify other potential Residents affected:

- Reviewed resident behaviors with Interdisciplinary team on 10/09/24 to identify any residents that are currently experiencing a potential significant change in condition, mental or physical status that has not already been addressed with physician, the resident and or resident representative. None identified at this time

- Daily at shift changes any noted changes in resident condition are reported to the oncoming shift, with routine IDT meeting changes in resident condition are also reviewed for follow up.

3. Measures put into place or systemic changes made to ensure that will not recur:

- Director of Nursing will provide education to all clinical staff by10/18/24 or will next shift worked, and to social services when they return from leave. Staff sign a signature page indicating that they understand the education provided.

1. Suicide Precautions-Rehab/Skilled policy including removal of all risks for safety, proper procedure for responding to a resident who verbalizes suicidal ideation or intent, and monitoring.
2. Where in Point of Care (POC) and Kardex to find care plan interventions so that they can consistently redirect behaviors.
3. The Notification of Change policy, so they are aware of who a significant change in a resident's physical, mental, or psychosocial status needs to be reported to.

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F 580	Continued From page 9 Review of resident 27's medical record revealed: *His nurse progress notes included: -On 7/17/24 he "came in with a long piece of plastic with a rusty pointy end on it. When she asked what he was doing with it he told her since they took his scissors he was going to kill himself. Nurse told him that was not funny and we take those comments quite seriously. He told the nurse he was just kidding. The Social Services Coordinator asked him what he was doing with it and he told her the same thing. Administrator went to his room." "[He] said he was not going to hurt himself or anyone else with it." -On 8/1/24 He "stated that he was about in a wreck [with his car]." -On 8/2/24 "Resident was insistent upon going for a drive in his car. Resident then got in his car, shut the door and drove off at a very fast speed, almost side-swiping the pick-up that was parked in front of his car." -On 9/15/24 He tightly squeezed a females buttock and stated, "That's nice." *There was no documentation to support his physician had been notified of his statements of suicidal ideation or regarding his observed unsafe driving. Review of the provider's 12/4/23 Notification of Change policy revealed: *"A facility must immediately inform the resident, consult with the resident's physician and notify, consistent with his or her authority, the resident representative(s) when there is:" -"A significant change in the resident's physical, mental or psychosocial status".	F 580	Continued From page 9 4. Monitor process for the system change including frequency and person responsible: - Director of Nursing or designee will complete audits on staff response to resident's threat of suicide once a week for 4 weeks, then monthly for 2 months, with all audits taken to QAPI monthly until the facility demonstrates sustained compliance as determined by the committee. - Director of Nursing or designee will complete audits on random residents on significant change in a resident's physical, mental, or psychosocial status and safety concerns once a week for 4 weeks, then monthly for 2 months. All audits will be taken by the Director of Nursing or designee to QAPI monthly until the facility demonstrates sustained compliance as determined by the committee.	
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		

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F 600	Continued From page 10 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (15) who was blind had his food and drink free from flies in and on it, received timely care for his incontinence needs, and received a bath as scheduled prior to attending a funeral. Findings include: 1.Review of the provider's 9/11/24 SD DOH FRI revealed: *Interim director of nursing (IDON) B received an allegation of abuse from resident 15 on 9/11/24. *Allegations included he: -Had made requests for his care needs and had to wait up to three hours for staff to come back and perform them. -Had urinary incontinence and had not been provided no incontinent products. -Had visitors during a mealtime who told him flies	F 600	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? -Resident number 15 was provided incontinence supplies as care planned. - Resident 15 was interviewed and bath schedule and care plan were updated on 10/4/24 to ensure two baths given weekly. Care plan verified for toileting needs. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? -All residents have the potential to be affected by this deficient practice. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? - Director of Nursing will provide education to clinical staff by 10/18/24 or will prior to next shift worked, and to social services when they return from leave. Staff sign a signature page indicating that they understand the education provided. - Education on call light expectations provided to all staff at meetings 9/24/24 and 9/25/24. Director of Nursing or designee will provide education to all nursing staff on timely call light response, providing incontinence supplies as needed, and residence bath preference. - On 9/19/24 Director of Environmental Services put up a Paraclipse Capture Cartridge (fly trap) in the dining room.	10/18/2024

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

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F 600

Continued From page 11

were on his food and in his cup of hot chocolate.
--Stated the visitors had told him they killed a total of 12 flies while seated at the table with him.

Observation and interview on 9/17/24 at 9:30 a.m. with resident 15 revealed:
*He was lying in bed with a book reading device next to him on the bed.
-He was unshaven, with whiskers approximately one-fourth inch in length on his face.
*His fingernails appeared dirty, with black residue underneath of them.
*He stated he wished he was dead as this was the "worst place" he had been in "all my life".
*He said he had "two loyal friends stop" in and have dinner with him.
-A "problem arose with flies".
-While eating dinner with his friends they told him that flies were on his food and in his hot chocolate."
*The interview was then ended as his son arrived to him to a take to a funeral.

Interview on 9/19/24 at 1:45 p.m. with interim director of nursing (IDON) B regarding resident 15 revealed she:
*Submitted a facility-reported incident (FRI) for resident 15 on 9/11/24 regarding suspected neglect.
*Completed an interview with the resident but had not completed her final investigation.
*Generally started an investigation when an issue was brought to her attention.
*Interviewed the resident and included the interview in the FRI.
-At the time of his interview, he expressed he was not provided incontinence care and had not used incontinence products.
*Talked with and provided education to staff

F 600

Continued From page 11

- On 9/19/24 Director of Environmental Service ensured the current "automizers" in the building were working properly.

- On 9/26/24 Olson's Pest Control added clam shell fly lights in dining room and an automizer in the double door entries.

- Pest control device(s) monitoring for functioning will be added to the preventative maintenance schedule.

- Resident #15 and those with significant visual impairments will be monitored during meals to ensure food and drinks are free from flies by assigned dining room staff.

- Staff educated as to where Kardex is in POC to see individual care planned needs.

4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur?

- Director of Nursing or designee will complete random audits to ensure residents' call lights are answered timely, residents are receiving their bath per their preference, residents have incontinence products as needed, and observe areas of the building for flies 1 x week for 4 weeks, and 1 x monthly for 2 months. All audits will be taken by the Director of Nursing or designee to QAPI monthly until the facility demonstrates sustained compliance as determined by the committee.

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

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F 600	Continued From page 12	F 600		

assigned to care for resident 15 regarding incontinence products, continued options, and incontinence care.
*Stated staff were to have provided him incontinence care every two hours and as needed.
-Was unsure if that had been added to his care plan.
*Stated flies were horrible this time of year with the doors opened throughout the day.
-Fly swatters were handed out, and the exterminator would came frequently to spray inside and outside the building.
-Was not sure what else they could have done about the flies.

Interview on 9/19/24 at 2:05 p.m. with resident 15 regarding his care revealed:
*The day of his bath had recently been changed from Fridays to Mondays.
-He was satisfied with bathing one time a week and had not minded the bath schedule change.
*He did not get bathed on 9/16/24 before a funeral he planned to attend on 9/17/24.
-He had specifically requested a bath from staff twice on 9/16/24, as he had wanted to be clean for the funeral.
-The staff had not communicated with him that they had no hot water in the tub room where he bathed until late the evening of 9/16/24 and he was not offered a bath the morning of 9/17/24 before the funeral.
-He was not offered a sponge bath or to have a bath in the other facility bathing room and was not offered assistance with shaving.
-He attended the funeral without being bathed or shaved.
*He had a bladder condition with incontinence and was told by his physician that he needed to

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	435124	A. BUILDING ______ B. WING ______	C 09/19/2024

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F 600	Continued From page 13	F 600		

be kept clean and dry and was to be checked for incontinence related needs) every two hours, but the staff did not consistently do that.
*He would go to bed at 8:00 p.m. and staff would not check on him until 5:00 a.m.
*He was not able to depend on his call light being answered and had waited for over an hour at times for staff to help him.
-Had an episode of bowel incontinence within the past month and called his daughter with his talk telephone to get help. She called the main office number and told the person who answered the phone to have staff check on him, and that he had bowel incontinence when he waited for his light to be answered and needed help to get cleaned up.
-Had another episode within two weeks, when he waited for over thirty minutes, and he couldn't hold it, so his roommate had helped him to the bathroom.

Interview on 9/19/24 at 6:10 p.m. with resident 15's daughter regarding her father revealed:
*She confirmed he called her within the last month asking for help and she called the office to have staff check on him.
-He told her he waited for over an hour, couldn't hold it, and had a bowel incontinent episode, and had needed help to get cleaned up.
*She visited later that day and he had not appeared to have been bathed or clean, his bedding was visibly dirty, and he had not appeared to have been changed.
-Whenever she or her sisters visited, he asked them to change his bedding, and the staff had not changed his bedding unless he had an episode of bowel or bladder incontinence in the bed.
*She and her siblings felt they couldn't say anything, or it would have made things worse for

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	435124	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER	**421 EAST 4TH ST MILLER, SD 57362**

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F 600	Continued From page 14	F 600		

her father.

Interview on 9/19/24 at 6:45 p.m. with business office manager C regarding resident 15 revealed:
*She confirmed his daughter called the facility's main number within the past month during the mid-morning and she answered the phone.
-His daughter reported her father called her for help and verbalized no one had answered his call light for an extended time.
-His daughter requested staff go to his room to help him to the bathroom and clean him up, and that he reported to her he had a bowel incontinence episode while waiting for his call light to be answered.
*She went to his room, saw the call light on in the hallway, but there was already a staff person in his room.
*She had not asked staff if he had been incontinent.
*She had not reported the call or episode to anyone.

Review of the provider's 7/22/24 Abuse and Neglect policy revealed:
*"Purpose"
-"To ensure that all identified incidents of alleged or suspected abuse/neglect, including injuries of unknown origin, are promptly reported and investigated."
*"The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation."

