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
	435075	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY HOWARD	300 WEST HAZEL AVENUE HOWARD, SD 57349

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/27/23 through 9/28/23. Good Samaritan Society Howard was found not in compliance with the following requirement: F609.	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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609	All incidents of injuries of unknown source will be reported within the 2hr timeframe to the designated agencies. Audits will be done by the QAPI coordinator, Administrator, or designee weekly x 4 weeks, then monthly for 6months on all incidents of injuries of unknown source. Audit findings will be brought to the monthly QAPI committee meeting for review. Any negative findings from the audit will be reviewed and corrected by the IDT immediately All residents that had any incidents involving injuries of any kind within the last 3months will be reviewed to ensure proper reporting to the	10/23/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jody Becker (N) — TITLE: Administrator — (X6) DATE: 10-19-23

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	435075	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY HOWARD	300 WEST HAZEL AVENUE HOWARD, SD 57349

(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 609	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review the provider failed to ensure one of one sampled resident (37) who had an injury of unknown origin was thoroughly investigated and reported to the South Dakota Department of Health (SDDOH). Findings include: 1. Review of resident 37's electronic medical record revealed her: *Diagnoses included: Parkinson's Disease, schizophrenia, bipolar disorder, anxiety disorder, major depressive disorder, muscle weakness, mild cognitive impairment, and pain in her right knee. *Medications included: Haldol (used to treat mental/mood disorders) and risperidone (used to treat bipolar disorder and schizophrenia. *Care plan included that she: -Had communication problems related to her Parkinson's disease. -Used a wheelchair for mobility. -Required a mechanical lift and two staff members to assist in transferring between surfaces. -Required total assistance of a staff member for positioning when in bed. *On 9/4/23 a "Suggestion or Concern" form was completed that indicated certified nursing assistants (CNA) heard a "popping" sound when repositioning resident 37. -On 9/5/23: --Resident 37 was interviewed and denied having had a fall or difficulty with transfers. --Two CNAs were interviewed and stated there had been no difficulty with transfers or with repositioning.	F 609	dedicated agencies was done, if any found that were not reported, the interdisciplinary team will report to the designated agencies. System process that has been changed to ensure no other potential residents are affected from not reporting timely to designated agencies is to report all injuries of unknown origin regardless if resident was discharged from facility. To ensure no other residents are affected our Interdisciplinary team meets to review incidents of falls, injuries, and injuries of unknown origin All charge nurses and staff have been re-educated on the policy to report any allegation including injuries of unknown origin immediately to the administrator, social worker, dns. Administrator, Social Worker, and DNS will then report to the designated agencies immediately, but not later than 2hours after the incident/allegation was done on OCt 12th. Audit findings of incident reports, allegations, and suggestion and concern forms will be used as a data source to ensure the process of reporting is being followed.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 2 --A charge nurse was interviewed and had knowledge of a "popping sound" while staff were providing care to her. --There had been no other identified concerns from the resident or staff. *Review of resident 37's medical record revealed: -A progress note dated 9/5/23 indicated: "Resident continues to c/o [complain of] pain and states her legs hurt bad. Will continue to monitor and repositioned with the right leg on a pillow. Resident closes her eyes off and on." -On 9/5/2023, at 10:14 a.m. the provider sent a facsimile to the primary care provider (PCP) that included the following: --When she had been repositioned on the night of 9/3/23 the staff heard a "loud pop." --She complained of "right knee into hip pain." -The PCP ordered an x-ray of her right knee to have been done on 9/6/23 due to her knee pain. -A nurse's progress note on 9/5/23 at 1:05 p.m. revealed she complained of an increase in "pain in her right hip area to the fore right thigh." -A nurse's progress note on 9/6/2023 indicated she had x-rays taken of her knee "due to knee and hip pain." *On 9/8/23, the PCP noted "knee xray reviewed" and "She has severe arthritis sometimes joints can make popping sounds with arthritis." *On 9/10/2023, resident 37: -Had her gastrostomy tube displaced. -Was transported to the hospital via ambulance. -Was admitted to the hospital for a fracture of her right hip. *On 9/10/23, a radiology report noted "Acute right subtrochanteric right femoral fracture." Interview on 9/28/23 at 3:07 p.m. with director of nursing (DON) B regarding resident 37 revealed:	F 609		

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F 609	Continued From page 3 *She had used a full-body mechanical lift for transfers. *She had a feeding tube in place for her nutrition. *She went to the emergency room on 9/10/23 due to having pulled out her feeding tube and she was having high blood sugars, not for any "pain or her hip". *She passed away on 9/11/23. *"We were waiting for some kind of information from hospital/final report." *The protocol for investigations was: -Investigations occurred when an incident on the premises, or a resident was out of the facility, or staff took a resident out and something happened was reported. -She had no knowledge of the hip fracture until after resident 37 had passed away. -She had not completed an investigation for the hip fracture. --She had not thought that a report needed to have been be filed with the SDDOH as resident 37 had passed away. -She agreed resident 37's hip fracture was an injury of unknown origin and should have been reported to the SDDOH. Interview on 9/28/23 at 4:14 p.m. with administrator (ADM) A regarding resident 37's fractured hip revealed: *The protocol was for any abuse or neglect allegation to have been reported to the SDDOH within two hours of notification of the allegation. -The ADM, DON, or social service designee would have completed and filed the report. -An investigation would have been started. -She was made aware of resident 37's hip fracture the day after she had died. -She had not reported the hip fracture to the SDDOH as they had not been aware if the	F 609		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 609	Continued From page 4 fracture occurred while resident 37 was in the facility. -She stated, "We had no incident, no trauma." -She agreed the hip fracture should have reported. Review of the provider's 10/13/22 Abuse and Neglect Policy revealed: *"Purpose" -"To ensure that all identified incidents of alleged or suspected abuse/neglect, including injuries of unknown origin, are promptly reported and investigated." *"Procedure" *"4. Notification procedures:" -"c. Designated agencies will be notified in accordance with state law, including the State Survey and Certification Agency." --"If there is an allegation ..., including injuries of unknown source ..., then it will be reported immediately, but not later than two hours after the allegation is made."	F 609		

