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 _____	05/13/2021

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 Surveyor: 40053 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 5/10/21 through 5/13/21. Good Samaritan Society New Underwood was found not in compliance with the following requirements: F558, F656, F686, F692, F755, F800, F804, and F812.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Surveyor: 42558 Surveyor: 40053 Based on observation, interview, record review, and policy review, the provider failed to accommodate two of two sampled residents (19 and 23) for Broda chair positioning and dining accommodations. Findings include: 1. Observation and record review on 5/10/21 from 5:30 p.m. through 7:30 p.m., 5/11/21 from 8:00 a.m. through 5:00 p.m. and 5/13/21 from 8:30 a.m. through 12:30 p.m. of resident 23 revealed he: *Had been admitted on 5/13/20. *Had used a Broda chair. *He had been given the Broda chair by his	F 558	1. Resident 23 BRODA wheelchair: Resident has been referred to Occupational Therpay to evaluate for positioning. Therapy recommendations include pl acement of wedge on resident's right side to prevent leaning to one side. Therapy also recommends a wedge cushion between residents legs that assist res ident with equal weight bearing to hips and prevent sliding down in wheelchair. Care plan has been up dated to reflect BRODA wheelchair postitioning as well as cushion and wedge placement. Care plan up dated on 06/03/2021. Resident 19 dining accomodations: Resident was last treated by Occupational Therapy on 05/28/2021. Res ident continues to refuse adaptive silverware but will continue to utilize two handled cup for liquids. Diet has been included to have food provided in bite size to allow for independent dining. Resident will sit at assist table for increased cuing. Care plan updated 06/03/2021. All residents have potential to be affected by failure to accomodate to resident's individual needs. 2. Therapy to evaluate/treat residents for proper fitting wheelchair and dietary adaptaions by 06/09/2021 if needed. Residents will be reevaluated and document ed quarterly at Quality of Life/Care Conference meet ings. 3. DNS or designee will complete audits 3 times a week for 3 weeks, then weekly for 3 weeks, then mon thly for 3 months. Each resident will then be reviwed quarterly. Audits will be brough to monthly QAPI meet ing to be discussed with IDT for recommendation for continuation/discontinuation/revisions based on audit findings. DNS WILL SUBMIT AUDITS TO QAPI. - IR 6/9/2021	06/09/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Aden Ramey | TITLE: Administrator | (X6) DATE: 06/09/2021

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.

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 _____	05/13/2021

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 558	Continued From page 1 advocate, Black Hills Advocates. *Had diagnoses which included left hemiparesis, cerebral infarction, type 2 diabetes, neuromuscular dysfunction of the bladder, and vascular dementia with behavioral disturbance. *His Brief Interview for Mental Status (BIMS) assessment resulted in a score of five indicating he had severe cognitive impairment. *Random observations throughout the survey revealed his Broda chair was equipped with cushioned areas: -On the foot rest. -Back of the head area. -Seat. -Upper sides, near the head and shoulders. *Continued observation revealed he slumped to the right in the chair. -This caused him to be below and in front of the upper side cushion's support attached to the chair at the head and shoulder area. --Due to their location the upper side supports had been useless to him. 2. Interview on 5/11/21 at 10:20 a.m. with resident 23 revealed he would like his upper side supports on his Broda chair adjusted so he did not slump forward and to the right while he sat in his chair. 3. Interview on 5/12/21 at 3:36 p.m. with the director of nursing B concerning resident 23's Broda chair support cushions revealed she could talk to therapy and have them look at it and see what they could do to give him more support. SURVEYOR 42558 4. Observation on 5/10/21 from 5:39 p.m. through 6:25 p.m. of resident 19 in the dining room revealed she: *Had severe contractures to her bilateral hands	F 558		

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 _____	05/13/2021

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 558	Continued From page 2 and wrists. -Had been unable to open her index through little fingers on both hands as they were pressed tightly against her palms. *Held her spoon between her thumb and forefinger with difficulty. -Observed her drop her spoon several times in an attempt to hold the spoon and scoop up her food. -Did not have any adaptive equipment located with her place setting. *Had not eaten any of her main meal. *Had received eating assistance from certified nursing aid (CNA) K after her main meal was removed and the ice cream dessert had been served. -Had eaten only bites of ice cream offered from CNA K. SURVEYOR 40053 5. Observation on 5/12/21 at 11:45 p.m. of resident 19 in the dining room revealed: *The lunch meal consisted of: -Chicken enchiladas. -Sweet and sour meatballs. -Rice. -Vegetable. *She was using a spoon to eat her meal. *Both of her wrists and hands had contractures. *She was unable to use that utensil to get a spoonful of food. *Neither the enchilada casserole nor the meatballs had been cut into pieces. -She put the side of the spoon onto the enchilada casserole and made a downward motion as if trying to cut it but nothing happened. *She was able to scrape a small amount of cheese from the enchilada casserole with her spoon and place that into her mouth. -She did not have an assistive utensil.	F 558		