Refer to F553 Finding 3, F657 Finding 5, and F925 Findings 5, 8, 9, and 10.

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	435124	A. BUILDING ______ B. WING ______	C 09/19/2024

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F 623 SS=D	Notice Requirements Before Transfer/ Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623		

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F 623	Continued From page 16 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

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	435124	A. BUILDING ______ B. WING ______	C 09/19/2024

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F 623	Continued From page 17 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to provide a copy of the transfer notice to the Office of the State Long-Term Care Ombudsman for one of one sampled residents (21) reviewed for facility-initiated transfer to the hospital. Findings include: 1. Interview on 9/17/24 at 9:00 a.m. with resident 21 revealed she did not think she had gone to the hospital recently. 2. Review of resident 21's electronic medical record (EMR) revealed: *She was transferred to the hospital on 5/15/24. -Her power of attorney (POA) was notified of her transfer. -There was no documentation the bed hold information was given to the resident or her POA. *She was transferred to the hospital on 6/18/24. -Her POA was notified.	F 623	1. Corrective action to residents affected: - Resident 21, notification was made to the Ombudsman on 10/10/24. 2. Identify other potential Residents affected: - No other residents identified at this time as potentially being affected. 3. Measures put into place or systemic changes made to ensure that will not recur: - The social services coordinator designee was provided educated on 9/26/24 and upon their return to work the Social Services Coordinator will be provided education on the Notification of Change policy including the process for reporting resident transfers to the Ombudsman.	10/18/2024

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	435124	A. BUILDING ______ B. WING ______	C 09/19/2024

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F 623	Continued From page 18 -There was no documentation the bed hold information was given to the resident or her POA. 3. Interview with the facility's local ombudsman on 9/18/24 at 2:51 p.m. regarding resident 21's transfers to the hospital revealed: *She said the facility normally filled out a report online about hospitalizations. *The facility has one month to notify them of the hospital transfer. *She stated that she had not received notifications for either of resident 21's hospital transfers above. 4. Interview on 9/19/24 at 11:12 a.m. with administrator A revealed: *The social services coordinator G was responsible for submitting hospital transfer reports to the ombudsman. *She was not aware that they had to report every hospital transfer to the ombudsman. *No documentation was provided to verify the ombudsman was notified of resident 21's hospital transfers. 5. Review of the provider's 12/6/23 Ombudsman policy revealed: *A website for more information regarding state-specific regulations. *The state-specific regulations on the website stated, "Copies of notices for emergency transfers must also still be sent to the ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis."	F 623	Continued From page 18 4. Monitor process for the system change including frequency and person responsible: - The Administrator or designee will complete audits of all transfers monthly for 6 months. All audits will be taken by the Administrator or designee to QAPI monthly until the facility demonstrates sustained compliance as determined by the committee	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)	F 625		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 625	Continued From page 19	F 625		

§483.15(d) Notice of bed-hold policy and return-

§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-
(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and policy review, the provider failed to provide bed-hold notices to the resident and/or their representative regarding transfers to the hospital on two occasions for one of one sampled resident (21).
Findings include:

1. Interview on 9/17/24 at 9:00 a.m. with resident 21 revealed she did not think she had gone to the

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

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F 625	Continued From page 20 hospital recently. 2. Review of resident 21's electronic medical record (EMR) revealed: *She was transferred to the hospital on 5/15/24. -Her power of attorney (POA) was notified of her transfer. -There was no documentation the bed hold information was given to the resident or her POA. *She was transferred to the hospital on 6/18/24. -Her POA was notified. -There was no documentation the bed hold information was given to the resident or her POA. 3. Interview on 9/18/24 at 2:23 p.m. with registered nurse H regarding resident 21's bed hold notice revealed: *She believed she had been the one to put the transfer in for her last hospital stay and didn't do a bed hold notice. *She could not find any bed hold notice pertaining to the last two hospital visits. 4. Interview on 9/18/24 at 2:25 p.m. with business office manager/dietary manager C revealed she did not find any bed hold notices for resident 21's recent hospital visits. 5. Interview on 9/18/24 at 3:15 with administrator A revealed they did not have bed hold notices signed for resident 21 for her hospital stays on 5/15/24 and 6/18/24. 6. Review of the provider's 12/7/23 Bed-Hold policy revealed: *"Purpose: To ensure that the resident/resident representative is made aware of the facility's bed hold and reserve bed payment policy before and upon transfer to a hospital or when taking a	F 625	.1.Corrective action to residents affected: - Resident 21 transferred to the hospital and returned to the facility before it was identified that the Bed Hold form was not sent. 2. Identify other potential Residents affected: - No other residents were affected. 3. Measures put into place or systemic changes made to ensure that will not recur: - On 9/19/24 the Administrator reviewed the Bed Hold policy. - Administrator or designee educated the facility's nurses on 10/17/24, and upon their return to work the Social Services Coordinator will be educated, on the bed hold procedure policy. 4. Monitor process for the system change including frequency and person responsible: The Social Services Coordinator or designee will complete audits of all bed holds monthly for 6 months. All audits will be taken by Administrator or designee to QAPI monthly until the facility demonstrates sustained compliance as determined by the committee.	10/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 625	Continued From page 21 therapeutic leave of absence from the facility." *"Policy: At the time of admission, transfer, or therapeutic leave, the location will provide written information to the resident or resident representative that specifies:" -"1. The duration of the state bed-hold policy, if any, during which a resident is permitted to return and resume residence. -"2. The reserve bed payment policy in the state plan." -"3. The location's policy regarding bed-hold periods permitting a resident to return." *"In Case of Emergency Transfer:" -"1. b. The charge nurse is responsible for completion of notification procedures if the transfer occurs at a time the social worker is not at the location." -"2. The social worker or designated individual will contact the resident/resident representative to inquire regarding their decision for holding a bed.? -"3. In cases where the facility was unable to notify the resident representative, the social worker or designated individual will document multiple attempts to reach the resident's representative."	F 625		
F 657 SS=E	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	F 657		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER	421 EAST 4TH ST MILLER, SD 57362

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F 657	Continued From page 22 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) 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, review of the provider's facility reported incident (FRI) to the South Dakota Department of Health (SD DOH), and policy review the provider failed to ensure 4 of 5 sampled residents (1, 15, 18, and 27) had their care plans were followed, updated, and revised promptly to reflect their current status and care needs. Findings include:	F 657		
	1. Interview and observation on 9/17/24 at 4:01 p.m. with resident 27 revealed: *He had an "electronic neuropathy machine [device]" that he used daily for neuropathy pain on his feet. Review of resident 27's medical record revealed: *His nurse progress notes included: -On 7/17/24 he "came in with a long piece of plastic with a rusty pointy end on it. When she		1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? - Resident #1 - Bath schedule updated to ensure three baths are given a week. - Resident #15 -Bath schedule and care plan updated to ensure two baths are given a week. Care plan verified for toileting needs.	10/18/2024

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

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F 657

Continued From page 23

asked what he was doing with it he told her since they took his scissors he was going to kill himself. Nurse told him that was not funny and we take those comments quite seriously. He told the nurse he was just kidding. The Social Services Coordinator asked him what he was doing with it and he told her the same thing. Administrator went to his room." "[He] said he was not going to hurt himself or anyone else with it."
-On 8/1/24 He "stated that he was about in a wreck [with his car]."
-On 8/2/24 "Resident was insistent upon going for a drive in his car. Resident then got in his car, shut the door and drove off at a very fast speed, almost side-swiping the pick-up that was parked in front of his car."
-On 9/15/24 He tightly squeezed a female staff's buttock and stated, "That's nice."
*His care plan had not included his use of the infra-red device, his suicidal ideations, use his inappropriate sexual touching of staff, or that he had a car and drove it.

Interview on 9/19/24 at 1:49 p.m. with interim director of nursing (IDON) B and registered nurse H regarding resident 27 revealed:
*He had a car that was parked at the facility, and he drove that car at times.
*They did not think that he was safe to drive.
-They had notified the police; the police had told them they were not able to take his driver's license away from him.
*There was no assessment completed for his cognitive abilities in relation to his driving a vehicle.

Follow-up interview on 9/19/24 at 2:40 p.m. with IDON B regarding resident 27's driving and his car revealed:

F 657

Continued From page 23

Resident #18 - Quarterly Sit-Stand-Walk assessment were done on 10/3/24 indicating new bathing preference of once a week. Care plan updated. Reviewed resident cares with staff. Resident bed height should be at normal bed height in which\h if resident were to sit at edge of bed feet would be touching the floor. Does not have a need for bed to be in lowest position to floor at this time.

- Resident Number 27 Behaviors and interventions updated on care plan for suicidal statements or ideations. Also updated to include sexual behaviors and remarks towards staff. . 10/1/24 PHQ9 2 BIMs 12. Electronic neuropathy device has been removed. Not currently ordered for resident and this device was old/ outdated. Resident sold car no longer drives.

2. How will other residents, having the potential to be affected by the same deficient practice, be identified?

- All residents have the potential to be affected by this deficient practice.

3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur?

- Director of Nursing will provide education to clinical staff by 10/18/24 or prior to their next shift worked, and to social services when they return from leave. Staff sign a signature page indicating that they understand the education provided.

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	435124	A. BUILDING ______ B. WING ______	C 09/19/2024

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GOOD SAMARITAN SOCIETY MILLER	421 EAST 4TH ST MILLER, SD 57362

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F 657

Continued From page 24

*She had found out that he was recently picked up by police "a couple of times" while driving.
-The police had taken his driver's license away from him.
-He had sold the car to an employee.

2. Interview on 9/18/24 at 10:35 a.m. with resident 1 regarding her bathing schedule revealed:
*She had been getting one bath a week after she was admitted.
*Her preference was three baths a week like she had received while she was an assisted living (AL) resident before her admission to the nursing home.

