

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/29/2016
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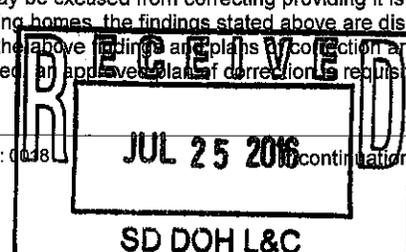
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY MILLER	STREET ADDRESS, CITY, STATE, ZIP CODE 421 EAST 4TH ST MILLER, SD 57362
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p><i>*Addendums noted with an asterisk per 8/10/16 per telephone with facility administrator. MLISDPOTHEL</i></p> <p>Surveyor: 32335 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/27/16 through 6/29/16. Good Samaritan Society Miller was found not in compliance with the following requirement(s): F281, F363, and F371.</p>	F 000	F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	1 of 7
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on closed record review, policy review, and interview, the provider failed to follow nursing professional standards by not ensuring a physician's order to release the body had been obtained for one of one resident (11). Findings include:</p> <p>1. Review of resident 11's closed medical record revealed: *He was admitted on 9/18/13. *He had died on 2/14/16. *The interdisciplinary progress notes on 2/14/16 after resident 11's death revealed: -He was found on the floor by staff. -He had no pulse or respirations. -The family and physician were notified. -The funeral home had been there at 12:10 a.m. *There was no physician's order located regarding the release of the deceased resident to the funeral home.</p>	F 281	<p>Plan of correction for not ensuring a physician's order to release the body had been obtained for one of one resident (11):</p> <p>For resident #11, the facility did not obtain a physician's order to release the body to the mortician/funeral home upon the death of the resident. The facility did not go back to obtain an order at this time due to this being a closed record and because the resident had passed away already several months prior. The body was already released to the funeral home without the proper order. For all other potential residents, a physician's order will be obtained at the time of the death of a resident to release the body to the mortician/funeral home. The Director of Nursing Services (DNS) reviewed the company's Death and Dying policy regarding obtaining a physician's order to release a body to the funeral home upon the death of a resident and educated on the proper procedure with all licensed nurses on July 13, 2016. The education included a checklist that the DNS implemented on July 22, 2016 stating that a physician's order is to be obtained per state regulation when a resident</p> <p>(continued)</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Christa Dittus</i>	TITLE <i>Administrator</i>	(X6) DATE <i>7/23/2016</i>
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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 281	Continued From page 1 Interview on 6/29/16 at 2:30 p.m. with the director of nursing revealed: *There was no physician's order in the medical record for the release of the deceased resident to the funeral home. *She did not state what her expectations of nursing staff were following the death of a resident. Review of the provider's September 2012 Death and Dying policy revealed: "When respirations and heartbeat stop, the charge nurse will notify the physician. If state requires, obtain permission to release the body to the mortician."	F 281	F-281 (continued) becomes deceased in the facility. This order allows the nurse to release the body to the appropriate funeral home. The DNS individually counseled and educated each nurse that was not in attendance for the July 13th meeting by July 22, 2016. The DNS or designee will complete an audit after the death of each resident for 6 months to ensure the physician's order has been obtained to release the body to the preferred funeral home. Audits will be completed after every death that occurs in the facility.	2 of 7	
F 363 SS=D	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, menu review, and interview, the provider failed to follow the menu for two of two observed meals. Findings include: 1. Observation and menu review on 6/28/16 at 11:30 a.m. revealed baked chicken had been served instead of crispy chicken that had been on the menu.	F 363	The audits will be completed for 6 months unless the audits reveal instances where an order was not obtained, and then the audits will continue for 1 year. The audit findings will be reported to the Quality Assurance and Performance Improvement (QAPI) committee monthly for further review, recommendations and timeline instructions. *by the DNS *ML/SD/DH/EL F363 483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE FOLLOWED Plan of correction for failing to follow the menu for two of two observed meals: (continued)	*7/28/16	

