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
	435104	A. BUILDING _____ B. WING _____	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 SOUTH MADISON NEW UNDERWOOD, SD 57761

(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 11/28/22 through 12/1/22. Good Samaritan Society New Underwood was found not in compliance with the following requirement: F700.	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.	
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review the provider failed to ensure: *Alternatives to side rails had been attempted and documented for 6 of 6 sampled residents (4, 8,	F 700	For residents 4, 8, 12, 18, 29, and 34 by 1/6/2023, DNS will assess each resident to determine if an alternative device would meet the resident's mobility needs and update care plans appropriately. Any resident using side rails has the potential to be affected by deficient practice. By 1/18/2023 Director of Nursing will audit all residents for the need and use of side rail and determine if alternative to device would meet the resident's needs. Unnecessary positioning bars/side rails will be removed by 1/18/2023. To ensure deficient practice will not recur, the new admissions checklist will also be updated by 1/18/2023 to include the assessment to verify if the resident needs a side rail or if an alternative can be used. Maintenance tech will install side rail/positioning bars once they are identified as needed. For beds where the controls are imbedded in the side rail, by 1/18/2023 nursing staff will be educated by DNS or designee to refer to care plan for instructions on side rail use. To monitor for sustained compliance, audits will be conducted by the Administrator or designee to ensure an alternative to side rails was considered for any newly admitted residents,	1/18/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Aden Ramey | TITLE: Administrator | (X6) DATE: 12/23/2022

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DEC 25 2022

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F 700	Continued From page 1 18, 12, 29, and 34) prior to the implementation of side rails. *The providers' policy for side rails had been followed. Findings include: 1. Observation on 11/28/22 at 1:58 p.m. of resident 8 revealed: *She was laying in her bed, with her eyes closed. *There had been bilateral side rails attached to the upper part of the bed in the up position. Review of resident 8's medical record revealed: *Her 11/23/22 BIMS score was a 99, meaning she had been unable to complete the interview. *There was a care plan intervention that included she required assistance of one staff person and cueing to use her grab bars. *There were side rail risk education versus benefit education, informed consent, and an assessment for side rail use completed. 2. Observation on 11/28/22 at 1:59 p.m. of resident 29 revealed: *He was in his recliner, with his feet up and eyes closed. *There had been bilateral side rails attached to the upper portion of the bed in the up position. Review of resident 29's medical record revealed: *His 11/7/22 BIMS score was a 3, meaning he had severe cognitive impairment. *His care plan included: -A focus that he had the potential for pressure ulcer development due to poor safety awareness and required assistance of one person for bed mobility. -A focus that he had an activity of daily living deficit related to a traumatic brain injury, Type II	F 700	and side rails are only in use for resident who have been properly assessed and an alternative is not appropriate. Audits will be conducted every week for 2 weeks, every other week x 2, and monthly x2. The administrator or designee will report findings to the QAPI committee monthly and the QAPI committee will continue ongoing monitoring and interventions.	

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F 700	Continued From page 2 diabetes, and Alzheimer's disease. --The intervention for this focus included he was independent in using his assist bar. *There were side rail risk education versus benefit education, informed consent, and an assessment for side rail use completed. 3. Observation and interview on 11/28/22 at 2:14 p.m. with resident 18 revealed: *She was laying in her bed, awake. *There had been bilateral side rails attached to the upper part of the bed in the up position. *She said she used the side rails. *They had been attached to the bed when she was admitted on 3/30/21. Review of resident 18's medical record revealed: *Her 9/20/22 brief interview of mental status (BIMS) score was a 15, meaning she was cognitively intact. *There was a care plan intervention that included she required two staff and extensive support with cueing to use her grab bars. *There were side rail risk education versus benefit education, informed consent, and an assessment for side rail use completed. 4. Observation on 11/29/22 at 10:25 a.m. with resident 4 revealed: *She was up in her wheelchair. *There had been bilateral side rails attached to the upper portion of the bed. *She had not been able to tell me what the side rails where, or if she used them. Review of resident 4's medical record revealed: *Her BIMS score was 4, meaning she had severe cognitive impairment. *There was a care plan intervention that included	F 700		