Review of resident 1's electronic medical record (EMR) regarding her bathing preferences revealed:
*A progress note dated 7/30/24 from social services coordinator G:
-"Resident talked to this writer about wanting more baths due to her room being warm."
-"She was getting 3 baths a week at the AL where she was."
*Her 6/27/24 initial care plan was revised on 8/6/24 to include "Resident requires whirlpool bath with 1 staff, preference is 2 weekly."

3. Interview on 9/19/24 at 6:40 p.m. with resident 18 regarding bathing revealed:
*Staff helped her with bathing, and she was not able to bathe herself.
*She thought her bath was scheduled for one time a week.
*She missed her bath recently, and the staff told her something had broken down.
*She did not know if she had not received bathing more often and stated her "brain can't compute".

F 657

Continued From page 24

1. Where in Point of Care (POC) and Kardex to find care plan interventions so that they can consistently redirect behaviors.
2. Behavioral Causes and Interventions policy.
3. Suicide Precautions-Rehab/Skilled policy
4. Education on bed height was sent out via OnShift and Point Click Care communication on 10/9/24 for all clinical staff.
5. Staff education on where in Point of Care to see the Kardex for resident care needs.

4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur?

- Director of Nursing or designee will complete random audits of baths to ensure residents are getting their baths as preferred, on staff response to resident's threat of suicide, beds being set at normal bed height unless otherwise care planned, and daily care needs of residents 1 time a week for 4 weeks, then monthly for 2 months. All audits will be taken by the Director of Nursing or designee to QAPI monthly until the facility demonstrates sustained compliance as determined by the committee.

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	435124	A. BUILDING ____ B. WING ____	C 09/19/2024

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F 657	Continued From page 25	F 657		

Review of resident 18's medical record revealed:
*Her 7/30/24 Sit-Stand-Walk Data Collection Tool indicated she preferred a tub bath, during the day, two or more times per week.
*Her 9/18/24 care plan indicated she preferred one or two whirlpool baths a week.

4. Observations of resident 18 revealed she was lying in her bed that was raised to its highest position:
*On 9/17/24 at 2:39 p.m.
*On 9.19.24 at 11:10 a.m.
*On 9/19/24 at 2:12 p.m.

Observation on 9/19/24 at 2:12 p.m. of resident 18 in her room revealed:
*She was in her bed, eyes closed, bedside table positioned across the bed at waist area.
*The bed was in the highest position.

Interview on 9/19/24 at 2:08 p.m. with certified nursing assistant (CNA) K regarding resident 18's height of her bed:
*Her bed should be in the lowest position possible to prevent her from falling.
*She required the assistance of staff and a full body mechanical lift to get into bed.
*CNA K had not assisted resident 18 on this day.

Review of resident 18's medical record revealed:
*Her admission date was 10/19/22
*Her Brief Interview of Mental Status score was a 10, indicating she had mild cognitive deficits.
*Her care plan did not include the height her bed should be at when she was lying in it.
*She required assistance of two staff members and a full-body mechanical lift for bed mobility.

5. Review of the provider's 9/11/24 SD DOH FRI

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER	421 EAST 4TH ST MILLER, SD 57362

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F 657	Continued From page 26 revealed: *Interim director of nursing (IDON) B received an allegation of abuse from resident 15 on 9/11/24. *Allegations included he had urinary incontinence and no incontinent products were "in place". Interview on 9/19/24 at 1:45 p.m. with IDON regarding resident 15 revealed: *She interviewed the resident and included the interview in the FRI. -At the time of that interview he expressed he was not provided incontinence care and had not used incontinence products. *She stated staff were to have provided incontinence care every two hours and as needed. -She was unsure if his incontinence care needs had been added to his care plan. Interview on 9/19/24 at 2:05 with resident 15 regarding his care revealed he had a bladder condition with incontinence and was told by his physician that he needed to be kept clean and dry and was to be be provided incontinence care every two hours, but the staff had not consistently done this. Review of resident 15's medical record revealed: *His admission date was 10/12/23. *His diagnoses included: malignant neoplasm of bladder, legal blindness, macular degeneration, and unspecified dementia. *His care plan indicated: -On 2/28/24 "Needs to be checked and changed approx. [approximately] q [every] 2-3 hours for incontinence. Uses an incontinent product. Voices that the urinal no longer works for him and he only uses the toilet for BM [bowel movement] purposes."	F 657		

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F 657	Continued From page 27	F 657		

-On 2/28/24 and revised on 5/18/24 "ambulates with cane at times, otherwise hangs on to a staff members arm for guidance to get to destinations. May use wheelchair when feeling week."

6. Interview on 9/19/24 at 3:05 p.m. with minimum data set nurse D regarding resident care plans revealed:
*The interdisciplinary team, including nursing, dietary, activity, and social services were involved in the development of the care plan.
-The resident's physician would review and sign the care plan.
-Each member of the interdisciplinary team was responsible for completing their area of the care plan.
*The care plan was updated whenever a resident had a change in the care they required and on a quarterly basis.
-CNAs would provide her with information on each resident and she would then update their care plan with that information.
--There had been "lots of turnover" with CNAs.
*Regarding resident bathing:
-Each resident's preference for bathing was obtained through interviews and documented on a Sit-Stand-Walk Data Collection Tool.
--Their preference was then documented on their care plan.
*Regarding resident 27's care plan:
-She had no knowledge of his suicidal ideation.
--His physician should have been notified of this.
--Social service designee G should have updated his care plan with this focus.
-Was not certain if his driving a vehicle was on his care plan.
-She was aware he had given a staff member an inappropriate written note asking her to meet him somewhere.

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	435124	A. BUILDING ______ B. WING ______	C 09/19/2024

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F 686	Continued From page 30 provider failed to ensure one of one resident (17) who required staff assistance with care had not developed facility acquired pressure injuries when left on a bedpan for an extended time. Findings include: 1. Observation and interview on 9/17/24 at 9:02 a.m. with resident 17 revealed: *He was bedridden and dependent on staff for care due to a back injury and a history of a broken arm that did not heal correctly. *He had a mesh sling under him staff used for repositioning and for the lift. *he felt staff did a good job but this shift, "but this shift, they don't want to help me." *He stated he pushed the call light button and, "she just answered while you are in here, sometimes I am ornery and turn on the call light and wait for them and I have the door wide open so I can yell at them, you should see them run! They should check on me, what if I am on my last breath." 2. Interview on 9/18/24 at 9:49 a.m. with registered nurse (RN) H revealed: *Resident 17 is dependent on staff for all of his cares. *He would forget to use his call light at times, yell, call on his phone or he would call the police. *He has some dementia. *He used the bedpan because the lift was hard on him due to a history of back fractures. *He would use the toilet on his bath days. *He had a mesh sling under him they used to reposition him or to lift him up in the mechanical lift. 3. Interview and observation on 9/18/24 at 10:08	F 686	1. Corrective action to residents affected: - Resident #17 Care plan verified that he is to be repositioned about every 2 hours as resident will allow. Staff have been educated on bed pan use. Staff educated to be checking on him frequently while on the bed pan in case he falls asleep and forgets to turn on call light to request it removed. Timer available If he would like staff to set a reminder timer for him. 2. Identify other potential Residents affected: - Any resident who uses the bed pan has the potential to be affected by the same deficient practice. 3. Measures put into place or systemic changes made to ensure that will not recur: - On 9/6/24 an OnShift message was sent to all nursing staff and a PCC Communications message to all staff educating them on bed pan use and pressure ulcer development and prevention. - Education on bed pan use and pressure ulcer development and prevention was provided at staff meetings on 9/24/24 and 9/25/24. - By 10/18/24 Director of Nursing or designee will provide additional education on causes of pressure ulcers, repositioning to prevent pressure injuries, use of repositioning sling, use of bed pan, and the potential for neglect by not following related policies and procedures. On 9/24/24 and 9/25/24 training was provided at the all staff meetings.. Those not in attendance were provided educational packets and completed quizzes to demonstrate education was received	10/18/2024

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 31 a.m. with RN H regarding resident 17 pressure ulcers revealed: *He had some wounds that were worse on admission but had improved. *She prepared for his wound care and stated it took three staff to reposition him. *She planned to be in his room for about one hour to complete his care. *CMA J and CMA T were in resident 17's room to assist RN H. *CMA J moved to the right side of his bed with CMA T and explained the care they would complete. *RN H placed a barrier down on a chair located on the left side of his bed for supplies. *She explained to resident 17 and the CM's they would clean him with wash cloths and then do his wound care. *She started at his face then his arms, and applied deodorant. *The CMAs rolled him to his right side with the mesh sling. *RN H removed his bandage from his coccyx (tailbone) wound. -That wound was open with pink and peeling skin on both of his outer buttocks. -RN H cleaned and irrigated the wound, applied collagen particles inside the wound and wound packing, she then covered the wound with a foam absorbent bandage. *The three staff repositioned him to his back for a break from wound care and continued to bathe him, then changed his gown. *The staff repositioned him back to his right side with the mesh sling. *RN H elevated his left heel on a pillow and his wound care was completed. *She put new elastic tubular bandage wraps on both of his lower legs.	F 686	Continued From page 31 In addition prevention of Pressure Ulcers education was provided in the Success Centers. 4. Monitor process for the system change including frequency and person responsible: Director of Nursing or designee will complete random audits on bed pan use and reposition once a week for 4 weeks, then once a month for 2 months. All audits will be taken by the Director of Nursing or designee to QAPI monthly until the facility demonstrates sustained compliance as determined by the committee	

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER	421 EAST 4TH ST MILLER, SD 57362

(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 657	Continued From page 28	F 657		

*Regarding resident 18's bed positioning and care plan:
-The head of the bed was to be elevated 30 degrees when she was in bed.
-Resident 18 preferred the bed height to be maintained at a "normal" height.
-Her bed was not to be in a low position as she was not a "high fall risk".
*Regarding resident 15's care plan and the use of incontinent products.
-She was not aware he had not been using incontinent products.

