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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435124	A. BUILDING _____ B. WING _____	06/02/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 5/31/22 through 6/2/22. Good Samaritan Society Miller was found not in compliance with the following requirements: F658 and F880.	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 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review the provider failed to ensure oxygen (O2) orders included specific liters per minute (LPM) for one of one sampled resident (10). Findings include: Observation on 5/31/22 at 6:00 p.m. of resident 10 revealed she was: *Seated in her wheelchair propelling herself through the hallway using her feet. *A nasal cannula in place. *A portable O2 tank attached to the back of her wheelchair. Observation and interview on 6/1/22 at 4:25 p.m. with resident 10 revealed: *She was seated in her wheelchair in her room. *A nasal cannula in place. *An O2 concentrator had been turned on, and was set at 2 LPM. *She stated she wore O2 all the time and knew it	F 658	On 6/4/2022, an order was obtained to clarify O2 LPM for Resident #10. Any resident using supplemental oxygen has the potential to be affected by deficient practice. Two additional residents were found without LPM specified. DNS or designee will obtain order clarifications by 6/23/2022. To ensure deficient practice will not recur, by 6/30/2022, DNS or designee will provide education to all licensed nurses on need for specification of O2 LPM in supplemental oxygen orders. To monitor performance DNS or designee will audit 4 residents with supplemental oxygen order to ensure specific LPM or titration range is included in the order. Audits will occur weekly x2, every other week x2, and monthly x1. DNS or designee will report audit finding to the QAPI committee monthly. QAPI committee will determine ongoing monitoring and interventions.	6/30/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Coleen McCarty	Interim Administrator	6/24/2022

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F 658	Continued From page 1	F 658		

was to be set at 2 LPM.
*She used the portable O2 tank when she went out of her room for meals and activities.

Review of resident 10's medical record revealed her:
*Diagnoses included: Heart failure.
-Atherosclerotic heart disease.
-Atrial fibrillation.
-Peripheral vascular disease.
-Chronic kidney disease.
*Care plan included O2 therapy to maintain oxygen saturations greater than 90 percent.
*Physician orders included O2 on per nasal cannula continuously for shortness of breath.
-This order did not include LPM.

Interview on 6/1/22 at 5:28 p.m. with director of nursing B regarding O2 use by resident 10 revealed:
*Resident 10 required 2 LPM of O2.
*The LPM would have been listed in the physician orders.
-Upon review of physician orders, agreed there was no LPM ordered.
*She expected the O2 order to include LPM.

Interview on 6/2/22 at 2:30 p.m. with administrator A regarding O2 use by residents revealed:
*She would have expected a physician's O2 order to include LPM.
*A nurse receiving the O2 physician order should have clarified the order to include LPM.
-If the order had been during a shift change, the oncoming nurse should have clarified the order.

Review of the provider's 12/2/21 Physician/Practitioner Orders policy revealed:

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F 658	Continued From page 2 *"Purpose: -To provide individualized care to each resident by obtaining appropriate accurate and timely physician/practitioner orders." *"Physician/Practitioner Orders Content -1. Clarification orders are needed when reviewing any type of physician/practitioner orders that are incomplete or raise questions." --"Orders may need to be clarified for the following reasons:...dosage questions, ..." -"If any question arises, nursing services is responsible for obtaining clarification." Review of the provider's 5/3/22 Oxygen Administration policy revealed: *"Policy: Oxygen administration is carried out only with a medical provider order. A licensed nurse or other employee trained according to state regulations in the use of oxygen will be on duty and is responsible for the proper administration of oxygen to the resident." *"Procedure: -Oxygen cylinder --1. Verify physician order." --"8. Turn gauge to start flow rate at prescribed liters per minute (per physician's orders) and make sure the oxygen is flowing freely. (Usual flow rates are 2 to 6 LPM with nasal cannula; 8 to 10 LPM with face mask or facial tent; oxygen concentrator 1 to 2 LPM.)" -"Oxygen Concentrator..." --8. Turn flow rate control slowly clockwise until center of ball in flow rate indicator moves up to number of liters per minute as ordered by physician (usually one to two LPM)."	F 658		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880	Directed Plan of Correction Good Samaritan Society Miller F880	6/30/2022