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 _____	05/13/2021

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 558	Continued From page 3 *No one was assisting or supervising her. *She put her spoon down and fell asleep at the dining room table. 6. Review of resident 19's complete medical record revealed: *She had been admitted on 3/5/21. *Her diagnoses included muscle weakness, unsteadiness on feet, abnormalities of gait and mobility, SICCA Syndrome (auto-immune disease characteristic dry eyes, dry mouth, and another connective tissue disease such as rheumatoid arthritis, also known as Sjogren syndrome) and dementia with behavioral disturbances. *Her BIMS test resulted in a score of three indicating severe cognitive impairment. *Her undated care plan indicated "The resident expresses need for customized dining services R/T [Related to] contracture of hands" and was to be supervised during meals. 7. Interview on 5/12/21 at 2:55 p.m. with DON B concerning resident 19 and assistive devices revealed she was unaware who would make the request or to whom the request would be submitted, but she would look into it and get it onto her care plan. 8. Review of the providers revised 9/8/20 Accommodation of Resident Need- Rehab/Skilled Policy revealed: *"PURPOSE -To ensure resident individual needs and preferences are reasonably accommodated. *POLICY -The resident has the right to reside and receive services in the center with reasonable accommodations of individual needs... *PROCEDURE	F 558		

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 _____	05/13/2021

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 558	Continued From page 4 -1. The center should attempt to adapt things such as staff schedules and room arrangements to accommodate residents' preferences, desires, and unique needs, i.e., furniture that enhances the resident's ability to maintain their independence in sitting and rising, such as seating choices of different types, sizes, firmness, depth, and height;... -3. In addition, this includes accommodating food, activity, or room choices. *PROCEDURE Wheelchair Position Normal Sitting Postural Alignment. -3. Resident is upright positioning and weight-bearing equally at hips (does not lean to one side)." 9. Review of the provider's last reviewed 12/17/20 Assistive Devices-Food and Nutrition Services Policy revealed: *"PURPOSE: -To provide assistive devices to maintain or improve the resident's ability to eat independently. *POLICY: -The location provides assistive devices (e.g., special eating equipment and utensils) for residents who need these items. *PROCEDURE: -1. The interdisciplinary team, including the director of food and nutrition services (DFN), determines the need for assistive devices. -2. The location maintains a basic supply of assistive devices... -6. Effectiveness of devices is evaluated initially and then at least quarterly..."	F 558		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656	1.Resident 8 care plan has been updated to ensure resident recieves adequate nutrition and dietician's recommendations are followed on 06/03/202. All residents are at potential risk by failing to update care plan timely. 2. Administrator, DNS, and Dietary Manager re-	06/09/21

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 _____	05/13/2021

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 656	Continued From page 5 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656	viewed Accomodation of Resident Needs policy on 05/14/2021. Education provided to dietary manager by dietician on care planning dietary recommendations timely to ensure residents weight loss is addressed timely on 05/16/2021. 3. DNS, QAPI Coordinator, or designee will audit resident care plans to ensure dieticians recommend ations are being followed twice monthly for one mo-nth, then monthly for two months. Audits will be br-ought to monthly QAPI meeting to be discussed with IDT for recommendation for continuation/discontin-ation/revisions based on audit findings. Type text here DNS, QAPI COORDINATOR, OR DESIGNEE WILL SUB MIT AUDITS TO QAPI. - IR 6/9/2021	

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 _____	05/13/2021

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 656	Continued From page 6 section. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on observation, interview, record review, and policy review, the provider failed to implement and follow a comprehensive care plan for two of twelve sampled resident (8 and 19) to ensure they had received services they required and appropriate care. Findings include: 1. Review of resident 8's medical record revealed: *She was admitted on 2/4/20. *Her diagnosis included: fracture of right femur, altered mental status, other specified mental disorders due to known physiological condition, essential hypertension, hyperlipidemia, dementia with behavioral disturbance, and anemia. *Her 5/3/21 brief interview for mental status was six, indicating severely impaired cognition. *Her weight on: -2/4/2021 was 135.2 pounds. -3/5/2021 was 132.0 pounds. -4/3/2021 was 131.0 pounds. -5/8/2021 was 120.8 pounds. *She had a significant weight loss of 7.79% from 4/2/21 to 5/8/21. *She had a 10.65% weight loss since admission. Interview on 5/11/21 at 2:56 p.m. with resident 8 revealed she: *Often did not like the food and did not eat. *Did not like to complain so would not tell the staff she didn't like it or ask for something different. *Indicated for lunch she had a variety of main dishes served; mashed potatoes and roast beef smothered with gravy, and spaghetti bake on her plate were unappetizing.	F 656		

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 _____	05/13/2021

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 656	Continued From page 7 *Was concerned because she felt like she was losing weight. Interview on 05/12/21 at 11:39 a.m. and at 1:52 p.m. with nutrition and food service supervisor C regarding resident 8 revealed she: *Was aware resident 8 was losing weight. *Was aware resident 8 did not like some of the food that was offered. -Had offered different items. -Resident 8 would not take the other items. *Was not aware resident 8 did not like all the different foods on her plate. *Had not documented all the interventions that had been tried to get resident 8 to eat. *Was responsible for dietary care plans. *Had not put interventions on her care plan yet because she was waiting for her condition to improve. *Had been giving her mighty shakes with meals, but this was not documented. Interview and record review on 05/12/21 at 12:44 p.m. with director of nursing/registered nurse B regarding resident 8 revealed: *Resident weights are reviewed daily at morning meetings with department heads. *She had been aware resident 8 was losing weight. *It was nutrition and food services supervisor's responsibility to update and revise the nutrition care plan. Review of the RD nutritional status notes for resident 8 revealed: *On 2/15/2021: -Resident 8 had poor intakes the previous two to three days. -Goal was to maintain weight from 135-140	F 656		