7. Social service designee G was not available for an interview.

8. Review of the provider's 11/1/23 Care Plan policy revealed:
*"Comprehensive care plan - Includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment."
*"Person-centered care - A focus on the resident as the locus of control and supporting the resident in making his or her own choices and having control over their daily life."
*"Policy
-Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment.
-Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed towards achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. Any problems, needs and

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER	421 EAST 4TH ST MILLER, SD 57362

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F 657	Continued From page 29 concerns identified will be addressed through the use of departmental assessments, the Resident Assessment Instrument (RAI) and review of the physician's orders." *"The plan of care will be modified to reflect the care currently required/provided for the resident. *"The care plan will emphasize the care and development of the whole person ensuring that the resident will receive appropriate care and services, and other employees as determined by the resident needs." *"The resident/family or legal representative will have the opportunity to participate in the planning of his or her care to the extent practicable." *"The interdisciplinary team will review care plans at least quarterly."	F 657		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), observation, interview, and record review the	F 686		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER	421 EAST 4TH ST MILLER, SD 57362

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F 686	Continued From page 32	F 686		

*Staff used the EZ way smart total body mechanical lift, attached his mesh sling to lift while CMA T stabilized his neck and head per RN H's direction.
-He was lifted and suspended off the bed.
-RN and H and CMA J changed his bedding placed a clean sling and an absorbent pad under, lowered him onto the bed, staff rolled him to his right and removed the dirty sling and replaced it with a clean one.
-The three staff positioned him on his back with the head of the bed elevated.
-The two CMAs then lifted and rolled resident 17 to his left as RN H pulled him toward her and the CMAs placed a wedge under his right side.
-Resident 17 stated he did not want the wedge but RN H explained it was for pressure relief for his right buttock for a while and he stated he knew what it was for and agreed to use it for a while.
*RN H placed pillows under each of his arms and under his left heel and a heel protector boot on his right foot.

4. Interview on 9/18/24 at 4:00 p.m. with CMA J regarding resident 17 revealed:
*She had heard resident 17 had been left on his bedpan from around 7:45 p.m. to 8:00 a.m. the next morning two weeks ago.
*He had been on the bedpan when the day shift came on shift.
* There was communication on the computer that stated when you put someone on the bedpan you are to take them off the bedpan.
*There had been no education about bedpans since this incident that happened two weeks ago.

5. Interview on 9/18/24 at 4:32 p.m. with interim director of nursing (DON) B revealed:

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER	421 EAST 4TH ST MILLER, SD 57362

(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 686	Continued From page 33	F 686		

*Resident 17 was left on the bedpan from 9/4/24 at 8:00 p.m. until 9/5/24 at 8:00 a.m.
*She stated she had been working and saw him still on the bedpan on 9/5/24 when he was repositioned.
-She had seen areas on his buttocks that were red where he had sat on the bedpan all night.
*She stated skin issues on his buttocks would have been noted on the Minimum Data Set (MDS).
*She stated she had done education about bed pan use.
*She did not have documentation of the education she provided.
*She did not have an attendance sheet of staff that had attended the education.
*She stated she had done the education when the incident occurred for those involved and had left resident 17 on the bedpan, and did not educate everyone.

6. Interview on 9/19/24 at 11:39 am with CNA K revealed:
*She was not trained on how to work with challenging residents, but she would leave the room and return later if a resident was being difficult.
*She was not involved in the incident when resident 17 was left on the bedpan but found out about it the next morning.
*She had no training about bedpans since that incident had happened.
*She had heard from other people that administrator A had said if it happened again people would be written up.

7. Interview on 9/19/24 at 12:48 p.m. with certified medication aid (CMA) Q revealed:
*She was aware resident 17 had been left on the

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER	421 EAST 4TH ST MILLER, SD 57362

(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 686 Continued From page 34 | F 686

bed pan from 7:00 p.m. or 8:00 p.m. to 7:00 a.m. or 8:00 a.m. but she could not remember the date.
*She had been called by RN R and DON B to his room to help get him off the bedpan.
*Resident 17 needed three people to move him for cares and repositioning.
*She saw a red mark on his right buttock she thought the red mark on his left upper buttock was a bruise from the bedpan.
*She stated there was a mass text that went to her personal phone and was put in computer communication system whoever put a resident on a bedpan were to take them off.
*She was not aware of any other education or meeting about bedpan use.

8. Interview on 9/19/24 at 1:15 p.m. with RN R regarding resident 17 being left on the bedpan revealed:
*She had gotten report the morning of 9/5/24, walked down the hallway and looked in on resident 17 from the hall and he was asleep.
-She was not aware he was still on the bedpan at this time.
*She had been providing care on the other hall and the business office manager C had come out of her office and stated resident 17 had called 911.
-They both went to resident 17's room and he was crying and stated he had been left on the bedpan all night.
*She stated they lifted the cover and could not see the bedpan and they lifted him with the sling and rolled him to his side and could then see the bedpan was still under him.
*She stated they had not done this in front of the police officer due resident 17's privacy.
*He is very difficult to move due to his size.

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER	**421 EAST 4TH ST MILLER, SD 57362**

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F 686	Continued From page 35 *He had had his medications the night before and had fallen asleep on the bed pan and didn't feel it. *Staff should have known to get him off the bedpan. *He had a red ring on his buttocks from being on the bedpan all night but the ring was gone now. *She was not aware of any education provided to staff in reference to him being left on the bedpan. 9. Review of resident 17's Minimum data set (MDS) quarterly assessment dated 8/27/24 for skin conditions revealed: *He was at risk of developing pressure ulcers/injuries. *He did not have any stage 2 pressure ulcers. *He did have a Stage 4 pressure ulcer that was present on admission. *He was not on a turning/repositioning program. 10. Review of resident 17's wound assessments revealed: *On 8/29/24 signed by RN H, "Left heel 1. Progress toward healing 1. Wound name -left heel deep tissue injury (DTI), 2. Type of wound a. Pressure ulcer, 2a. No, was this pressure ulcer present on admission/re-admission? 2b. Staging e) Unstageable 3. Healing process-evidenced by: Area is 60% dark pink, pink beefy granulated tissue with 40 percent white slough at the center. 4. Deterioration of wound - evidenced by: Green purulent drainage. Peri-wound border now has dark purple non-blanching tissue." *On 8/29/24 signed by RN H, "Left lower leg 1. Progress toward healing 1. Wound name, DTI with epidermal avulsion at center to posterior aspect of left lower leg. 2. Type of wound a. pressure ulcer 2a. No, was this pressure ulcer present on admission/re-admission? 2b. Staging k) Not staged 3. Healing process- evidenced by:	F 686		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER	421 EAST 4TH ST MILLER, SD 57362

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F 686	Continued From page 36	F 686		

Superficial, scant serosanguineous drainage, no erythema. 4. Deterioration of wound - evidenced by: Non-blanching dark purple intact tissue."
*On 9/11/24 signed by RN R, "Left buttock 1. Progress toward healing 1. Wound name, none 2. Type of wound a. Pressure ulcer, 2a. No, was this pressure ulcer present on admission/re-admission? 2b. Staging b)Stage 2, 3. Healing process- evidenced by: none, 4. Deterioration of wound - evidence by: Skin is sloughing off."
*On 9/11/24 signed by RN R, "Right buttock 1. Progress toward healing 1. Wound name, none 2. Type of wound a. Pressure ulcer 2b Staging b) Stage 2 3. Healing process- evidence by, none 4. Deterioration of wound - evidenced by: Maceration."

11. Review of resident 17's skin observations revealed:
On 8/20/24 signed by RN R, "1. Skin check b. All other skin observations noted (e.g., bruising, abrasion, skin tears, rash, location of closed pressure injury) 2. Location -identify the site of the skin observation. In the description field, include the following: Type of skin condition, size/measurements, other information that further identifies the skin condition. Site 23) coccyx Description stage 4, site 44) Left lower leg (rear) Description stage 2, site 50) Left heel, description unstageable wound."
*On 9/10/24 signed by Interim DON B, 1. "Skin check 1. B. a1. Skin check b. All other skin observations noted (e.g., bruising, abrasion, skin tears, rash, location of closed pressure injury) 2. Location -identify the site of the skin observation. In the description field, include the following: Type of skin condition, size/measurements, other information that further identifies the skin

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER	421 EAST 4TH ST MILLER, SD 57362

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F 686 Continued From page 37 F 686

condition. Site 31) Right buttock, Description Redness noted with skin hardening noted. Continue to monitor. Site 32) Left buttock Description Redness with skin hardening noted. Provider aware."

12. Review of resident 17's diagnosis revealed:
*Pressure ulcer of sacral regional, stage 4, Dementia, Pressure ulcer of left heel, unstageable, Spinal stenosis, lumbar region without neurogenic claudication, Morbid obesity, Muscle weakness, Abnormalities of gait and mobility.