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F 700	Continued From page 3 she required assistance of one staff person and cueing to use her side rail. *There were side rail risk education versus benefit education, informed consent, and an assessment for side rail use completed. 5. Observation on 11/29/22 at 10:33 a.m. of resident 34 revealed: *He was in bed with blanket over his head. *There had been bilateral side rails attached to the upper portion of the bed. Review of resident 34's medical record revealed: *He was admitted on 10/18/22 to facility and had a BIMS of 99, meaning he had been unable to complete the interview. *There had been a care plan intervention that included he required assistance of one staff person cueing to use side rail and guiding hands to the rail. *There were side rail risk education versus benefit education, informed consent, and an assessment for side rail use completed. 6. Observation and interview on 11/30/22 at 11:20 a.m. with resident 12 revealed: *She was awake in her recliner. *There had been bilateral side rails attached to the upper portion of the bed. *She had not been able to tell me what the side rails where, or if she used them. *There were side rail risk education versus benefit education, informed consent, and an assessment for side rail use completed. Review of resident 12's medical record revealed: *Her BIMS score was 7, meaning she had severe cognitive impairment. *There had been a care plan intervention that	F 700		

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F 700	Continued From page 4 included she required assistance of one staff person cueing to use side rail and guiding hands to side rail. 7. Interview on 12/1/22 at 1:43 p.m. with director of nursing B regarding side rails revealed: *All new residents have side rails when they are admitted. *When a resident was admitted there were no interventions attempted prior to installation of side rails on their bed. *If it is determined a resident does not need side rails, then they are removed. *She had no concerns of residents continuing use to a side rail when they had a decline in their overall condition. 8. Interview on 12/1/22 at 2:27 p.m. with administrator A revealed: *The side rails on the beds had not been hindering residents getting out of bed and were not a restraint. *The bed controller for some of the beds was attached to the side rail, making it necessary to have a side rail on the bed for residents to move the bed up and down. *There were no interventions attempted prior to residents using side rails. *Assessments had been completed for residents using side rails, but no other interventions had been attempted prior to the installation of side rails on the beds. 9. Review of the provider's 9/6/22 bed safety including bed rails, side rails, assist bars policy revealed: *"Purpose:" -"To promote appropriate use of bed rails for resident safety when being used for a medical	F 700		

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F 700	Continued From page 5 provider-identified medical necessity." *"Policy:" -"Bed rail/side rail/assist bar usage will occur only when: --a. Medical necessity is supported by resident assessment and data collection documentation allowing resident to assist or be independent with bed mobility and/or transfer." *"Procedure:" -*8. Documentation of this informed consent may done ... and should include the following" --"Alternatives attempted that failed to meet the resident's needs and alternatives considered but not attempted because they were considered to be inappropriate." *The provider had no documententation for use of alternatives attempted in order to meet the residents needs before implementing side rail use.	F 700		

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 11/28/22 through 12/1/22. Good Samaritan Society New Underwood was found not in compliance with the following requirement: E001.	E 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.	
E 001 SS=D	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements.	E 001	By 1/18/2023, Administrator will revise the Emergency Management Plan to include all required elements. Administrator will educate all-staff on the emergency management plan by 1/18/2023. All residents have the potential to be impacted by deficient practice. To ensure deficient practice will not recur, going forward, Administrator will be responsible for maintaining and updating Emergency Management Plan at least yearly. Administrator will provide education to all staff on the Emergency Management Plan at least yearly. QAPI committee will review Emergency Management plan twice a year and recommend updates as needed. To monitor performance and ensure ongoing compliance QAPI coordinator or designee will audit the Emergency Management plan to ensure it address all areas described in the survey findings. Audits will occur monthly x1 and quarterly x2.	1/18/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Aden Ramey	Administrator	12/23/2022

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E 001	Continued From page 1 The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on interview and emergency preparedness plan review, the provider failed to ensure a complete emergency response plan had been developed and implemented. Findings include: 1. Interview and emergency preparedness plan review on 11/30/22 at 5:05 p.m. with administrator A revealed: *He agreed not all necessary items had been identified, developed, and implemented. *The plan had not: -Addressed resident population. -Addressed cooperation and collaboration with State and Federal emergency preparedness officials. -Addressed a plan or contractual agreements or arrangements with other long term care facilities to receive individuals in the event of any emergency limitations or facility shut down. -Addressed a listing with names and contact information for resident physician, other long term	E 001		