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 _____	05/13/2021

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 656	Continued From page 8 pounds. *On 3/5/2021: -Weight was 132 pounds. -Goal was to maintain weight from 135-140 pounds. -Plan to review weight and intakes with nutrition and food service supervisor C related to poor intakes and weight being lower than the goal weight. *On 3/25/2021: -Weight on 3/21/21 was 127.8 pounds. -Goal was to avoid any further weight loss and new goal of 127-135 pounds. -Recommendations had been made for: --"8 oz. [ounces] chocolate milk hot or cold or chocolate Mighty Shake or cocoa mix made with 8 oz. milk 1-3x/day [one to three times a day] r/t [related to] how often resident accepts." --"If wt below 127 lbs [pounds] then recommend 2 oz. 2.0 Med pass tid [three times a day] between meals.". --"Report any further wt loss to RD for follow up and any triggered wt [weight] loss to MD [medical doctor]." --None of the recommendations had been implemented. Review of resident 8's revised 5/10/21 care plan revealed: *Her current body weight was 135 pounds. *Goal: "Feels supported in decision keep weight within 10 lbs [pounds] of current weight." *Interventions: -"Dietitian, healthcare provider, medical director to discuss strategies for keeping weight stable." -"Encourage resident to attend activities that promote physical activity and socialization: enjoys knitting and sitting at the nurse's station." -"Praise all resident's progress or efforts."	F 656		

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 _____	05/13/2021

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 656	Continued From page 9 *It had not addressed the residents weight loss. Review of the provider's 5/10/21 Interventions for Nutritional Risk of Residents-Food and Nutrition policy revealed: *The purpose: "To provide guidelines for interventions for residents at risk for decline in nutritional status." *"The director of food and nutrition services will interview residents identified to be at nutritional rick and/or their caregivers/family to identify interventions that meet the resident's food/beverage preferences." *"Care Plan is updated as changes are made." *"Suggestions for employees:" -"Substitutions and alternate menu choices per individual preferences." -"Monitor snacks in PCC [Point Click Care] - POC [Point of Care]." -"Medical nutritional supplement only when absolutely necessary; either two hours before a meal or two hours after a meal (physician order required)." -"Snacks between meals." -"Offer finger foods." -"Provide smaller, more frequent meals." -"Observe residents during meals." Surveyor 40053 Review of the revised 9/8/20 Accommodation of Resident Need Policy revealed: *"PURPOSE -To ensure resident individual needs and preferences are reasonably accommodated." Refer to F686, findings 4, 7, 8, and 9.	F 656		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686	1. Resident 19 was referred for for formal wound care consult with Monument Health. Appointment made for 06/07/2021 and put on waiting	06/09/21

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 _____	05/13/2021

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 686	Continued From page 10 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Surveyor: 40053 Based on observation, interview, record review, and policy review, the provider failed to ensure a resident (19) who was admitted without pressure injury but was identified as a high risk for development of one did not develop pressure inurys. Findings include: 1. Observation on 5/11/21 at 3:40 p.m. of resident 19 during a brief change revealed: *She was laying on her right side in her bed. *She had foam boots on. -She had a pillow between her knees. *Nursing assistant (NA) O and unlicensed assistive personnel (UAP) P were conducting the brief change. *Resident 19 had a 3.5 inch by 3.5 inch border foam dressing on her coccyx area that fell off during the removal of her brief which revealed a wound to that area. -That wound was approximately the size of a half dollar.	F 686	list for any earlier appointment. Wound care specialist from AMT wound care supplier was able to assess on 05/20/2021 and recommended the following: d/c Santyl, continue to irrigate with daikins solution 0.125%, loosely pack w/ calcium alginate and cover with super absorbent dressing. Updated PCP, treatment and careplan per the recommendations on 06/03/2021. All residents have potential to be affected by failing to prevent pressure ulcers. 2. Will provide education to nursing staff re: daily skin assessments by 06/09/2021. The facility will educate nursing staff re: policy for pressure ulcer prevention and documentation requirements including all UDAs and comm unications required, including forms GSS230F-4 - stand ardized wound care fax for physician. Resident's Braden Scale scores to be reviewed and assess ed for interventions to be put in place for prevention as according to GSS Braden Scale guidelines and care plan updated When skin changes do occur, wound data collection and wound RN assessment will be initiated immediately, PCP notified using GSS230F-4, treatment initiated and care plan 3. DNS or designee will audit 3 care plans a week for 3 weeks, then one weekly for 3 weeks, then monthly for 3 months to reflect appropriate interventions have been implemented based on admitting and quarterly Braden Scale score or presence of pressure ulcers. Each res- ident will then be reviewed quarterly. Audits will be brought to monthly QAPI meeting to be discussed with IDT for recommendation for continuation/discontinuation/re visions based on audit findings. DNS OR DESIGNEE WILL PROVIDE EDUCATION THE NURSING STAFF REGARDING DAILY SKIN ASSESS MENTS. - IR 6/09/2021 DNS OR DESIGNEE WILL EDUCATE NURSING STAFF REGARDING PRESSURE ULCER PREVENTION AND DOCUMENTATION REQUIREMENTS INCLUDING GSS230F-4. - IR 6/09/2021 MDS OR DESINGEE WILL REVIEW AND ASSESS THE RESIDENTS BRADEN SCALE SCORES AND PUT I NTERVENTIONS INTO PLACE. - IR 6/09/2021 NURSING STAFF WILL USE STOP AND WATCH TOOL AND OR VERBALIZE SKIN CHANGES AND CHARGE NURSE OR DESIGNEE WILL FOLLOW UP. - IR 6/09/2021 CHARGE NURSE OR DESIGNEE WILL COMPLETE WOUND DATA COLLECTION AND RN ASSESSMENT. - IR 6/09/2021 CHARGE NURSE OR DESIGNEE WILL BE RESPONSIBLE FOR NOTIFYING PCP- IR 06/09/2021	