F 689 SS=D Free of Accident Hazards/Supervision/Devices F 689
CFR(s): 483.25(d)(1)(2)

§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
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 (27) who used an infra-red device for neuropathy pain in his feet had a current physician order for its use and had been assessed for safety of its use. Findings include:

1. Interview and observation on 9/17/24 at 4:01 p.m. with resident 27 revealed:
*He had an "electronic neuropathy machine [device]" that he used daily for neuropathy pain

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
	435124	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER	**421 EAST 4TH ST MILLER, SD 57362**

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F 689	Continued From page 38 on his feet. *He stated, "I had to go through a lot to get it approved" to have in his room. -The device would shut off automatically after twenty minutes of use. *He pointed toward the device that was located on a folding chair, next to the window, and stated he used it every day. *The device had uncleanable surfaces, with areas of carpet taped to it electrical tape. -There was a piece of paper taped to the device with Scotch tape that had instructions to shut it off in 20 minutes. Review of resident 27's medical record revealed: *His admission date was 11/8/23. *His diagnoses included: dementia, chronic atrial fibrillation, chronic kidney disease, and heart failure. -He did not have a diagnosis for neuropathy. *His 7/9/24 Brief Interview of Mental Status (BIMS) score was a 14, which indicated his cognition was intact. *His physician orders included: *An 11/8/23 order to use a personal infra-red device for no more than 20 minutes every other day as needed for pain to his waistline or feet. *A 1/15/24 order to discontinue that order for use of the infra-red device. *His treatment administration record from 11/8/23 through 1/5/24 revealed there was no documented use of the infrared device. *There was no current order for use of the infra-red device. *His care plan did not include the use of the infra-red device. *On 9/18/24 a Communication/Visit with Physician that indicated "[resident 27] previously had an order to use the infrared device he	F 689	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? - Resident number 27. The electronic infrared neuropathy device wasremoved on 9/19/24. It was not currently ordered for resident and it was old/outdated. Resident educated on risks associated with using the device. Collaborating with physician to determine if alternate therapy or treatment appropriate. Resident has voiced he didn't want more medication he would prefer that Infrared device. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? - Room audits have been completed for all residents looking for any potentially unsafe equipment or devices that a resident may have brought in or had family bring in without facility knowledge. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? - On 10/11/24 the Administrator provided education to all staff via Point Click Care Communications, and on 10/12/24 to families via email about identifying new equipment or devices that show up without nursing or facility knowledge to alert nursing to evaluate for safety and if appropriate for resident.	10/18/2024

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	435124	A. BUILDING ______ B. WING ______	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 689

Continued From page 39

privately purchased years ago to treat his foot neuropathy. Order had been discontinued in Jan. of 2024 as DON [director of nursing] at that time didn't realize he was still using it. Faxed a request to [clinic name] for a new order as he is in fact using it. Safety assessment will need to be done prior to his next use of it. Device should be stored in the med room when not in use."

Interview on 9/19/24 at 1:45 p.m. with interim director of nursing [IDON] B and registered nurse (RN) H regarding resident 27's use of the infra-red device revealed:
*RN H confirmed resident 27 did not have a diagnosis of neuropathy.
*RN H was first aware of the infrared machine on 9/19/24 in the morning.
*RN H confirmed there was no safety assessment for his use of the infra-red device.
-She confirmed the infrared device was in resident 27's room and stated it should have been in the medication room and the use of it should have been documented on resident 27's treatement administration record (TAR).
-She indicated it needed to "come out of his room".
*IDON B was not certain who was to remove the infra-red device from his room.
-On 09/19/24 at 3:14 p.m. the infra-red device was again observed in resident 27's room.

A policy was requested regarding electronic medical equipment from the provider and there was none provided.

F 689

Continued from Page 39

-Director of Nursing will provide education to clinical staff by10/18/24 or prior to their next shift worked, and to social services when they return from leave. Staff sign a signature page indicating that they understand the education provided.

– Email sent to families in regard to potential safety hazards of unsafe equipment or devices that should not be brought to residents.

4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur?

- Director of Nursing or designee will complete random audits on resident room safety hazards 1 x a week for 4 weeks, then 1 x a month for 2 months. All audits will be taken by the Director of Nursing or designee to QAPI monthly until the facility demonstrates sustained compliance as determined
by the committee.

F 812 SS=J

Food Procurement,Store/Prepare/Serve-Sanitary
CFR(s): 483.60(i)(1)(2)

§483.60(i) Food safety requirements.

F 812

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER	421 EAST 4TH ST MILLER, SD 57362

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F 812	Continued From page 40	F 812		

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 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 that staff were able to verify the chemical sanitation level required to sanitize the dishes used for preparation and serving residents' food. Failure of that increased the potential risk of foodborne illnesses for the entire resident population who received meals prepared in the kitchen and served to the residents.
Findings include:

1. IMMEDIATE JEOPARDY
Interviews with dietary staff throughout the survey indicated that the dishwasher's chemical sanitation was not functioning.

Staff were not aware of any process to follow when the dishwasher's chemical sanitation was not functioning. Staff could not accurately verify

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER	421 EAST 4TH ST MILLER, SD 57362

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F 812	Continued From page 41 the chemical sanitation level of the dishwasher to ensure proper sanitation due to the expired test strips. IMMEDIATE JEOPARDY NOTICE Notice of immediate jeopardy was given verbally and in writing on 9/18/24 at 4:25 p.m. to administrator A and business office manager (BOM)/dietary manager (DM) C. An immediate removal plan was requested. IMMEDIATE JEOPARDY REMOVAL PLAN On 9/19/24 at 7:43 a.m., administrator A provided the survey team with a final written immediate jeopardy removal plan. The removal plan had been approved by the survey team on 9/19/24 at 8:32 a.m. with guidance from the assistant administrator and long-term care advisor for the South Dakota Department of Health. The provider gave the following acceptable immediate jeopardy removal plan on 9/19/24 at 7:43 a.m.: 1. Provided to surveyors the requested dishwasher manufacturer manual and disinfectant information to support the instructions are being followed and appropriate sanitation is occurring and documentation from Ecolab's 9/17/24 visit. 2. Use disposable paper plates, cups, and silverware until dishwasher is up and running appropriately. 3. Placed new non expired strips in, for the 3 comp sink. 4. Removed all expired strips in kitchen. 5. All dishes to be washed in the 3-comp sink until dishwasher is fixed to verify levels. 6. On 9/18/24 implemented the use of a "Monitoring Use of Ecolab disinfectant Test	F 812	1. Corrective action to residents affected: - On 9/18/24: 1. Placed new non expired strips in, for the 3 comp sink. 2. Removed all expired strips in the kitchen 3. Completed immediate education with Food Service Assistant (FSA) M. and Cook V. who were on duty. - On 9/19/24 EcoLab technician verified the Ultra San sanitizer was testing properly and educated dietary staff on proper use of test strips and WareWash machine usage. 2. Identify other potential Residents affected: - All residents could have been affected	10/18/2024

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER	421 EAST 4TH ST MILLER, SD 57362

(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 812

Continued From page 42

Strips" form for staff to sign off on what the expiration date is of a cartridge when they replace it and the label in the cartridge holder on the wall.
7. On 9/18/24 completed immediate education with all dietary staff. Food service assistant M and Cook V were trained onsite at 6:30 p.m. At 10:12 p.m. all dietary staff were texted education and informed prior to their next shift they will receive in person training on proper procedure for non-working dishwasher and education on non-expired test strips with return demonstration.
8. On 9/18/24 at 7:06 p.m. all staff were educated via PCC Communications with the following message "Kitchen staff must ensure all chemical test strips are NOT EXPIRED. This goes for the dishwasher and the 3 comp sink. See BOM/DM C for education before start of your next shift."
9. By 9/20/24 will add to the TELS Service Provider a task for Director of Environmental Services to monitor weekly if a cartridge is near expiration and needs to be replaced.
10. On 9/18/24 left messages for EcoLab to come fix dishwasher ASAP. In the meantime BOM/DM C, who holds the dietary manager license, tried a new bucket of Ultra San Ecolab 5 gallon liquid sanitizer in the dishwasher. Retested and the low-temp dishwasher disinfectant tested properly at 50 ppm. Unsure why the initial bucket tested at 0 ppm. It was promptly disposed of.

The immediate jeopardy was removed on 9/19/24 at 12:25 p.m. after verification that the provider had implemented their removal plan. After the removal of the immediate jeopardy, the scope and severity of the citation level was lowered to an F.

2. Observation on 9/18/24 at 10:05 a.m. of the kitchen revealed the sanitizing testing strips

F 812

Continued From page 42

3. Measures put into place or systemic changes made to ensure that will not recur:

- Implemented the use of a "Monitoring Use of Ecolab disinfectant Test Strips" form for staff to sign off on what the expiration date is of a cartridge when they replace it and the label in the cartridge holder on the wall.

- All dietary staff were texted education on 9/18/24.

- By 9/19/24 the Business Office Manager/ Dietary Manager ensured all dietary staff received face-to-face training on proper procedure for non working dishwasher and education on non-expired test strips with return demonstration. Staff signed a signature page indicating training was received.

- On 9/18/24 all staff were educated via PCC Communications with the following message. Kitchen staff must ensure all chemical test strips are NOT EXPIRED. This goes for the dishwasher and the 3 comp sink. See Misty Manning for education before start of your next shift.

- By 10/11/24 will add to the TELS Service Provider a task for Director of Environmental Services to monitor weekly if a cartridge is near expiration and needs to be replaced.

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER	421 EAST 4TH ST MILLER, SD 57362

(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 812

Continued From page 43

located by the three compartment sink had an expiration date of 3/15/21.

3. Interview on 9/18/24 at 10:06 a.m. with food service assistant (FSA) M revealed:
*She used those same sanitizing testing strips located by the three-compartment sink to test the red bucket of water and sanitizing solution to ensure the parts per million (PPM) was correct for effective sanitization.
*That red bucket would be dumped out and new water and sanitizing solution would be put into it and tested.
-That process was done in the morning, at noon, supper time, and whenever it was "terrible."
*The sanitizing solution used was Oasis 146 Multi-Quat Sanitizer.

4. Observation on 9/18/24 at 10:07 a.m. of the testing documentation of the red sanitizing bucket revealed it was completed at 10:00 a.m. that day.

5. Observation and interview on 9/18/24 at 10:10 a.m. with cook L revealed:
*She tested the sanitizing bucket at the 3-compartment sink and it tested at 10 ppm with the expired testing strips.
-She confirmed the test strips were expired.
-She emptied the bucket of sanitizing solution.
-She then ran new water and sanitizer into the bucket, while priming the sanitizer to add more.
-The bucket of sanitizing solution then tested and read at 400 ppm using the outdated testing strips.

6. Interview and observation on 9/18/24 at 10:12 a.m. with Nutrition and Food Services Supervisor (NFSS) F regarding testing the sanitizing solutions revealed:
*She stated the red bucket of sanitizing solution

F 812

Continued From page 43

. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur?

