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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435074 | A. BUILDING _____ B. WING _____ | 12/02/2021 |

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

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| F 000 | INITIAL COMMENTS<br><br>Surveyor: 06365<br>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 11/30/21 through 12/2/21. Good Samaritan Society De Smet was found in compliance. | F 000 | | |

EREMich ADMINISTRATOR 20 DEC 2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

DEC 20 2021

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| E 000 | Initial Comments<br><br>Surveyor: 06365<br>A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 11/30/21 through 12/2/21. Good Samaritan Society De Smet was found not in compliance with the following requirements: E013, and E039. | E 000 | DISCLAIMER:<br><br>Preparation and execution of this respone 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. | |
| E 013 SS=D | Development of EP Policies and Procedures<br>CFR(s): 483.73(b)<br><br>§403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b).<br><br>(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.<br><br>*[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.<br><br>*Additional Requirements for PACE and ESRD | E 013 | Jeremiah J. Schneider<br>Administrator | 30 Dec 2021 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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| E 013 | Continued From page 1<br>Facilities:<br><br>*[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years.<br><br>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 06365<br>Based on interview and emergency preparedness plan review, the facility failed to provide sufficiently detailed procedures regarding: | E 013 | By 12 January 2022 Emergency Management Plan will be updated to include 6 month average daily census as well as 13 staff on Days/Evening/Night shift to produce an approximate number of people to be served meals/water over a 3 day period. In the event resident/staffing numbers need to be adjusted this adjustment will be documented and updated in the EMP. Emergency Services Agreement (ESA) in place with Close Septic Service to have our Cistern drained daily during an interruption in sewer service. Waste disposal we have (3) total dumpsters that can be utilized for waste disposal which will hold approximately 6 days' worth of refuse. In the event that waste disposal is not an option greater than 6 days we can store trash double bagged and stored in our garage for transport refuse to the local solid waste site. By 12 January 2022 will educate staff on policy/procedure for "shelter in place" scenarios regarding sewer/solid waste issues. On 17 December and 20 December, respectively, Transportation ESA with Wilder House and ESA with De Smet School District was signed and placed in the EMP Binder. Administrator or designee will perform audit for completion of education, proof of EMP review, and current transportation agreements. Audits will occur monthly for 3 months. Administrator or designee will report findings to QAPI Committee monthly. QAPI committee to determine ongoing monitoring and interventions. Substantial compliance will be achieved by 12 January 2022.<br><br>Addendum:<br><br>Administrator or designee will educate all current staff on EMP updates to incude sewer/solid waste and transportation changes.<br><br>JJS | 12 Jan 2022<br><br>12 Jan 2022 |

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| E 013 | Continued From page 2<br>*Each hazard placing the facility at risk for an emergency.<br>*Maintenance needs for sheltering in place during an emergency.<br>*Arrangements with other providers for continuity of services.<br>This has the potential to affect all residents residing in the facility at the time of an emergency situation.<br>Findings include:<br><br>1. Review of the facility's emergency preparedness plan revealed:<br>*The all-hazards risk assessment did not include infectious disease outbreak situations.<br>*Detailed procedures were not included for each hazard identified in the risk assessment.<br>*Maintenance needs for sheltering in place did not specify:<br>-How many persons would be served using the three days of stored food and water.<br>-A back-up plan for disposal of sewage and waste.<br>*Arrangements with other providers for transportation and sewage/waste disposal were not included.<br><br>Interview with administrator H on 12/2/2021 at 2:00 p.m. revealed:<br>*Outbreak situations should have been included in the risk assessment.<br>*He agreed defining the number of persons served by three days of food and water would be helpful when sheltering in place.<br>*They had not thought about having a back-up plan for sewage and waste disposal during an emergency situations.<br>*They had made arrangements for transportation but did not have it documented with an | E 013 | | |