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 _____	05/13/2021

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 686	Continued From page 11 -Was opened and was able to be looked into approximately one inch. -Was reddened around the outside of the area. -Had a tan colored sticky material at the edge of the bottom portion of the wound which stretched onto her buttock. *That tan colored sticky material was cleansed away by licensed practical nurse (LPN) N who had come into the room to replace the dressing and conducted wound care. *She cleaned the area with Dermal Wound Cleanser and covered the area with a boarder foam. *She stated: -Yesterday the wound had a thin covering over the area that was now open. -They had faxed paperwork to the physician earlier that day for a new order to "Pack the tunneling." -They did not have a current wound nurse, they all took care of wounds. *NA O stated "It looks way worse than it was." -She had last worked and seen the wound five days prior. 2. Record review of resident 19's Minimum Data Set (MDS) revealed: *She had an admit date of 3/5/21. -She was an extensive assist with a two person physical assist for: --Bed mobility, transfers, dressing, toilet use, and personal hygiene. *She had no current pressure ulcers or skin wounds but was at risk of developing them. *She had no open wounds to her heels or feet. *She frequently had urinary incontinence and always had bowel incontinence. *Her Braden scale for predicting pressure ulcers on 3/5/21, 3/12/21, and 3/19/21 were all 18 and	F 686	DNS OR DESIGNEE WILL BE RESPONSIBLE TO INITIATE WOUND CARE TREATMENT AND UPDATE CARE PLAN. - IR 6/09/2021 DNS OR DESIGNEE WILL SUBMIT AUDITS TO QAPI. - IR 6/09/2021	

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 _____	05/13/2021

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 686	Continued From page 12 on 3/26/21 her score was 17, all indicating she was at risk of developing pressure ulcers. *She had a pressure relieving Panacea mattress on her bed and a wheelchair cushion. *She was not on a turning or repositioning schedule. 3. Record review on 5/12/21 of progress notes revealed: *"4/17/21 1945 [7:45 p.m.] Communication/Visit with Physician -Resident noted to have stage II pressure ulcer to left heel, clear fluid filled blister. Will leave open to air, offload and apply foam booties when in bed. PCP [Primary care physician notified]." *There had been no prior progress notes related to this wound before 4/17/21 when it was documented as a stage II pressure ulcer. *"4/19/21 14:22 [2:22 p.m.] Health Status -Resident noted to have red, open area to her coccyx, measuring 2.8 cm [centimeters] x 1 cm. Zinc cream applied, staff reposition and keep area dry." *"4/27/21 15:27 [3:27 p.m.] Health Status ...[Name of certified nurse practitioner (CNP) Q] will also send prescription for a pressure-relieving mattress and pressure-relieving cushion to be used to prevent further skin breakdown. She will also send a prescription for wound tx [treatment] to open area at coccyx." *"5/7/21 1150 [11:50 a.m.] Communication/Visit with Physician Faxed advising of change in wound to coccyx requesting to change treatment to santyl and cover with foam dressing. Also asked if antibiotic would be advised. Requested multivitamin as well per request from dietician." *"5/10/21 13:26 [1:26 p.m.] Communication/Visit with Physician Late entry	F 686		

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 _____	05/13/2021

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 686	Continued From page 13 -Received orders agreeing to Santyl and foam dressing. Also received orders for wound culture ..." *That order was different from what LPN N used on the wound during the 5/11/21 3:40 p.m. wound care that was performed as documented above in finding one. *"5/11/21 09:56 [9:56 a.m.] Communication/Visit with Physician R.D. [Registered Dietician] recommends 8 oz. [ounces] Ensure + BID [two times a day] for calories and protein." *"5/12/21 13:58 [1:58 p.m.] Communication/Visit with Physician -Wound evaluation today, see assessment note with concern over hard induration of pressure ulcer at 12-3 o'clock alert sent to MD [medical doctor] for further evaluation and for wound care orders. *"5/12/21 14:11 [2:11 p.m.] TC [text communication] to wound care consultant, plans on coming in on Monday May 17 to assess wound, discussed wound care recommendations and alert of MD of induration." *There had been no prior progress notes related to this wound before 4/17/21 when resident 19 was noted to have a red, open area to her coccyx, measuring 2.8 cm [centimeters] x 1 cm. 4. Review of resident 19's undated care plan and progress notes revealed: *Intervention dated 3/22/21: -"Provide pressure redistributing Panacea mattress on bed to help reduce pressure when resident is on her bed, and provide a pressure reducing cushion in resident's wheelchair." *A health status progress note dated 4/27/21 at 3:27 p.m. revealed: -CNP Q will also send a prescription for a	F 686		