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F 880	Continued From page 3 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880	Corrective Action: 1. For the identification of lack of: * Appropriate infection control practices during environmental cleaning by housekeeping staff. * Appropriate techniques for placing barrier before supplies are set-up and change of "cover" over dressing during a wound care procedure. The administrator, DON, and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas. All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by 6/30/2022 by environmental services manager for infection control practices during environmental cleaning; and by 6/30/2022 by Director of Nursing (DON) for licensed nurses on appropriate techniques during wound care. 2. Identification of Others: ALL residents and staff have the potential to be affected by lack of: * Appropriate resident care needs as noted in above identified care areas. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by 6/30/2022 by environmental services manager and Director of Nursing.	

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F 880	Continued From page 4 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: A. Based on observation, interview, and policy review, the provider failed to prevent cross-contamination during floor care during one of one sampled resident 28's room cleaning by housekeeper E. 1. Observation and interview on 6/1/22 at 10:59 a.m. of housekeeper E cleaning resident 28's room revealed: *She had worked in housekeeping for one year and had received her training from another housekeeper.	F 880	System Changes: 3. Root cause analysis conducted answered the 5 Whys: Administrator, DON, QAPI, Environmental Services, and Quality Advisor participated in RCA. For infection control during wound care, it was determined adequate staff training was not provided during the onboarding of the nurse. For potential cross-contamination during housekeeping, facility leaders were unaware of need to change mop heads believing risk was eliminiated by strength of cleaning product being used. Administrator, DON, medical director, and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency and documentation. DON, Administrator, Environmental Services manager, and Business Office manager contacted the South Dakota Quality Improvement Organization (QIN) on 6/23/2022. QIN reviewed 2567 and F880 citation examples and provided best practices for related infection control concerns. ESM confirmed microfiber mop heads have been implemented with a clean mop head being used for each resident room. DON implemented use of nonpermiable deli paper to be used as barrier during dressing changes and wound care. Barriers have been placed in wound kits to be readily available. QIN gave tutorial of GPQIN website and available resources.	

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F 880	Continued From page 5 -In that time she had no other training about housekeeping or infection control. *She stated she used the same mop head and mop water for multiple rooms and bathrooms, changing the mop water halfway through her cleaning. Interview on 6/2/22 at 12:05 p.m. with supervisor ancillary services D regarding the process for environmental cleaning and disinfecting revealed: *He and another housekeeper trained new staff during their orientation period. *Training was completed on all the chemicals and what they do to include: -Wet times. -What chemicals to use for clostridium difficile and Methicillin-resistant Staphylococcus aureus (MRSA). -To wipe down everything in the room. -Staff were to use one rag for each half room. -The bathroom was cleaned last. -3M Quat disinfectant was used to clean floors. --It was mixed with water in a mop bucket and they used a mop. *When asked about changing mop heads he denied housekeepers were trained to use one mop head for each room or to not use the same mop head & mop water between resident rooms and bathrooms. *He agreed this posed a risk for cross contamination between resident rooms and bathrooms and did not maintain infection prevention or follow the facility's Standard Cleaning policy. Interview on 6/2/22 at 2:45 p.m. with administrator A regarding the process for environmental cleaning and disinfecting revealed: *She was unaware of the floor cleaning process.	F 880	Monitoring: 4. Administrator, DON, and/or designee will conduct auditing and monitoring 2 to 3 times weekly over all shifts to ensure identified and assigned tasks are being done as educated and trained. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. * Staff compliance in the above identified area. * Any other areas identified through the Root Cause Analysis. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by administrator, DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	

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F 880	Continued From page 6 *Her expectation was the housekeeping staff follow the facility policy and maintain infection control. *She agreed using the same mop water and mop head in several residents rooms and bathrooms would be a concern for cross contamination. *She agreed the current floor cleaning process was not consistent with the facility's Standard Cleaning policy. Review of the facilities 2/18/22 Standard Or Light Cleaning policy revealed: *"Purpose -To provide procedures for the proper, daily cleaning of resident rooms. *Background -Rehabilitation/skilled care settings provide care and services to residents who are often vulnerable to infections and the effects of infections due to weakened immune systems. As such, thorough, routine, and high quality cleaning procedures are necessary to minimize the prevalence of infection." *"Procedure" -"4. Microfiber rags and mops are recommended. Unused rags and mop cloths should be used for each room." -"11. Daily damp mopping is much more manageable when employing a microfiber mop system." B. Based on observation, interview, and policy review, the provider failed to place a barrier for dressing supplies and ensure a new Tubigrip was used during wound care by registered nurse (RN) G for one of one sampled resident 27. 1. Observation and interview on 6/2/22 at 9:29 a.m. with RN G completing wound care for	F 880		