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E 001	Continued From page 2 care facilities, or volunteers. -Addressed a way identified to provide information about their occupancy, needs, and/or their ability to help, to the authority with jurisdiction to act in an emergency. -Addressed way to share their emergency plan information with residents and their families or representatives.	E 001		

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	435104	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/29/2022**

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing healthcare occupancy) was conducted on 11/29/22. Good Samaritan Society New Underwood 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 2012 LSC for existing healthcare occupancies upon correction of the deficiencies identified at K321 and K353 in conjunction with the providers 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 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet)	K 321	All residents have the potential to be affected by this deficiency. By 12/23/2022 Food and Nutrition Supervisor removed plastic wedge used to keep dry storage pantry door open and posted a sign outside of the pantry door instructing staff that the door cannot be propped open. To ensure continued compliance, audits will be conducted by the maintenance supervisor or designee to ensure the door to the dry storage pantry is not being propped open and the door is closed. Audits will be conducted every week for 2 weeks, every other week x 2, and monthly x2 to ensure the door to the dry storage pantry is closed. The maintenance supervisor or designee will report to the QAPI committee on a monthly basis the audit results and the QAPI committee with determine ongoing interventions and monitoring.	12/23/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Aden Ramey
TITLE: Administrator
(X6) DATE: 12/23/2022

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K 321	Continued From page 1 c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain proper separation of one of four hazardous areas (kitchen pantry) in one randomly observed area (kitchen). Findings include: 1. Observation on 11/28/22 at 12:30 p.m. revealed the kitchen pantry storage room was over 100 square feet in area and held copious amounts of combustible products. The door to the kitchen was held open with a plastic floor wedge. An interview with the maintenance supervisor at the time of the observation confirmed that finding. Doors to hazardous areas are required to be self-closing. The deficiency affected one of several requirements regarding the separation of hazardous areas.	K 321		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design,	K 353	All residents have the potential to be affected by this deficiency. A 5 Year Fire Sprinkler Inspection report was completed by Midwestern Mechanical, Inc. on December 6, 2022. The inspection found that the interior of the sprinkler piping appeared in satisfactory condition, the sprinkler system did not need internal cleaning, and an obstruction investigation was not recommended.	12/23/2022

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GOOD SAMARITAN SOCIETY NEW UNDERWOOD	**412 SOUTH MADISON** **NEW UNDERWOOD, SD 57761**

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K 353	Continued From page 2 maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, the provider failed to verify the required five-year internal obstruction testing of the automatic fire sprinkler system riser components had been performed. Findings include: 1. Review of the provider's sprinkler maintenance records revealed no documentation of the required five-year internal obstruction testing of the automatic fire sprinkler system riser components had been performed. Observation by checking the vendor's tags on the sprinkler riser valve on 11/28/22 at 1:30 p.m. did not reveal a tag noting a five-year internal obstruction inspection had been performed. The pressure gauges on the riser also did not have a date written on them to say when a five-year internal obstruction inspection might have been performed. Interview with the maintenance supervisor on 11/29/22 at 2:15 p.m. revealed that he could not confirm the test had been performed due to becoming a new employee in May 2022. The deficiency affected a single component of the	K 353	The 5 year internal obstruction testing has been added to the facility TELS (The Equipment Lifecycle System) software system used to monitor and track asset management procedures to notify the maintenance technician or designee of 5 Year Fire Sprinkler Inspection deadline in December 2027.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435104	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/29/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY NEW UNDERWOOD	**412 SOUTH MADISON** **NEW UNDERWOOD, SD 57761**

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K 353	Continued From page 3 building's automatic fire sprinkler system required maintenance.	K 353		

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
	10657	A. BUILDING: _____ B. WING _____	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 S MADISON POST OFFICE BOX 327 NEW UNDERWOOD, SD 57761

(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 11/28/22 through 12/01/22. Good Samaritan Society New Underwood was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement 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 11/28/22 through 12/1/22. Good Samaritan Society New Underwood was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Aden Ramey

TITLE: Administrator

(X6) DATE: 12/23/2022

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