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F 363	Continued From page 2 Interview on 6/28/16 at 11:30 a.m. with cook A revealed the dietary manager had not ordered the crispy chicken that had been on the menu. She had to make substitutions on other days as well. She had lasagna on the menu two times, but the lasagna noodles had not been ordered either time. So she had to make something different. This evenings menu item had included a Waldorf salad. However there was no recipe for it, so she had to substitute something else. Observation on 6/28/16 at 5:00 p.m. revealed tapioca pudding with mandarin oranges had been served instead of the Waldorf salad that had been on the menu. Interview on 6/29/16 at 9:45 a.m. with the administrator revealed she had been aware the dietary manager had not been ordering the correct items. They had a discussion regarding that issue a few weeks ago. She was not sure why she was not ordering the correct items that were on the menu.	F 363	F-363 (continued) All residents are potentially affected as they eat their meals at the facility. Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council. The facility must ensure the correct food items are ordered and available for utilization per the company-provided menu. The Dietary Manager (DM) or Designee is now responsible to [REDACTED] the menus with staff and ensure all food items are available for the menus 1 day prior to that meal being served to ensure the food items are available and the staff can find them. The DM was instructed on 6/30/2016 by the Administrator to follow the menus, and in the rare instances with unforeseen circumstances, when an item is not available, the Registered Dietician (RD) must be notified and must approve the change prior to serving the meal. The DM was instructed on 6/30/2016 to provide recipes to staff for all pre-planned meals according to the menu, and instructions on what to do if staff cannot find an item. The DM provided education on 7/15/2016 for dietary staff. Education was derived from the Good Samaritan Society's (GSS) policy and procedures regarding menus and ordering.	3 of 7	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371			

*audit
MUSDDOHEL

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

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F 363	<p>Continued From page 2</p> <p>Interview on 6/28/16 at 11:30 a.m. with cook A revealed the dietary manager had not ordered the crispy chicken that had been on the menu. She had to make substitutions on other days as well. She had lasagna on the menu two times, but the lasagna noodles had not been ordered either time. So she had to make something different. This evenings menu item had included a Waldorf salad. However there was no recipe for it, so she had to substitute something else.</p> <p>Observation on 6/28/16 at 5:00 p.m. revealed tapioca pudding with mandarin oranges had been served instead of the Waldorf salad that had been on the menu.</p> <p>Interview on 6/29/16 at 9:45 a.m. with the administrator revealed she had been aware the dietary manager had not been ordering the correct items. They had a discussion regarding that issue a few weeks ago. She was not sure why she was not ordering the correct items that were on the menu.</p>	F 363	<p>F-363 (continued) 3a of 7</p> <p>The RD will provide follow-up training on 7/28/2016 regarding menus meeting the resident's needs, prepping in advance, and following the pre-planned company menus to all staff, including the staff that did not attend the training that was provided on 7/15/2016 by the DM. The Dietary Manager or Designee will complete audits to ensure food items are ordered correctly and are available for the staff to prepare the correct meals as designated by the menu. The DM will complete audits to ensure the menus are being followed and recipes are provided for each meal on the menu. The Administrator or Designee will conduct audits to ensure the DM is ordering the correct menu items prior to when they must be served, recipes are given to staff prior to each meal and are followed, and that meals are served according to the GSS pre-planned menu with little to no deviations unless they are approved by the RD prior to implementation. All audits will be completed weekly for 4 weeks and then monthly for 6 months. All audits will be turned into the QAPI committee monthly for review and further recommendations. If audits do not show that the deficiencies have been correct, re-training by the DM and RD will occur and the audits will be continued for a longer period of time.</p>	
F 371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced</p>	F 371	<p>F371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY</p> <p>(continued)</p>	