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| E 013 | Continued From page 3<br>agreement. | E 013 | | |
| E 039 SS=D | EP Testing Requirements<br>CFR(s): 483.73(d)(2)<br><br>§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).<br><br>*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:<br><br>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:<br><br>(i) Participate in a full-scale exercise that is community-based every 2 years; or<br>(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or<br>(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.<br>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, facility-based | E 039 | By 12 January 2022 Safety Committee will complete COVID-19 Tabletop drill to ensure compliance with regulations as well as ensure ALL tabletop exercises are documented and placed in the EMP Binder for easy access. Tornado Drills will be completed annually with cooperation with the Kingsbury County Emergency Manager during statewide drill. Communication between all entities to ensure drill dates and completion are met and drill is correctly documented. Staff participation in planning will be encouraged with staff education to follow tabletop/drill to ensure understanding. Administrator or designee will perform audits for completion of table top exercise, staff education, and documentation of required EMP drills. Audits will occur monthly for 3 months. Administrator or designee will report findings to QAPI Committee monthly. QAPI committee to determine ongoing monitoring and interventions. Substantial compliance will be achieved by 12 January 2022.<br><br>ADDENDUM:<br><br>Administrator or designee will educate all current staff on tabletop drill exercise time/location and results/findings.<br><br>JJS | 12 Jan 2022<br><br>12 Jan 2022 |

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| E 039 | Continued From page 4<br>functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.<br><br>*[For Hospices at 418.113(d):]<br>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:<br>(i) Participate in a full-scale exercise that is community based every 2 years; or<br>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or<br>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or | E 039 | | |

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| E 039 | Continued From page 5<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br><br>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or<br>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the | E 039 | | |

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| E 039 | Continued From page 6<br>hospice's emergency plan, as needed.<br><br>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]<br>(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or<br>(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the | E 039 | | |

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| E 039 | Continued From page 7<br>[facility's] emergency plan, as needed.<br><br>*[For PACE at §460.84(d):]<br>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or<br>(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. | E 039 | | |

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| E 039 | Continued From page 8<br><br>*[For LTC Facilities at §483.73(d):]<br>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.<br>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.<br><br>*[For ICF/IIDs at §483.475(d)]:<br>(2) Testing. The ICF/IID must conduct exercises | E 039 | | |

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| E 039 | Continued From page 9<br>to test the emergency plan at least twice per year. The ICF/IID must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.<br>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.<br><br>*[For HHAs at §484.102]<br>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:<br>(i) Participate in a full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not | E 039 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435074 | A. BUILDING _____ B. WING _____ | 12/02/2021 |

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

| (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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| E 039 | Continued From page 10<br>accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.<br>(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.<br><br>*[For OPOs at §486.360]<br>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:<br>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group | E 039 | | |

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| | 435074 | A. BUILDING _____ B. WING _____ | 12/02/2021 |

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

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| E 039 | Continued From page 11<br>discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.<br>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.<br><br>*[ RNCHIs at §403.748]:<br>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:<br>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 06365<br>Based on interview and emergency preparedness plan review, the provider failed to document exercises conducted to test the effectiveness of their emergency preparedness plans. The findings include:<br><br>1. Interview on 12/2/21 at 2:00 p.m. with | E 039 | | |

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| | 435074 | A. BUILDING _____ B. WING _____ | 12/02/2021 |

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| E 039 | Continued From page 12<br>administrator H revealed they had completed two emergency preparedness tests during 2021, but failed to document those tests, including:<br>*Implementation of emergency procedures during a COVID outbreak in September 2021.<br>*Participation with local and county response partners during two tornado drills during the summer of 2021.<br><br>The administrator displayed in the emergency preparedness binder where documentation would be included if it had been documented. | E 039 | | |

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

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|---|---|---|---|
| | 435074 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 11/30/2021 |

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

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| K 000 | INITIAL COMMENTS<br><br>Surveyor: 40506<br>A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 11/30/21. Good Samaritan Society De Smet was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. | K 000 | | |