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 _____	05/13/2021

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 686	Continued From page 14 pressure-relieving mattress and pressure-relieving cushion to be used to prevent further skin breakdown. *Interventions dated 4/17/21: -"Monitor location, size and treatment of skin injury. Report abnormalities, failure to heal, s/s [signs and symptoms] of infection, maceration, etc. to health care provider." -Elevate heels off bed. -Resident needs protection for the feet, foam booties, when in bed. *There was no mention of a stage II pressure ulcer to her left heel. *Those interventions had been put into place after they had found the wound on her left heel and had staged it as a stage II pressure ulcer. *There was no documentation that interventions for her left heel pressure ulcer had been put into place proactively. *There was no documentation in the care plan that she had a pressure ulcer to her coccyx. *There was no documentation in the care plan that she was to be repositioned. 5. Review of Wound Data Collection for resident 19's left heel revealed: *The initial data collection was on 4/17/21 at 7:22 p.m. * The wound measured: -Length 3.25 centimeters (cm). -Width 4.0 cm. *No other measurements were taken through 5/12/21 at 11:48 a.m. when it was documented as: -"1. Stage one possible. -2a. Was this pressure ulcer present on admission/re-admission? --b. No. *Other	F 686		

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 _____	05/13/2021

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 686	Continued From page 15 -1. Wound healed: discontinue weekly RN [registered nurse] assessment." 6. Review of Wound Data Collection for resident 19's coccyx revealed: *The initial data collection was on 4/27/21 at 1:19 p.m. *The wound measured: -Length 2.8 cm. -Width 2.1 cm. *The wound was documented as a stage II pressure ulcer. -2a. Was this pressure ulcer present on admission/re-admission? --b. No. *Documentation on 5/5/21 at 3:17 p.m. indicated: -Length 3.0 cm. -Width 1.6 cm. -Depth 0.2 cm. -Slough 100%. -Reddened. -Indurated. *Documentation on 5/8/21 at 5:00 p.m. indicated: -Length 2.6 cm. -Width 2.4 cm. *Documentation on 5/10/21 at 6:35 p.m. indicated: -Length 2.6 cm. -Width 2.7 cm. -Depth 0.5 cm. *Documentation on 5/12/21 at 1:32 p.m. indicated: -Length 3.0 cm. -Width 2.0 cm. -Depth 1.5 cm. 7. Interview on 5/13/21 at 3:26 p.m. with the director of nursing B concerning resident 19 revealed:	F 686		

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 _____	05/13/2021

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 686	Continued From page 16 *When questioned she was hesitant to agree that they had been more reactive than proactive with resident 19's left heel and coccyx pressure areas. *She could not be positive of when the pressure ulcers began and relied on the progress notes. -Progress notes had not indicated a problem until both areas were staged as pressure ulcers. *She stated she could tell the coccyx wound was tunneling but the wound bed had been covered by a thin layer of skin. -She was not aware the wound bed area was currently open. *She stated resident 19 was not on a repositioning schedule. *She stated they did change her mattress to an air mattress to relieve pressure. *The progress notes revealed the air mattress was discussed ten days after the pressure ulcer to her left heel and eight days after the open red area to her coccyx had been noted. -She was unable to confirm the date the air mattress and wheelchair (w/c) seat cushion had been implemented. *The facility used Point Click Care for documentation. *When care plan's are updated that information carries over to the tasks (Kardex) which can be seen by the nursing staff. -Nurse aides conduct their documentation in the task area when they complete a task intervention. -If interventions are not entered into the care plan then nurse aides do not see the interventions in the task area. *She believed that nursing standards play a part and a repositioning schedule should not have to be care planned or put into the task area of PCC to ensure the task was being completed. -They should just know how to do that. -She could not provide me with documentation	F 686		

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 _____	05/13/2021

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 686	Continued From page 17 that repositioning had occurred for resident 19 when she was in her w/c or in her bed. *She was unable to confirm how the resident received the two facility-acquired pressure ulcers. *She agreed resident nine's care plan needed to updated. -She stated all nurses were responsible to update them but it was ultimately up to the MDS coordinator to ensure they were correct. 8. Interview on 5/13/21 at 9:42 a.m. with MDS coordinator R revealed: *She had not worked from 4/15/21 through 5/10/21. *When she completes the MDS's she updates the care plan's. *She does attend stand-up meetings on Monday through Friday mornings. -That is where she got most of her information on residents to be able to update the MDS's. *Nurse's are responsible to update the care plan's. -She update's them when she completes the required quarterly and significant change MDS's. 9. Continued interview with MDS coordinator R concerning resident 19's undated care plan revealed: *"3/25/21 Focus -The resident has COVID 19 positive test results. *Interventions -When possible, all services brought to resident in room. -Contact precautions..." *The MDS coordinator stated "Ow, I need to update her COVID information". *She also agreed that the care plan needed to be updated to include the resident's current status. -"Things go better when we have a specific	F 686		