**daily mySDOHHJEL*

**or designee mySDOHHJEL*

**daily mySDOHHJEL*

**The DM or designee will ensure substitutions are approved by the RD prior to serving the meal. ml/SDOHHJEL*

**Weekly mySDOHHJEL*

**By the administrator 7/28/16 and the DM. mySDOHHJEL*

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F 371	<p>Continued From page 3</p> <p>by: Surveyor: 32335</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure:</p> <ul style="list-style-type: none"> *All dietary staff had been properly trained on how to test the sanitizer used to wipe off tables. *Proper glove use had occurred when preparing ready-to-eat foods for one of one observed meal. *Items were properly labeled for seven of seven frozen bags located in the walk-in freezer. <p>Findings include:</p> <p>1. Observation and interview on 6/28/16 at 9:55 a.m. with dietary assistant C revealed:</p> <ul style="list-style-type: none"> *She had been wiping off tables with sanitizer. *She filled the bucket of sanitizer in the kitchen. *She had not had to measure the sanitizer as it was mixed with water as it came out of the dispenser. *She had been unsure of how to test the sanitizer. *She had not received any training on how to test the sanitizer. <p>Observation and interview on 6/28/16 at the above time with dietary assistant D revealed:</p> <ul style="list-style-type: none"> *She had attempted to test the bucket of sanitizer dietary assistant C had been using in the dining room. -It had not registered any parts per million (ppm). *She obtained a new test strip, and it still had not registered any ppm. *She obtained a third test strip, and it still had not registered any ppm. *She used that third test strip to test the sanitizer coming directly out of the dispenser, and it registered the correct ppm. *She filled a new bucket and tested the water immediately after coming out of the dispenser. -It registered above 400 ppm. 	F 371	<p>F-371 (continued) 4 of 7</p> <p>All residents are potentially affected as they eat their meals at the facility. The facility must store, prepare, distribute and serve food under sanitary conditions. The DM or Designee will ensure that all dietary staff are properly trained on how to test the sanitizer used to wipe tables. They will ensure the sanitizer solution tests within the appropriate range per manufacturer's directions so it maintains the appropriate level of effectiveness throughout the day and sanitizes properly for both the sanitization solution in the pails and for the pot/pan sanitization process. Instructions were posted for the staff regarding sanitizer testing procedures on 7/15/2016. The DM or Designee will ensure that proper glove usage and hand hygiene when handling ready-to-eat foods are followed per the GSS policies and procedures, and that all dietary staff are trained accordingly (other staff receive this education separately on an annual basis). The DM or Designee will ensure food is properly labeled and dated anywhere that it is stored per GSS policy and procedure and in accordance with state and federal regulations, and that all dietary staff are trained on these guidelines and practices. [redacted] were educated on the importance of these requirements for the</p> <p style="text-align: right;">(continued)</p>	

*All staff
MLSPD/HJ/EL

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F 371	<p>Continued From page 4</p> <p>*Normal range was 150 to 400 ppm. *When asked what do to if the ppm were not in the correct range she stated she was unsure.</p> <p>Observation and interview on 6/28/16 at 10:10 a.m. with dietary assistant B and cook A revealed: *Both employees had been employed since the end of May 2016. *Dietary assistant B was training dietary assistant C. *Neither employee had been trained on testing the sanitizer.</p> <p>Review of the 6/1/16 through 6/28/16 pot/pan chemical sanitizing log revealed: *There were six slots per day to be completed with the recorded ppm for the sanitizer test results. *One entry had been completed on 6/1/16, 6/2/16, 6/3/16, 6/4/16, 6/5/16, and 6/8/16. *Four of those six entries had ppm at 100. *There had been do documentation on what had occurred to correct that problem.</p> <p>Interview on 6/28/16 at 11:30 a.m. with the business officer manager revealed the signatures on the pot/pan chemical sanitizing log had been the dietary managers.</p> <p>Review of the Oasis 146 Multi-Quat Sanitizer instructions revealed the normal range was 150 to 400 ppm. Testing solution should be at room temperature 65 degrees Fahrenheit (F) to 75 degrees F. The test strip should have been dipped in the solution for ten seconds.</p> <p>2. Observation on 6/28/16 at 5:07 p.m. of dietary assistant B revealed: *She had put on gloves and was preparing to</p>	F 371	<p>F-371 (continued) 5 of 7</p> <p>Resident's safety and they acknowledged their understanding on 7/15/2016. The DM educated the dietary staff on 7/15/2016. The education included training on GSS policies and procedures regarding sanitization use and testing, proper glove usage and hand hygiene, handling ready-to-eat foods, and food labeling and storage. The RD and DM will provide follow-up training on the above named topics on 7/28/2016 to ensure all dietary staff understand them, and to provide make-up education and training to those who did not attend the training on 7/15/2016. Any staff that do not attend the in services will be trained one on one by the DM or Designee by-8/12/2016. The DM or Designee will ensure the sanitization logs are complete every week for 6 months to ensure the sanitizer is being tested up to 6 times per shift. The audits will be completed weekly for 4 weeks and then monthly for 6 months to ensure the sanitizer solution sustains the appropriate ppm measurement. Audits will also include the observation of 5 meals per week for 3 months to monitor the appropriate usage of gloves, hand hygiene, and the handling of ready-to-eat foods during food preparation and distribution.</p> <p>(continued)</p>	

*by the DM or designee MUST DO IT!

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F 371	Continued From page 5 serve the meal. *Staff informed her two residents wanted peanut butter and jelly sandwiches. *With those same gloves on she touched the diet cards, bread sack, bread, and opened the butter container. *She had put the bread directly on the counter. *She then: -Retrieved a knife, opened a drawer, and took out one individualized peanut butter container. -Went back and touched the bread with those same gloves while spreading the peanut butter. -Opened the walk-in refrigerator and brought out the jelly container. -Went back to the drawer and retrieved another individualized peanut butter container. -Buttered the other sandwich while touching the bread with those same gloves on. -Opened the jelly container and spread it on the sandwiches. *She removed those gloves and put on a new pair. *With that new pair on she touched the pen, clipboard, diet cards, counter, and contaminated knife. *She picked up two plates, picked up the two sandwiches from the counter, and placed them on the plates. *Before beginning to serve the meal she had been instructed by another coworker not to use gloves to serve the buns but to use tongs instead. Review of the provider's February 2013 Food Handling policy revealed gloves should have been changed whenever staff changed an activity, the type of food being worked with, or whenever they left the workstation. 3. Observation on 6/27/16 at 4:00 p.m. in the	F 371	F-371 (continued) 6 of 7 All audits will be [redacted] the QAPI committee on a monthly basis for review and further recommendations. → *reported by the DM or designee to ML/SDDOT/EL	7/28/16	