Jeremiah — Administrator — 20 Dec 2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

DEC 20 2021

South Dakota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 10614 | A. BUILDING: _____ B. WING _____ | 12/02/2021 |

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| GOOD SAMARITAN SOCIETY DE SMET | 411 CALUMET AVE NW DE SMET, SD 57231 |

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| S 000 | Compliance/Noncompliance Statement<br><br>Surveyor: 06365<br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 11/30/21 through 12/2/21. Good Samaritan Society De Smet was found not in compliance with the following requirement: S210. | S 000 | DISCLAIMER:<br><br>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 210 | 44:73:04:06 Employee Health Program<br><br>The facility shall have an employee health program for the protection of the residents. All personnel shall be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Any personnel absent from duty because of a reportable communicable disease which may endanger the health of residents and fellow employees may not return to duty until they are determined by a physician or physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Surveyor: 32332<br>Based on employee file review, interview, and policy review, the provider failed to evaluate four of five newly hired employees (A, B, D, and E) for communicable disease by a licensed health professional within fourteen days after | S 210 | By 12 January 2022 will educate staff involved with orientation as well as Staff Development/IP RN that all new hire Health Questionnaires will require review and signature by an RN. DON/Administrator will review all new hire paperwork to include the Health Questionnaire to ensure RN review and signature. Administrator or designee will perform monthly audits of health questionnaires for all new hires. Audits will occur monthly for 3 months. Administrator or designee will report findings to QAPI Committee. QAPI committee to determine ongoing monitoring and interventions. Substantial compliance will be achieved by 12 January 2022.<br><br>Administrator or designee will educate all staff involved in New Hire Orientation on changes requiring RN screening/signature of Health Questionnaires. Staff RN will evaluate/sign all New Hire Health Questionnaires. Procedure will be updated to reflect RN evaluation and signature requirements.<br><br>JJS<br><br>Jeremiah J. Schneider<br>Administrator | 12 Jan 2022<br><br>12 Jan 2022<br><br>30 Dec 2021 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | 10614 | A. BUILDING: _____ B. WING _____ | 12/02/2021 |

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| S 210 | Continued From page 1<br>employment. Findings include:<br><br>1. Review of five employee Medical History Questionnaires revealed:<br>*Certified nursing assistant (CNA) C had a hired date on 12/22/20.<br>-Her medical questionnaire had been reviewed and signed by registered nurse (RN) G.<br>*Cook A had been hired on 9/14/21.<br>-His medical questionnaire had been reviewed and signed by business manager F.<br>*Director of nursing services (DNS) B had a hired date of 6/7/21.<br>-His medical questionnaire had been reviewed and signed by business manager F.<br>*RN D had a hired date of 11/16/21.<br>-Her medical questionnaire had been reviewed and signed by business manager F.<br>*Environmental services employee E had a hired date of 8/4/21.<br>-His medical questionnaire had been reviewed and signed by business manager F.<br><br>Review of a blank medical history questionnaire form revealed the conditional employee was to have answered medical history questions including whether the employee was:<br>-Free of communicable diseases.<br>-Currently free of any contagious diseases that could put the residents at risk.<br>The signature page indicated the human resources representative or designee was to have reviewed and signed the form.<br><br>Interview on 12/2/21 at 3:30 p.m. with administrator H regarding business manager F reviewing medical histories revealed neither administrator H nor DNS B were aware the questionnaire was to have been reviewed by a medical professional. | S 210 | | |

South Dakota Department of Health

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| S 210 | Continued From page 2<br><br>Review of the provider's updated February 2019 Health Questionnaire policy revealed:<br>*The form was to have been reviewed prior to the employee beginning work.<br>*All health concerns were to have been addressed immediately.<br>*Only if there were concerns noted by the supervisor, manager, or human resources representative the conditional employee would have been sent to their medical provider for recommendations. | S 210 | | |