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 _____	05/13/2021

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 686	Continued From page 18 wound care nurse." 10. Review of the revised 7/8/20 Wound and Pressure Ulcer Management-Rehab/Skilled Policy revealed: *"Programs should include: -Good Samaritan Society (GSS) skin care [skincare] systems, guidelines and protocols that are consistent with acceptable standards of practice... -Up-to-date care approaches consistent with GSS protocols and policy (employee knowledge, competency and consistency in following policy and acceptable standards of practice). -A comprehensive management program to prevent development of a pressure ulcer or other skin conditions (Braden, following interventions identified on care plan, nutritional intervention, specialty surfaces, etc."	F 686		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to	F 692	1. Resident 8 diet plan has been uipdated to en sure resident receives adequate nutrition and dieticiann's recommendations are followed on 06/03/2021. Type text here All residents are at potential risk by failing to address weight and nutrition concerns. 2. Administrator, DNS, and Dietary Manager re viewed Nutritional Risk of Residents policy and Weight and Height policy on 05/14/2021 3. DNS, QAPI Coordinator, or designee will aud it resident care plans to ensure dietician's recom mendations are being followed twice monthly for one month, then monthly for two months. Audits will be brought to monthly QAPI meeting to be discussed with IDTfor recommendation for continuation/discontinuation/revisions based on audit findings. DIETARY MANAGER WILL MONITOR RESIDENT'S WEI GHTS ON A DAILY/WEEKLY BASIS FOR DECLINE. - IR 6/09/2021 DNS, QAPI COORDINATOR, OR DESIGNEE WILL SUB	6/09/21

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 _____	05/13/2021

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 692	Continued From page 19 maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident's nutritional needs had been met. Findings include: 1. Review of resident 8's medical record revealed: *She was admitted on 2/4/20. *Her diagnosis included: fracture of right femur, altered mental status, other specified mental disorders due to known physiological condition, essential hypertension, hyperlipidemia, dementia with behavioral disturbance, and anemia. *Her 5/3/21 brief interview for mental status was six, indicating severely impaired cognition. *Her weight on: -2/4/2021 was 135.2 pounds. -3/5/2021 was 132.0 pounds. -4/3/2021 was 131.0 pounds. -5/8/2021 was 120.8 pounds. *She had a significant weight loss of 7.79% from 4/2/21 to 5/8/21. *She had a 10.65% weight loss since admission. *An order to increase mirtazapine from 15 mg (milligrams) to 30 mg one time a day for major depressive disorder with a start date of 5/6/21. 2. Interview on 5/11/21 at 2:56 p.m. with resident 8 revealed she: *Often did not like the food and did not eat. *Did not like to complain so would not tell the staff	F 692	MIT AUDIT TO QAPI. - IR 06/09/2021 Type text here	

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 _____	05/13/2021

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 692	Continued From page 20 she didn't like it or ask for something different. *Indicated for lunch she had a variety of main dishes served; mashed potatoes and roast beef smothered with gravy, and spaghetti bake on her plate were unappetizing. *Was concerned because she felt like she was losing weight. 3. Interview on 05/12/21 at 11:39 a.m. and 1:52 p.m. with nutrition and foodservice supervisor C regarding resident 8 revealed she: *Was aware resident 8 was losing weight. *Was aware resident 8 did not like some of the food that was offered. -Had offered different items. -Resident 8 would not take the other items. *Was not aware resident 8 did not like all the different foods on her plate. *Had not documented all the interventions that had been tried to get resident 8 to eat. *Was responsible for dietary care plans. *Had not put interventions on her care plan yet because she was waiting for her condition to improve and her weight to stabilize. *Was responsible for follow-up on registered dietician (RD) recommendations and had missed the recommendations given in March. *Had been giving her mighty shakes with meals, but this was not documented. *Indicated the only time snacks were offered and documented was at bedtime. *Indicated a resident could have a snack at any time of day if they asked for one. *The RD did a visit on 5/6/21 but had not documented or sent recommendations from that visit yet. 4. Interview and observation on 05/12/21 at 12:30 p.m. of resident 8 during meal service revealed	F 692		

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 _____	05/13/2021

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 692	Continued From page 21 she: *Was sitting at the dinner table. *Had not eaten the food on her plate and only ate 1/2 her cake. *Drank a cup of hot chocolate. *Said she had no appetite and was not hungry. *Said she had started a new medicine to help increase her appetite and is hoping it will work. 5. Interview and record review on 05/12/21 at 12:44 p.m. with director of nursing B regarding resident 8 revealed: *Resident weights are reviewed daily at morning meetings with department heads. *She had been aware resident 8 was losing weight. *She did not know if the physician was aware of resident 8's weight loss. *The mirtazapine had been prescribed by resident 8's psychological nurse practitioner for depression and to help stimulate her appetite. *Agreed there was no documentation from the registered dietician (RD) since March 2021. *The RD had made some recommendations on 3/25/21 and those recommendations had not been implemented. -She had thought they had accidentally been missed. *It was nutrition and food services supervisor's responsibility to: -Follow up and implement RD recommendations. -Update and revise the nutrition care plan. 6. Review of the RD nutritional status notes for resident 8 revealed: *On 2/15/2021: -Resident 8 had poor intakes the previous two to three days. -Goal was to maintain weight from 135-140	F 692	Type text here	