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F 880	Continued From page 7 resident 27 revealed: *After collecting wound care supplies she placed them on the seat of her recliner without placing a barrier. *When surveyor inquired about use of a barrier, she obtained paper towels from the bathroom, placed them on the seat and then replaced the supplies on the towels. *She proceeded with the wound care. *As RN G completed the wound care and was pulling the soiled Tubigrip back over the new Telfa, the surveyor inquired about the re-use of the Tubigrip, she stopped and obtained a new piece of Tubigrip and completed the care. Interview on 6/2/22 at 3:32 p.m. with director of nursing (DON) B regarding infection control revealed: *She was the facilities designated infection preventionist. *She had completed the required Centers for Disease Control and the provider's infection preventionist training and certification. *Staff were educated and completed competencies on infection prevention at new hire orientation and annually. *They had one specific place for wound supplies storage in the residents room. *Nursing was to clean a surface and place a barrier. *Nursing was to pull all wound care supplies that were needed and place them on the barrier. *Her expectation was for nursing staff to use a clean surface and a barrier for wound care supplies. *Her expectation was for nursing staff to change Tubigrip during wound care if it had drainage on it.	F 880		

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F 880	Continued From page 8 Review of the facility's Wound Dressing Change policy revealed: *"PURPOSE -To promote wound healing. -To help wound remain free of infection. *Equipment -Gloves -Dressings -Tape -Plastic bag for disposal of soiled dressings -Solution to clean wound -Gauze wipes" *"PROCEDURE" -"8. Create field with equipment/dressing wrappers. Use sterile technique if required."	F 880		

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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 5/31/22 through 6/2/22. Good Samaritan Society Miller was found in compliance.	E 000		

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

Coleen McCarty Administrator June 23, 2022

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	435124	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/02/2022**

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 6/2/22. 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 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K741 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
		K741	On 6/2/2022 Environmental Services manager placed approved ashtray smoking poles and covered metal containers at both designated smoking areas. Environmental services manager or designee will audit designated smoking areas to ensure smoking poles and covered metal containers are available and staff and residents are using them appropriately. Audits will occur weekly x2, every other week x2 and monthly x1. Environmental services manager or designee will report audit findings to the QAPI committee monthly. QAPI committee will determine ongoing monitoring and interventions.	6/23/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Coleen McCarty	Interim Administrator	6/24/2022

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STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	435124	A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	**6/2/2022**

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 741	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to include proper ashtrays and metal containers in one of two areas where smoking was permitted. Findings include: 1. Observation on 6/2/22 at 11:15 a.m. revealed two staff persons outside the building adjacent to the soda vending machines at the back of the building. There was not an acceptable ashtray of noncombustible material and safe design located in that area. There was not a metal container with a self-closing cover device into which ashtrays could be emptied readily available for use in that area. Interview with the maintenance supervisor at the time of the observation confirmed that finding.

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The above isolated deficiencies pose no actual harm to the residents