- Dietary manager or designee will complete audits on staff using the “Monitoring Use of Ecolab disinfectant Test Strips” form 3 times a week for 8 weeks, then 2 x monthly for 2 months, and then monthly for 2 months . All audits will be taken by the Dietary manager or designee to QAPI monthly until the facility demonstrates sustained compliance as determined by the committee.

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER	421 EAST 4TH ST MILLER, SD 57362

(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 812	Continued From page 44	F 812		

should test at 400 ppm.
-That solution should be changed first thing in the morning, at 9:00 a.m., 1:00 p.m., 3:00 p.m., 4:30 p.m., 6:00 p.m., and as needed.
-She confirmed the test strips used to test the red bucket of sanitizer were outdated.
-She opened a drawer and pulled out a different box of test strips.
-She confirmed those expired on May 15, 2024.
-There were no other test strips available for use.
*She stated the dishwasher temperature for washing and rinsing of dishes should be at 120 degrees Fahrenheit.
-It tested at 120 degrees.
-The disinfectant should be at 50 ppm.
-She then tested the dishwasher sanitizer and it tested at 10 ppm.
-She confirmed that was not a sufficient sanitizing solution to prevent food-borne illness.
-The chemical used for sanitation in the dishwasher was Ulta San.
*The dishwasher had been leaking water when used and repairs were completed on 9/17/24.

7. Observation on 9/18/24 at 12:05 p.m. revealed the noon meal was served with Styrofoam plates, the drinks and desserts were served in multi-use dishware.

8. Interview and observation on 9/18/24 at 1:35 p.m. with ancillary services supervisor E revealed:
*He was attempting to repair the dishwasher.
*There was a rack of trays on the clean side of the dishwasher that appeared to have been run through the dishwasher.
*There was a rack of used pitchers on the dirty side of the dishwasher.
*Numerous dirty cups and bowls from the noon meal were sitting on the counter.

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 812	Continued From page 45	F 812		

Continued From page 45

9. Interview and observation on 9/18/24 at 1:45 p.m. with cook L revealed:
*The dishwasher was being tested for correct sanitizing chemical amount after each dishwashing cycle.
-The sanitizer was correct for two cycles of dishwashing.
*She then tested the dishwasher sanitizer and it tested at 0 ppm.
*She stated it was not working and they would have to rewash or hand wash the dishes.

10. Interview on 9/18/24 at 1:51 p.m. with NFSS F revealed testing of the dishwasher had been done "all day and has not changed" (the chemical sanitizing remained at 0 ppm).

11. Observation on 9/18/24 at 1:52 p.m. of cook L revealed she filled the third compartment of the three compartment sink with water and sanitizer.

Interview on 9/18/24 at 2:00 p.m. with cook L revealed:
*The dishwasher sanitizer normally needed to be changed "about every three weeks".
-She was usually the person to change it.
*She had recently been on vacation and was not sure the last time it was changed.

12. Interview on 9/18/24 at 2:50 p.m. with NFSS F revealed:
*Anyone was able to change the sanitizer bucket.
*She had placed an order for more sanitizer and it would be delivered on 9/20/24.
*She had changed the test strips by the three compartment sink.
-She was not aware they had an expiration date.
-She stated she thought if the test strips expired,

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER	421 EAST 4TH ST MILLER, SD 57362

(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 812	Continued From page 46	F 812		

they should have turned a different color.

13. Review of the provider's June 2024, July 2024, and August 2024 monthly cleaning log revealed:-*There was an area labeled "Chemical Dispensers".
*That area was left blank.

Review of the provider's documented Ultra San five-gallon bucket supply revealed:
*On 9/7/23 the local school district had donated five buckets to the nursing home.
*One bucket of Ultra San was delivered from the provider's chemical supplier on 11/24/23, 1/11/24, 4/25/24, and on 6/20/24.
*The Safety Data Sheet for Ultra San revealed the ingredients were sodium hypochlorite and chlorine.

Review of the provider's 1/10/24 Consultant Dietitian's Report revealed:
*On the Sanitation and Safety area there was a hand written note that indicated, "Reviewed audit (business office manager/dietary manager) Conducted. See her report. Many issues identified that need correction."
*Attached to that report was a document that included:
-Sanitizing strips were expired and given to NFSS F.
-The "Summarize potential cause." And "Summarize action taken" areas were left blank.

Review of the provider's dishwasher operation manual revealed:
*A handwritten note that indicated the dishwasher was installed on 11/30/12.
*"Sanitizer in original concentration is caustic and may cause damage to wash tank and or sump

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER	421 EAST 4TH ST MILLER, SD 57362

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F 812	Continued From page 47 without dilution." *The manual did not indicate the appropriate concentration to be used. Review of the contractor's service record on 9/17/24 revealed the dishwasher sanitizing solution was to be between 50-100 ppm, it was at 75 ppm. Review of the Oasis 146 Multi-Quat Sanitizer guidelines revealed: *The "solution's broad efficacy range of 150-400 ppm stays within proper longer." *It was EPA-registered (Environmental Protection Agency) for third sink sanitizing and on hard non-porous food-contact surfaces and ware. *It prevented cross-contamination of food contact surfaces. Review of the provider's Supervisor, Nutrition and Food Services job description revealed: *"Assists in the training of new staff members and the development of existing staff members." *"Ensure department meets all regulatory requirements." *"Advises on the... and sanitation of food." Review of the provider's Manager, Nutrition and Food Services job description revealed: *"Assists in the training of new staff members and the development of existing staff members. *Trains others on main considerations and issues related to laws and regulations in the implementation of healthcare and nutritional practices." Review of the provider's 6/25/24 General Sanitation - Food and Nutrition policy revealed: *"Appropriate sanitizers and test strips can be	F 812		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER	421 EAST 4TH ST MILLER, SD 57362

(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 812	Continued From page 48	F 812		

ordered through (provider's supplier name)."
*"Director of food and nutrition services (DFN) or senior living dining director maintains a supply of appropriate test strips and thermometers to monitor sanitizing products in use."
*"Cleaning and sanitizing equipment surfaces is a two-step process. Surfaces are cleaned and rinsed before being sanitized. All food contact surfaces will be washed, rinsed and sanitized:"

Review of the provider's 5/20/24 Sanitizing Food Contact Services - Food and Nutrition Services policy revealed:
*"Food-contact surfaces - The surface of equipment, worktables, dining tables dishware or utensils were food normally comes into contact, or from which food may drain, drip, or splash onto food or a surface that may come in contact with food."
*"Employees are trained during orientation on proper handling of all cleaning, disinfecting and sanitizing agents in use as well as the difference between disinfecting and sanitizing."
*"Monitor to ensure all products are correctly labeled and dated when opened."
*"Sanitizing solution: Mix sanitizing chemicals I the recommended concentration levels for proper concentrations measure in parts per million (ppm). High concentrations can be unsafe and may leave an odor or bad taste on the objects and corrode metals."
*"Check solution concentrations frequently with an appropriate test kit since they may become depleted when they kill microorganisms and bind with food."
*"Change the sanitizing solution when it becomes depleted or when the water is visibly dirty.

Review of the provider's 3/25/24

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER	421 EAST 4TH ST MILLER, SD 57362

(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 812	Continued From page 49 Warewashing-Mechanical and Manual policy revealed: *"To promote good practice during ware washing regarding prevention of foodborne illness. *"Food and nutrition employees ensure that food preparation equipment, dishes and utensils are effectively cleaned, sanitized to destroy potential disease carrying organisms and stored in a protective manner.", *"Temperature information found below refers to temperatures listed in the FDA (Food and Drug Administration) Food Code and can be used for additional guidance as needed." -"Low Temp [temperature] - 120 degrees Fahrenheit + [plus] 50 parts per million (ppm) of sodium hypochlorite (or according to manufacturer's guidelines)." "If temperature/chemicals are outside acceptable parameters, employees notify the DFN,... before proceeding with ware washing.", *"Manual Ware Washing" *"Sanitize" -"c. Chemical Treatment --1) The third compartment of the three compartment sink will be filled with hot water (75 degrees Fahrenheit or per manufacturer's instructions.) Sanitizing solution will be measured and dispensed according to manufacturer's instructions. --2) A high concentration of sanitation solution may be potentially hazardous and can contaminate food. --3) Use proper test strips to ensure accurate results for the chemical use." -"7. Temperature and chemical concentration --a. Proper test strips and thermometers are available."	F 812		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt	F 865		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER	421 EAST 4TH ST MILLER, SD 57362

(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 865	Continued From page 50 CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.	F 865	1. Corrective action to residents effected: - At the QAPI committee meeting held on 9/26/24, reviewed areas identified and discussed preliminary process improvement action plans. Initiated a PIP to address residents' bath needs. 2. Identify other potential Residents affected: - All residents within the facility have the potential to be affected by deficient practice. 3. Measures put into place or systemic changes made to ensure that will not recur: - On 10/17/24 the Senior Director and Regional Clinical Services Director provided education and training to the location's QAPI Committee. - All citations will be reviewed at monthly QAPI meetings and PIPs developed for Food Procurement, Pressure Ulcers, and Abuse and Neglect. - QAPI committee will implement a review of quality audits findings during QAPI meetings to solicit feedback and further recommendations. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? - To monitor performance and ensure on going compliance the Regional Quality Improvement Advisor or designee will attend 3 monthly QAPI committee meetings. The QAPI committee meetings will continue monthly or more frequently as recommended by QAPI committee.	10/18/2024

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 865	Continued From page 51 §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;	F 865	Continued From page 51 QAPI committee meeting minutes will be audited for 6 months by the Regional Improvement Advisor or designee to ensure quality of care deficiencies submitted by the QAPI committee are being analyzed and written in the minutes for QAPI meetings. - Completed suggestion and concerns forms will be submitted to the QAPI Coordinator for monthly auditing.	

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 865	Continued From page 52	F 865		

§483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.

§483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and

§483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect.

§483.75(h) Disclosure of information.
A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.