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F 371	<p>Continued From page 6</p> <p>walk-in freezer revealed seven brown bags that had not been labeled.</p> <p>Interview on 6/28/16 at 10:30 a.m. with cook A revealed those seven brown bags had been in the freezer for a couple of weeks. The dietary manager had not labeled them. They contained hash browns, tator tots, and fries. When she needed to use them she had to feel the bag to determine what they were.</p> <p>4. Interview on 6/29/16 at 9:45 a.m. with the administrator revealed: *The dietary manager was unavailable for interview during the time of survey. *The staff should have been properly trained on how to test the sanitizer. *The staff should have changed gloves or used tongs when preparing ready-to-eat foods. *The items in the freezer should have been labeled.</p>	F 371			

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ORIGINAL

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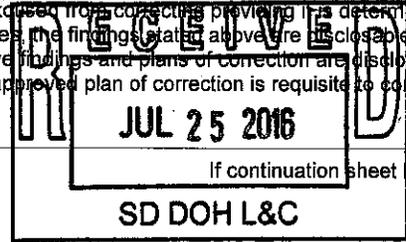
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K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 6/29/16. Good Samaritan Society Miller was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 6/30/16. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiencies identified at K144 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		1 of 4
K 032 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and record review, the provider failed to maintain at least two conforming exits from each floor of the building. The only basement exit did not meet the standard for a	K 032		F

(continued)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Christa Dittus</i>	TITLE Administrator	(X6) DATE 6/17/16
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K 032	Continued From page 1 means of egress. Findings include: 1. Observation revealed the basement was not provided with an approved means of egress. The only exit from the basement discharged into the main level corridor system. Review of previous life safety code survey data confirmed that finding. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K 032	K032 Continued	2 of 4
K 033 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit enclosures (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 7.1.3.2, 8.2.5.2, 8.2.5.4, 19.3.1.1 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and record review, the provider failed to maintain a one hour fire resistive path of egress from the basement to the exterior of the building. Findings include: 1. Observation revealed the only basement stairway adjacent to the west nurses station discharged into the main level corridor system. A one hour fire resistive path of egress was not provided to the exterior of the building. Review of previous life safety code survey data confirmed that finding. The facility meets the FSES. Please mark an "F" in the completion date column to indicate the	K 033		F
			(continued)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435124	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/29/2016
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY MILLER			STREET ADDRESS, CITY, STATE, ZIP CODE 421 EAST 4TH ST MILLER, SD 57362	
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K 033	Continued From page 2	K 033	K033 Continued	3 of 4
K 144 SS=D	<p>facility's intent to correct the deficiencies identified in K000.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334</p> <p>Based on interview, the provider failed to ensure the emergency power system (EPS) was maintained in accordance with NFPA 110 Standard for Emergency and Standby Power Systems for the power transfer switch. Findings include:</p> <p>1. Interview with the environmental services director at 10:45 a.m. on 6/29/16 revealed the transfer switch that was provided to transfer from normal power to the emergency power was not functioning properly. He indicated the transfer switch would transfer back and forth between normal power and emergency power with no time delay. NFPA 110 requires a minimum of five minutes of time delay to transfer between emergency power and normal power. He indicated he had talked with Butler Machinery Company on April 26, 2016 when a service technician was at the facility to conduct an annual inspection of the generator. He indicated the transfer switch would switch back and forth with no delay, but no service was conducted to correct the issue. He did not indicate if he was aware the switch was not in conformance with NFPA 110 but was aware the issue did not seem normal.</p>	K 144	<p>K144 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>The transfer switch on the generator that serves as a back-up power source for the facility that was provided to transfer from normal power to the emergency power was not functioning properly and had the potential to affect all residents residing in the facility. The transfer switch will be adjusted to meet the life safety code standard. On 6/30/2016, the Environmental Services Director (ESD) contacted Butler Machinery (who services generators) to evaluate and correct the time required for the transfer switch to transfer from emergency power back to normal power on the generator as it should be no less than 10 seconds and the generator shall power the facility for no less than 5 minutes, (15-30 minutes) not including the cool down time following the transfer back to normal power. On 7/20/2016, Butler Machinery evaluated the transfer switch on the generator and found that adjustments needed to be made to obtain proper timing and settings. The building load was coming off of emergency power too quickly and needed to be adjusted.</p> <p>(continued)</p>	