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10651	A. BUILDING: _____ B. WING _____	06/02/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 5/31/22 through 6/2/22. Good Samaritan Society Miller was found not in compliance with the following requirement: S323.	S 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
S 323	44:73:08:06 Documentation of Drug Disposal Legend drugs not controlled under SDCL chapter 34-20B shall be destroyed or disposed of by a nurse and another witness. Destruction or disposal of medications controlled under SDCL chapter 34-20B shall be witnessed by two persons, both of whom are a nurse or pharmacist, as designated by facility policy. Methods of destruction or disposal may include: (1) Disposal by using a professional waste hauler to take the medications to a permitted medical waste facility or by facility disposal at a permitted municipal solid waste landfill. Prior to disposal all medications shall be removed from original containers and made unpalatable by the addition of adulterants and alteration of solid dosage forms by dissolving or combination into a solid mass; (2) Return to the dispensing pharmacy for destruction or dispose according to federal and state regulations; (3) Return to an authorized reverse distributor company licensed by the South Dakota Board of Pharmacy; or (4) Release to resident upon discharge after authorization by the resident's prescribing practitioner. This Administrative Rule of South Dakota is not met as evidenced by:	S 323	By 6/30/2022, DNS or designee will provide education to all licensed nurses and medication aides regarding proper disposal and documentation of resident medication upon discharge. To ensure deficient practice will not recur, upon discharge a licensed nurse will document in the electronic medical record if medications will be sent will be destroyed, returned to pharmacy, or sent with the resident under order of the provider. Non-controlled drugs destroyed in house will be recorded on GSS-247B form by a licensed nurse and witnessed by either a licensed nurse, pharmacist of medication aide. Controlled substances destroyed in house will be recorded on GSS 247 form by a registered nurse and witnessed by either a registered nurse or a pharmacist. Non-controlled medications sent with resident upon discharge will be record in the EMR by a licensed nurse and include the quantity of each drug sent with the resident. Another nurse or medication aide will make a notation in the EMR affirming the resident discharged with the medications. Controlled medications sent with the resident will be documented on the GSS-247 form and signed by two licensed nurses. Non-controlled medications to be returned to the pharmacy will be recorded by a licensed nurse on the form provided by the pharmacy and witnessed appropriately. Controlled medications may not be returned to the pharmacy and will be destroyed in-house. All forms used for documentation will be scanned into the medical record. To monitor compliance, DNS or designee will audit chart of each resident discharged during the look back period to ensure proper disposal and documentation of medication. Audits will occur weekly x2, every other week x2 and monthly x2. DNS or designee will report audit finding to the QAPI committee monthly. QAPI committee will determine ongoing monitoring and interventions.	7/8/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Coleen McCarty

TITLE: Interim Administrator

(X6) DATE: 6/24/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 323	Continued From page 1 Based on closed record review, interview, and policy review, the provider failed to ensure medications were: *Destroyed by two witnesses at the time of discharge for one of one sampled resident (35). *Accounted for at the time of discharge for one of one sampled resident (36). Findings include: 1. Review of sampled resident 35's closed record revealed: *He had been admitted on 6/15/16. *He passed away at the facility on 3/6/22. *His medications included: -Atropine 1% solution and had approximately one-half of a bottle remaining. -Acetaminophen 500 mg and had 42 pills remaining. --The disposition record reflected destruction of his medications had been signed off by a nurse with no witness. 2. Review of resident 36's closed record revealed: *She was admitted on 2/25/22. *She was discharged on 3/28/22 to an assisted living facility. *There was no documentation to support what had been done with her medications at the time of her discharge. 3. Interview on 6/2/22 at 1:30 p.m. with director of nursing B regarding accounting for medications when residents were discharged or passed away revealed: *Medication disposition records, including name of medication and the amount of medication, should have been completed at the time of discharge or death and located in each resident's chart. *She confirmed the destruction of non-controlled	S 323		

South Dakota Department of Health

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S 323	Continued From page 2 medications had been completed by one person for resident 35. *She reported resident 36's medications had been returned to the pharmacy and that there had been no documentation of what or how many medications were returned. *She confirmed the provider's policy had not been followed. Interview on 6/2/22 at 2:10 p.m. with administrator A regarding accounting for medications on the discharge of a resident revealed: *Her expectation would have been that non-controlled medications required a nurse and a witness when destroying them. *She confirmed the provider's policy had not been followed. Review of the provider's 7/1/21 medication disposition policy revealed: *"Purpose - to ensure accurate disposal of medications". *"Policy - to provide instruction for the disposition of medications". *"Procedure - ... -Disposal of any medication will be carried out under local,state and federal guidelines or in consultation of the pharmacist in the appropriate disposal procedure. Documentation will include the resident's name, medication name, prescription number (as applicable), quantity, date of disposition and the involved staff member, consultant or other applicable individuals".	S 323		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article	S 000		

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S 000	Continued From page 3 44:74, Nurse Aide, requirements for nurse aide training programs was conducted from 5/31/22 through 6/2/22. Good Samaritan Society Miller was found in compliance.	S 000		