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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 9/27/23 through 9/28/23. Good Samaritan Society Howard was found in compliance.	E 000		

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

Jody Becker | Administrator | 10/16/2023

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OCT 16 2023

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
	10631	A. BUILDING: _____ B. WING _____	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY HOWARD	300 W HAZEL AVE HOWARD, SD 57349

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 9/27/23 through 9/28/23. Good Samaritan Society Howard 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 9/27/23 through 9/28/23. Good Samaritan Society Howard was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jody Becker

TITLE: Administrator

(X6) DATE: 10/16/2023

STATE FORM 6899 PIN311 If continuation sheet 1 of 1

OCT 16 2023

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

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	435075	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/27/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY HOWARD	**300 WEST HAZEL AVENUE** **HOWARD, SD 57349**

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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 9/27/23. Good Samaritan Society Howard was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 9/28/23. Please mark an F in the completion date column for K233 and K241 deficiencies identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K321 and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 233 SS=C	Clear Width of Exit and Exit Access Doors CFR(s): NFPA 101 Clear Width of Exit and Exit Access Doors 2012 EXISTING Exit access doors and exit doors are of the swinging type and are at least 32 inches in clear width. Exceptions are provided for existing 34-inch doors and for existing 28-inch doors where the fire plan does not require evacuation by bed, gurney, or wheelchair. 19.2.3.6, 19.2.3.7 This REQUIREMENT is not met as evidenced by: Based on measurement and document review,	K 233		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jody Becker
TITLE: Administrator
(X6) DATE: 10/16/2023

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K 233	Continued From page 1 the provider failed to maintain proper exit access door widths for two of two randomly observed sets of cross-corridor doors (north and east of the nurses' station). Findings include: 1. Measurement on 9/27/23 at 12:30 p.m. revealed each leaf in the pair of one-hour fire-rated cross-corridor doors to the north of the nurses station measured 30 inches in clear width. That clear opening width did not provide the minimum requirement of 32 inches. Review of the previous survey report confirmed the condition was part of the original construction. 2. Measurement on 9/27/23 at 12:40 p.m. revealed each leaf in the pair of one-hour fire-rated cross-corridor doors east of the nurses station measured 31.5 inches in width. That clear opening width did not provide the minimum requirement of 32 inches. Review of the previous survey report confirmed the condition was part of the original construction. 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 233		F
K 241 SS=C	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment.	K 241		

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K 241	Continued From page 2 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced by: Based on observation and document review, the provider failed to ensure at least two conforming exits existed from each floor of the building (basement has only one conforming exit). Findings include: 1. Observation on 9/27/23 at 11:51 a.m. revealed the basement did not have a conforming exit. The primary exit was the basement stairway that discharged onto the main level corridor system. The second basement exit was through a window to an area well-equipped with a fixed ladder. Review of the previous survey report confirmed the condition existed since the original construction. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct the deficiencies identified in K000.	K 241		F
K 321 SS=C	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	K 321		

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K 321	Continued From page 3 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) 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 a hazardous area (physical therapy storage room) as required. Findings include: 1. Observation on 9/27/23 at 3:30 p.m. revealed the physical therapy storage room was over 100 square feet and had large amounts of combustibles stored in it. The door was not equipped with an automatic closer. Interview with the director of maintenance at the time of the above observation confirmed the finding. The deficiency affected one of numerous requirements for hazardous storage rooms and had the potential to affect 100% of the occupants of the smoke compartment.	K 321	The door to the physical therapy storage room has been equipped with a static door closer and spring loaded hinges to ensure proper closing. Audits will be performed by maintenance supervisor or designee to ensure door closes automatically weekly x 4 weeks, monthly x 4months. Audit findings will be brought to QAPI monthly committee meetings by maintenance supervisor. Any negative findings from the audits will be corrected by maintenance supervisor at the time of the finding.	10/20/23

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K 712 K 712 SS=E	Continued From page 4 Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (inadequate number of required fire drills). Findings include: 1. Record review on 9/27/23 at 3:00 p.m. revealed there was no documentation of any second-shift fire drills for quarter one (October, November, and December) or for first-shift fire drills for quarter two (January, February, and March) in the past twelve months. Ten fire drills were conducted during the past twelve months. Interview with the environmental services supervisor at the time of the record review confirmed those findings. She was unaware the minimum number of fire drills per the required frequency had not been met for each shift during the past twelve months. The deficiency had the potential to affect 100% of the occupants of the building.	K 712 K 712	Fire Drills have been scheduled monthly to have 1 fire drill per shift done quarterly per regulation. Audits will be done monthly x 6months to ensure drills are done according to regulation. Audits will be done by the Qapi coordinator, or designee, all findings will be brought to the monthly QAPI meeting for review. Re-education on fire drill regulation was done to Environmental services supervisor on 10/12/23 by Administrator along with the Fire drill schedule.	10/20/23

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