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K 144	Continued From page 3 This deficiency has the potential to affect all residents.	K 144	K-144 (continued) Butler Machinery adjusted the timer for emergency to normal to 20 minutes. They performed an outage test on the generator and found it to start and come back online in about 14 seconds. Butler Machinery ran the load for 20 minutes and shut it off, and then ran it for 2 minutes for cool down. They adjusted the cool down timer and utility lost start delay timer to correct the transfer switch timing error. The generator was retested and then the generator was found to start and be running online within 10 seconds. The generator ran under load for 20 minutes before transferring back to utility (20 minutes of uninterrupted utility power available) and then cooled down for 7 minutes. The ESD or Designee will monitor the transfer switch for proper functioning during routine inspections and testing. The ESD or Designee added transfer testing on the generator to the TELS program on 7/21/2016, which will create a quarterly work order to remind the ESD to perform the quarterly work order and routine preventative maintenance and monitoring to prevent reoccurrence. Butler Machinery will be called immediately for any generator issues from now on. The ESD or Designee will audit the quarterly testing logs to ensure compliance and (continued)	4 of 4	

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

PRINTED: 07/12/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435124	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2016
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K 144	Continued From page 3 This deficiency has the potential to affect all residents.	K 144	K-144 (continued) 4a of 4 will report findings to the QAPI committee quarterly for 1 year for further review.	7/21/16	

ORIGINAL

PRINTED: 07/12/2016
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10651	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/29/2016
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY MILLER	STREET ADDRESS, CITY, STATE, ZIP CODE 421 E 4TH STREET MILLER, SD 57362
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S 000	Compliance/Noncompliance Statement Surveyor: 32335 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 6/27/16 through 6/29/16. Good Samaritan Society Miller was found not in compliance with the following requirement(s): S301.	S 000	1 OF 2	
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32335 Based on interview and record review, the provider failed to ensure five of the nine required dietary trainings (food preparation, handwashing, leftover food handling, serving and distribution, and sanitation) were completed by all dietary staff. Findings include: 1. Review of the provider's training logs revealed nutrition and hydration, safe eating, and safe food handling were topics covered through online training. Food borne illnesses had been covered in a meeting. Food preparation, handwashing, leftover food handling, serving and distribution, and sanitation trainings had not been completed since the last survey.	S 301	S301 44:73:07:16 REQUIRED DIETARY INSERVICE TRAINING On 7/28/2016, The RD and DM will hold an in-service training for all dietary staff and other food handling employees such as activities personnel and Certified Nursing Assistants (C N A's), on the nine-state specific trainings including food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitization requirements. The RD and DM will be responsible for providing training on each topic annually going forward. They will produce a calendar with the trainings planned for nine months to cover all trainings by 8/12/2016 to ensure dietary staff and other food handling employees receive the proper training according to state regulations. All facility staff are scheduled to receive training on nutrition and hydration and safe food handling in August of 2016 as well. Each staff (continued)	

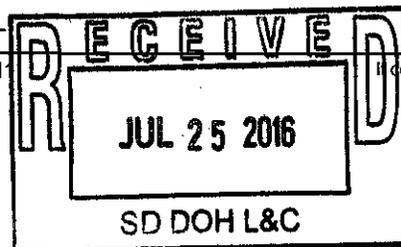
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Christa Dittus Dittus

Administrator



08/17/2016

STATE FORM

6899

T5131

If continuation sheet 1 of 2

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10651	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/29/2016
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S 301	Continued From page 1 Interview on 6/29/16 at 1:15 p.m. with the administrator revealed she could not locate any training records for the above mentioned trainings. The dietary manager was unavailable for interview during the time of survey. There had been no annual training agenda or calendar that covered those topics. They could not ensure those five trainings had been done with all dietary staff annually.	S 301	S-301 continued 2 of 2 member who does not attend the meeting on 7/28/2016 will be required to come in and train one-to-one with the DM by 8/12/2016 to make up the training. The training of the staff will be audited by the Administrator or Designee monthly and reported to QAPI for review and further recommendations.	8/12/16
S 000	Compliance/Noncompliance Statement Surveyor: 32335 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 6/27/16 through 6/29/16. Good Samaritan Society Miller was found in compliance.	S 000		