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 _____	05/13/2021

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 692	Continued From page 22 pounds. *On 3/5/2021: -Weight was 132 pounds. -Goal was to maintain weight from 135-140 pounds. -Plan to review weight and intakes with nutrition and foodservice supervisor C related to poor intakes and weight was lower than the goal weight. *On 3/25/2021: -Weight on 3/21/21 was 127.8 pounds. -Goal was to avoid any further weight loss and a new goal of 127-135 pounds. -Recommendations had been made for: --"8 oz. [ounces] chocolate milk hot or cold or chocolate Mighty Shake or cocoa mix made with 8 oz. milk 1-3x/day [one to three times a day] r/t [related to] how often resident accepts." --"If wt below 127 lbs [pounds] then recommend 2 oz. 2.0 Med pass tid [three times a day] between meals.". --"Report any further wt loss to RD for follow up and any triggered wt [weight] loss to MD [medical doctor]." --None of the recommendations had been implemented. 8. Review of resident 8's meal intake records from 4/13/21 through 5/12/21 revealed she: *Had eaten 0-25% of her meal 27 times. *Had eaten 25-50% of her meal 46 times. *Had eaten 51-72% of her meal 7 times. *Had eaten 76-100% of her meal 2 times. *Was not available for 1 meal. *Had refused 3 meals. 9. Review of resident 8's bedtime snack intake records from 4/15/21 through 5/11/21 revealed she:	F 692	Type text here	

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 _____	05/13/2021

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 692	Continued From page 23 *Had accepted a snack 6 times. *Was sleeping 7 times. *Refused a snack 1 time. *Not applicable was marked 3 times. 10. Review of resident 8's 4/6/21 physicians progress note revealed: *The visit was performed via telemedicine. *"History obtained from patient, SNF [skilled nursing facility] nurse, and chart review." *It indicated resident 8 was eating well. *It had not addressed the resident's weight loss. 11. Review of resident 8's revised 5/10/21 care plan revealed: *Her current body weight was 135 pounds. *Goal: "Feels supported in decision keep weight within 10 lbs [pounds] of current weight." *Interventions: -"Dietitian, healthcare provider, medical director to discuss strategies for keeping weight stable." -"Encourage resident to attend activities that promote physical activity and socialization: enjoys knitting and sitting at the nurse's station." -"Praise all resident's progress or efforts." *It had not addressed the residents weight loss. 12. Review of the provider's 11/3/20 Weight and Hight-Rehab and Skilled policy revealed: *"The licensed nurse should notify the director of food and nutrition (DFN) within 24 hours regarding any significant weight change. -Significant weight change is defined as five percent in 30 days, 7.5 percent in 90 days and 10 percent in 180 days." *"The licensed nurse should immediately notify the medical provider regarding any significant weight change ..."	F 692		

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 _____	05/13/2021

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 692	Continued From page 24 13. Review of the provider's 5/10/21 Interventions for Nutritional Risk of Residents-Food and Nutrition policy revealed: *The purpose: "To provide guidelines for interventions for residents at risk for decline in nutritional status." *"The director of food and nutrition services will interview residents identified to be at nutritional risk and/or their caregivers/family to identify interventions that meet the resident's food/beverage preferences." *"Care Plan is updated as changes are made." *"Suggestions for employees:" -"Substitutions and alternate menu choices per individual preferences." -"Monitor snacks in PCC [Point Click Care] - POC [Point of Care]." -"Medical nutritional supplement only when absolutely necessary; either two hours before a meal or two hours after a meal (physician order required)." -"Snacks between meals." -"Offer finger foods." -"Provide smaller, more frequent meals." -"Observe residents during meals."	F 692		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide	F 755	1.Employee H will be educated on proper dis posal of refused/dropped medications by 06/09/2021. All nursing staff will be educated that proper disposal and and documentatio of refused/dr opped medications must include: resident's name, medications name, prescription number, quantity, date of disposition, and the involved staff member, consultant, or other applicable individuals. This education will be done by 06/09/2021. 2. Documentation will completed in a binder in the medication room to record non-controlled medications that are destroyed using GSS247B and education provided to nursing staff on use	06/09/21