§483.75(i) Sanctions.
Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, quality assurance and performance improvement (QAPI) program review, and job description review, the provider failed to ensure an effective, ongoing, and comprehensive QAPI program was in place to track and measure performance; systematically analyze underlying causes of systemic quality deficiencies; develop and implement corrective action or performance improvement activities; and monitor or evaluate the effectiveness of the corrective action/performance improvement activities, and

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 865	Continued From page 53	F 865		

revise the actions, as needed.
Findings include:

1. Interview on 9/19/24 at 5:28 p.m. with quality assurance (QA) specialist/certified medication assistant (CMA) I regarding the QAPI Program revealed:
*She had been the QAPI coordinator for the past three years.
*The committee met monthly.
*The provider's medical director attended monthly.
*They had developed and completed a performance improvement plan (PIP) for pressure ulcer prevention and treatment from 12/18/23 through 6/11/24.
*There was not a current PIP in place.

Continued interview with QA specialist/CMA I regarding areas of non-compliance identified by the survey team and recent facility-reported incidents (FRI) were reviewed and QA specialist/CMA I revealed:
*She was aware that there were problems with resident baths not being completed as scheduled and honoring resident preferences and was going to propose a bathing PIP at next week's QAPI meeting on 9/26/24.
*She was not aware of any facility-reported incidents through the SD DOH's online reporting system and only tracked adverse events through the provider's electronic medical record (EMR) system.
-She was aware of the adverse event regarding a resident (17) who had been left on a bedpan for an extended period of time as administrator A had sent a message to the nursing staff through their online scheduling system and EMR communication system regarding the incident.

(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 865	Continued From page 54 -She was aware of abuse concerns, both verbal and sexually inappropriate behavior from specific male residents (27 and 37) towards staff members as they had been brought up at the staff stand-up meetings, but those abuse concerns had not been addressed through their QAPI committee. *The dietary department's outdated chemical sanitation test strips had not been identified through the QAPI process. -She had become aware of the problem that morning, 9/19/24. -She was not aware the report from the consultant dietitian for January 2024 had identified the outdated test strips. *She was aware of the problems with communication within the facility including concerns with communication from the facility leadership to the front-line staff. -The last all-staff meeting was on 3/6/24 and the previous all-staff meeting was on 8/31/24. -She agreed that staff meetings were held twice a year but was not aware of expectations regarding how often the all-staff meetings should be held. -Observation on 9/19/24 at 6:11 p.m. was made of the facility's "SAFE" board, which stood for [provider's parent corporation] Accountability for Excellence, and was located in the facility's beauty salon, where the daily stand-up meeting was held. -The board had 22 sections which included census activity, residents' clinical needs, and staff information. -The board's current date was "September 16, 2024" and QA specialist/CMA I agreed that was three days ago. *She was aware of staff complaints regarding the grievance process which included concerns not being taken care of or appropriately responded	F 865		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER	421 EAST 4TH ST MILLER, SD 57362

(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 865	Continued From page 55	F 865		

to.
-The concern forms were given to social services coordinator (SSC) G, who was the provider's grievance official and SSC G routed the concern form to the specific department responsible for addressing the concern.
-She stated some concern forms went missing or were not addressed.
-The QAPI committee had not collected or monitored data reflecting the performance of the grievance process.
*Customer satisfaction surveys were conducted last year by an outside company, but the resulting feedback was not reviewed through the QAPI committee.
*She was aware of environmental issues with flies that she stated happened every year in the fall.
-She stated the pest control company sprays in an effort to control the flies.
-The QAPI committee had not addressed the issue.

2. Review of the provider's 11/14/23 Grievances, Suggestions or Concerns-Rehab/Skilled policy revealed:
*"Grievances, suggestions and concerns are to be deemed high priority customer satisfaction issues and thus will be followed up on in the quickest time frame possible."
*"The grievance official will route the [grievance form] to the appropriate department manager as soon as reasonably possible."
*"An investigation must be completed for all grievances..."
*"The grievance official will issue a written grievance decision to the individuals filing the concerns and to the administrator."

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 865	Continued From page 56	F 865		

Review of the provider's 2/1/24 Quality Assurance and Performance Improvement (QAPI) Plan revealed:
*QAPI Plan Purpose:
-"The Quality Assurance Performance Improvement (QAPI) Plan is designed to outline a comprehensive and data driven QAPI program that focuses on improving the outcomes and experiences of those we serve."
-"The QAPI Plan provides a description of the strategic approach to prevention, identification, reporting, investigation, analysis, and development of performance improvement activities."
*Guidelines for Governance and Leadership:
-"Quality, safety, rights, choice, and respect are priorities for everyone within [provider's name]."
-"Executive leadership supports improvement work by ensuring the location has a well-defined, adequately resourced QAPI program to address facility specific issues that arise."
*Location QAPI Committee:
-"The location administrator is the leader of the QAPI Committee, with assistance from the QAPI Coordinator, and is responsible for its effective operation."
-" The location QAPI Committee ensures an effective QAPI program is in place and the program is adequately resourced with time, personnel, training (including contract staff), equipment, and financial resources."
*QAPI Program:
-"The QAPI program addresses the complexity and uniqueness of the care and services provided at [provider's name]."
-"The location QAPI Committee is responsible to track and trend performance, systematically analyze and prioritize quality deficiencies, develop action plans, and monitor for effectiveness."

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 865	Continued From page 57 -"Quality of care and safety concerns can be identified through the review of multiple sources including but not limited to safety event reports, grievances, feedback from staff, annual facility or program assessments, and department-specific initiatives." *The committee should have implemented appropriate plans of action to correct identified quality deficiencies. Review of the provider's 11/20/23 Administrator, Long Term Care - 1 job description revealed the administrator: *Was responsible for ensuring a Quality Assurance Performance Improvement (QAPI) Program is in place. *Assigned responsibility to an individual(s) for the daily management of QAPI. *Ensured the leadership of monthly QAPI committee meetings. *Sponsored performance improvement projects and reviews, approved or rejected performance improvement team findings and recommendations. *Provided access to information needed to support quality assurance performance improvement. *Provided equipment and supplies to support QAPI efforts. Refer to F553, F600, F657, F686, F812, and F925.	F 865		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER	421 EAST 4TH ST MILLER, SD 57362

(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 880	Continued From page 58 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and	F 880	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? - Facility has a qualified Infection Preventionist on staff to meet the requirement as of 9/30/2024. Infection Surveillance has been initiated. A process for antibiotic stewardship has been initiated. Infection control program is in place. Current Policies and procedures for infection control are available. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? - All residents had the potential to be affected by the deficient practice 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? - Facility will have a qualified Infection Preventionist on staff to meet the requirement, When a new Director of nursing is hired part of the onboarding process will be to either already have or receive the required education and training to serve at the facility Infection Preventionist. Meanwhile the Interim Director of Nursing and a Charge Nurse have the required training to serve at the facility Infection Preventionist. - Current policies and procedures are available via our company's internal website. - All staff are being educated to infection control in their role in long term care.	10/18/2024

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F 880	Continued From page 59 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview the provider failed to ensure they had not established and maintained an infection prevention and control program. Findings include: 1. Interview on 9/19/24 at 3:16 p.m. with interim director of nursing B revealed: *She stated she had not done anything with the infection control program in the month she had been there except make two binders. *She did not have updated policies and procedures for the program. *She was not doing any infection surveillance.	F 880	Continued From page 59 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? -Administrator or designee will complete random audits on a variety of infection prevention practices 1 x a week for 4 weeks, then 1 x a month for 2 months. All audits will be taken by the Administrator or designee to QAPI monthly until the facility demonstrates sustained compliance as determined by the committee.	

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F 880	Continued From page 60 *She stated she did not have a process in place for antibiotic stewardship and she did not have someone monitoring antibiotic use or orders. 2. Interview on 9/19/24 at 4:30 p.m. with administrator A revealed she agreed they did not did not have an active infection prevention and control program. 3. Interview on 9/19/24 at 5:28 p.m. with quality assurance specialist/certified medication assistant I revealed: *The former director of nursing had been the provider's infection preventionist but she had resigned from her position effective at the beginning of August 2024. *The provider had no current qualified infection preventionist.	F 880		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized	F 882	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? - Facility has a qualified Infection Preventionist on staff to meet the requirement as of 9/30/2024. Infection Surveillance has been initiated. A process for antibiotic stewardship has been initiated. Infection control program is being initiated. Current Policies and procedures for infection control are available. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? - All residents had the potential to be affected by the same deficient practice	10/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 882	Continued From page 61 training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on interview the provider failed to ensure that they had an infection preventionist (IP). 1. Interview on 9/19/24 at 3:16 p.m. with interim director of nursing (DON) B revealed: *She was told she would be the IP. *She stated she did not have her certificate for infection preventionist as it had expired. *She was not currently enrolled to regain her certification and was not going to enroll since she was an interim DON. 2. Interview on 9/19/24 at 4:30 p.m. with administrator A revealed she agreed they did not did not have an infection preventionist. 3. Interview on 9/19/24 at 5:28 p.m. with quality assurance specialist/certified medication assistant I revealed: *The former director of nursing had been the provider's infection preventionist but she had resigned from her position effective at the beginning of August 2024. *The provider had no qualified infection preventionist.	F 882	Continued From page 61 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? - Facility will have a qualified Infection Preventionist on staff to meet the requirement, When a new Director of nursing is hired part of the onboarding process will be to either already have or receive the required education and training to serve at the facility Infection Preventionist. Meanwhile the Interim Director of Nursing and a Charge Nurse have the required training to serve at the facility Infection Preventionist. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? - Administrator or designee will complete random audits on a variety of infection prevention practices 1 x a week for 4 weeks, then 1 x a month for 2 months. All audits will be taken by the Administrator or designee to QAPI monthly until the facility demonstrates sustained compliance as determined by the committee.	
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review the provider failed to ensure pest control	F 925		

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	435124	A. BUILDING ____ B. WING ____	C 09/19/2024

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F 925	Continued From page 62 for flies was effective. Findings include: 1. Observation on 9/17/24 at 8:15 a.m. in the conference room revealed a live beetle crawling on the floor. 2. Observation on 9/18/24 at 8:40 a.m. in the dining room revealed a live fly on a clean clothing protector. 3. Observation on 9/18/24 from 8:41 a.m. through 8:45 a.m. revealed: *Ten dead crickets in the hallway by rooms 24 through 38. *Five dead crickets in the side entrance by the nurses station. 4. Observation on 9/17/24 at 9:15 a.m. of resident 22 revealed: *He was in his room, seated in a recliner, and had a blanket covering him. -There were five live flies on the blanket that was covering him. 5. Observation and interview on 9/17/24 at 9:30 a.m. with resident 15 revealed: *He stated he had two "loyal friends stop" and have dinner with him. -A "problem arose with flies". --While eating dinner with his friends they told him that there were flies on his food and in his hot chocolate." -He stated he would not have known there were flies in his food if his friends had not told him as he was blind. 6. Observation on 9/17/24 at 2:08 p.m. of resident 37 revealed: *An unknown number of dead flies on the floor.	F 925	1. Corrective action to residents affected: - On 9/19/24 Director of Environmental Services put up a Paraclipse Capture Cartridge (fly trap) in the dining room. - On 9/19/24 Director of Environmental Service ensured the current “automizers” in the building were working properly. - On 9/26/24 Olson’s Pest Control added clam shell fly light in dining room and an automizer in the double door entries. 2. Identify other potential Residents affected: - All residents had the potential to be affected by the same deficient practice 3. Measures put into place or systemic changes made to ensure that will not recur: - By 10/18/24 Director of Environmental Services or Designee will provide education to all staff on Pest Control. - Monitoring of pest control practices will be added to the preventative maintenance schedule. 4. Monitor process for the system change including frequency and person responsible: Director of Environmental Services or designee will complete audits of monitoring for pest infestations once a week for 4 weeks, and 1 x month via TELS. All audits will be taken by the Administrator or designee to QAPI monthly until the facility demonstrates sustained compliance as determined by the committee	10/18/2024

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F 925		F 925		

Continued From page 63
*A live fly was flying around a surveyor's head.

7. Observation on 9/18/24 at 10:27 a.m. of resident 1 in her room revealed three live flies, one had been flying around her head, one on her shirt, and one on her shoe.

8. Interview on 9/19/24 at 12:30 p.m. with ancillary services supervisor E regarding pest control revealed:
*A professional pest control company came once a month to the facility.
*The North and South hallways had an automatic spray system for killing flies.
*The kitchen had a device that looked like a light but had sticky tape in it for catching flies.
*The dining room did not have any fly control.
-He was not aware there had been a concern with flies in the dining room.
*He had knowledge of "quite a few crickets".
*He stated the facility is close to a bird seed plant and the city sewer lagoon.
-He thought these might contribute to the flies in the facility.

9. Interview on 9/19/24 at 1:45 p.m. with interim director of nursing B regarding resident 15 and his concern of flies in his food revealed:
*She stated flies were horrible this time of year with the doors opened throughout the day.
-Fly swatters were handed out, and the exterminator came frequently to spray inside and outside the building.
-She was not sure what else they could have done about the flies.

10. Review of the provider's 8/2/24 Pest Control policy revealed:
*"All... locations will comply with any federal,

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F 925	Continued From page 64 state, or local laws concerning pest infestations." *"Applicable pest threats will be identified in the plan along with mitigation steps." *"Sanitary conditions will be maintained on the grounds and all common areas. The location will have properly fitting exterior doors and will dispose of garbage in a manner so as not to promote insect or rodent infestations. Resident and patient rooms and units should be monitored by staff members performing assigned tasks in the rooms and units for signs of insect or rodent infestations."	F 925		

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

PRINTED: 10/03/2024
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
	435124	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**09/17/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER	**421 EAST 4TH ST** **MILLER, SD 57362**

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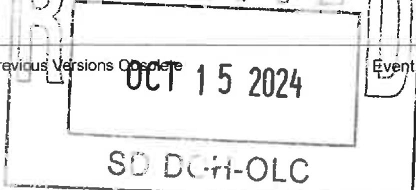
K 000	INITIAL COMMENTS A recertification survey was conducted on 9/17/24 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Good Samaritan Society Miller was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K222 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	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 conclusions set forth in the statement of deficiencies. 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 compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
K 222 SS=C	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be	K 222		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kimberly Sivertsen
TITLE: Administrator
(X6) DATE: 10/15/2024

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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	435124	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**09/17/2024**

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K 222	Continued From page 1 electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain egress doors as	K 222		

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

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K 222	Continued From page 2 required at one of ten locations (northeast wing). Findings include: 1. Observation on 9/17/24 at 10:15 a.m. revealed the exterior exit door for the northeast resident wing was equipped with magnetic lock hardware that prevented egress. The door was labeled as a delayed egress-locked door. Testing of the door by applying force in the direction of the path of egress revealed the audible signal would not sound. The required irreversible process of unlocking the door did not initiate. Interview at the time of the observation with the maintenance supervisor confirmed that condition. The supervisor knew how to repair the door, and did so at the time of discovery. The deficiency affected one of ten exit doors. Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6.2(3)(a)	K 222	1. Corrective action to residents affected: - The northeast exterior exit door was fixed with delayed egress -locked door with audible signal with sound. All 10 Exit doors were checked to ensure that delayed egress- locked doors are audible signal with sound. 2. Identify other potential Residents affected: -All residents potentially affected. 3. Measures put into place or systemic changes made to ensure that will not recur: -Educated maintenance director on ensuring the delayed egress- locked doors are audible signal with sound for all 10 Exit doors. -Exterior exit door for the northeast resident wing is tested daily by environmental services department staff to ensure the alarm sounds when force is applied in the direction of the path of egress and that the irreversible process of unlocking the door initiates. This will be done until the door is permanently fixed. 4. Monitor Process for the system change including frequency and person responsible: -Administrator or designee will complete audits to ensure the alarm sounds when force is applied in the direction of the path of egress.and that the irreversible process of unlocking the door initiates for 1 x week for 4 weeks and then 1 x monthly for 3 months with all audits taken to QAPI monthly until the facility demonstrate sustained compliance as determined by the committee.	10/18/24

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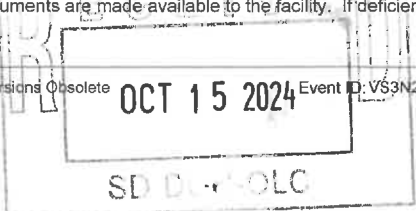
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 9/17/24. Good Samaritan Society Miller was found in compliance with the requirements.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kimberly Sivertsen
TITLE: Administrator
(X6) DATE: 10/13/24

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.



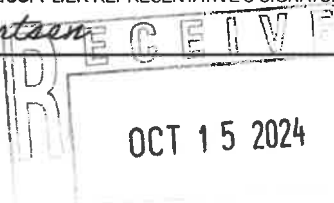
South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10651	A. BUILDING: ______ B. WING ______	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER	**421 E 4TH STREET MILLER, SD 57362**

(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 9/17/24 through 9/19/24. Good Samaritan Society Miller was found not in compliance with the following requirement: S206.	S 000	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 conclusions set forth in the statement of deficiencies. 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 compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and. (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section. Additional personnel education shall be based on	S 206		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kimberly Sivertsen — TITLE: Administrator — (X6) DATE: 10/13/24



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S 206	Continued From page 1 facility identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure training was completed for fire prevention/response, emergency procedures/preparedness, infection control & prevention, accident prevention and safety procedures, confidentiality of resident information, and abuse, neglect, misappropriation, and mistreatment, for one of six sampled employees (L). Findings include: 1. Review of employee personnel records revealed: *Employee L was hired on 2/10/23. *There was no documentation she completed the following education within the last year: -Fire prevention/response. -Emergency procedures/preparedness. -Infection control & prevention. -accident prevention and safety procedures. -confidentiality of resident information. -abuse, neglect, misappropriation, and mistreatment. Interview and review of employee training records on 9/19/24 with business office manager/dietary manager C revealed: *They use an on-line training program and in-person training. *All staff are required to complete training annually. *She confirmed there was no documentation to support employee L had completed her annual training. Review of the provider's revised 9/17/24	S 206	1. Corrective action to residents affected - Employee L completed education and is in proper compliance as of 10/11/2024 2. Identify other potential Residents affected: - All residents had the potential to be affected by the deficient practice 3. Measures to put into place or systemic changes made to ensure that will not recur: - All reports for required education were checked to ensure any possible staff were due for education. - Clinical Learning and Development Specialist will run monthly reports to monitor annual training completion.	10/17/2024

South Dakota Department of Health

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S 206	Continued From page 2 Competency and Mandatory Education Requirements Policy revealed: *"Mandatory Education: -Education that is required for specific roles, departments, or for all employees. Mandatory education and other ongoing education maintains and improves competency. -Competency Achievement and mandatory education requirements are required to be documented and are reviewed as part of the performance appraisal process."	S 206	Continued From page 2 4. Monitor process for the system change including frequency and person responsible: - Busy office manager or designee will complete audits on necessary orientation and annual Training/Education for 3 months with all audits taken to QAPI monthly until the facility demonstrates sustained compliance as determined by the committee.	

South Dakota Department of Health

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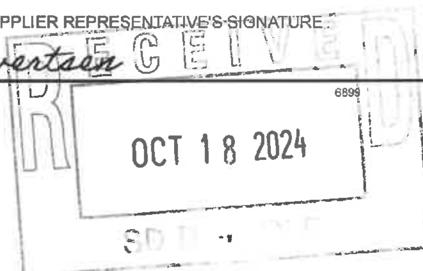
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kimberly Sivertsen	Administrator	10/18/24



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