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 _____	05/13/2021

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 755	Continued From page 25 pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on observation, interview, and policy review, the provider failed to ensure accountability of destroyed medications. Finding include: 1. Interview 05/12/21 at 8:15 am with unlicensed assistive personnel (UAP) H during medication pass revealed: *If she drops a pill or a resident refuses the medication she tells a nurse. *The nurse and she put them in the Drug Buster Drug Disposal System. *They do not document what is destroyed unless it is a controlled drug.	F 755	by 06/09/2021. Education on documentation will be provided to all nursing staff to include the resident's name, medication name, prescription number, quantity, date of disposition and the involved staff member, consultant, or other applicable individuals by 06/09/2021. Any staff unable to attend will complete education prior to their next scheduled shift. 3. DNS or designee will audit the GSS247B twice a week for 3 weeks, then weekly for 3 weeks, and once a month for 3 months. Audits will be brought to monthly QAPI meeting to be discussed with IDT for recommendation for continuation/discontinuation/revisions based on audit findings. DNS EDUCATED EMPLOYEE ON PROPER DISPOSAL OF MEDICATION. - IR 6/09/2021 DNS WILL EDUCATE EMPLOYEES ON DISPOSAL AND REFUSAL OF DROPPED MEDICATION. - IR 6/09/2021 DNS WILL EDUCATE ALL NURSING STAFF ON DOC UMENTATION. - IR 06/09/2021 DNS WILL EDUCATE ANY NURSING STAFF UNABLE TO ATTEND ORIGINAL TRAINING. - IR 6/09/2021 DNS OR DESIGNEE WILL SUBMIT AUDITS TO QAPI. - IR 06/09/2021	

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 _____	05/13/2021

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 755	Continued From page 26 2. Interview on 5/12/21 at 8:30 am with licensed practical nurse (LPN) I revealed: *When a medication is dropped or refused it is put into the Drug Buster Drug Disposal System. *The medication is only documented if it is a controlled drug. 3. Observation on 5/12/21 at 8:19 a.m. of UAP H and director of nursing (DON)/Registered Nurse (RN) B: *Resident 17 had refused her medications. *They had taken the medications into the medication room. *UAP H had told DON/RN B what the medications were and then put them into the Drug Buster Drug Disposal System. *They had not written down what had been destroyed. 4. Review of resident 17's progress notes revealed on 5/12/2021 at 8:21 a.m. "[Resident] Refused to take states she swore off medications due to believing their sleeping pills in there." *This was documented by UAP H. *It did not indicate the nurse had been notified. *It did not indicate the medications had been destroyed. 5. Interview on 5/12/21 at 10:59 a.m. with DON/RN B about the above observation and destruction of medications revealed: *UAP would be expected to notify a nurse if a resident had refused medications or if the medication had been dropped. *The UAP should have documented in the progress note the medications had been destroyed. *She had agreed a UAP could not destroy medications without a nurse so they should not	F 755		

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 _____	05/13/2021

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 755	Continued From page 27 be documenting the destruction. *The provider did not have a system to ensure all medications that had been destroyed had been accounted for. 6. Review of the provider's 10/6/20 Medication, Disposition (Disposal) Of policy revealed: *"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, medications name, prescription number (as applicable), quantity, date of disposition [,] and the involved staff member, consultant, or other applicable individuals."	F 755		
F 800 SS=F	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 40053 Based on observation, interview, food temperature log review, and policy review, the facility failed to ensure: *Food temperatures were palatable to residents. *Both hot and cold foods were served at the required temperatures. *Food temperatures were tested and documented throughout the meals per facility procedure. *Dietary staff were aware of the required food holding temperatures for prepared foods.	F 800	1.'On Demand Menu' for instance when residents do not care for the daily menu have been presented to resident's on the dining room tables as of 06/03/2021. All residents are at risk for being affected by failure to ensure each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional needs. 2. All dietary staff will receive training with topics related to: food handling and prep aration techniques, food-borne illnesses, serving and distribution procedures, left over food handling policies, time and temp erature controls for food preperation and service, nutrition and hydration, and sani tation requirements at a dietary inservice by 06/09/2021. Any staff unable to attend will complete education prior to next scheduled shift. 3. Resident council review of the meals will be brought to monthly QAPI meeting to be discussed with IDT for recommend ation for continuation/discontinuation/re visions based on audit findings.	06/09/2021

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 _____	05/13/2021

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 800	Continued From page 28 *Dietary staff had completed yearly dietary training requirements. Findings include: 1. Random observations and interviews from 5/10/21 through 5/11/21 revealed: *Anonymous residents and resident 184 revealed: -"Food is all cold." -"I am losing weight so bad." -"Only have one option and cannot get anything else." -"Cold food is not served cold." -"No fresh vegetables or salads were offered." 1.a. Refer to F692, Finding 2. 1.b. Refer to F804, Findings 1-5. 1.c. Refer to F812, Findings 3-5, 8, and 9-14.	F 800	DIETARY MANAGER OR DESIGNEE EDUCATE RESIDENTS ABOUT "ON DEMAND MENU". - IR 6/09/2021 DIETARY MANAGER OR DESIGNEE WILL COMPLETE THE DIETARY STAFF EDUCATION. - IR 6/09/2021 DIETARY MANAGER OR DESIGNEE EDUCATE STAFF WHO ARE UNABLE TO ATTEND THE MEETING. - IR 6/09/2021	
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Surveyor: 42558 Surveyor: 40053 A. Based on observation, interview, food temperature log review, and policy review, the	F 804	1. Administrator and Dietary Manager have reviewed Food Temperature Monitoring policy on 05/14/2021. Dietary Manager has re-educated all cook staff on proper Food Temperature procedure on 05/14/2021. All residents are at risk for being affected by failure to ensure each resident with a palatable, well-balanced diet that meet his or her daily nutritional and special dietary needs. 2. All dietary staff will receive education with topics related to: food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature control for food preparation and service, nutrition and hydration, and sanitation requirements at a dietary in service by 06/09/2021. Any staff unable to attend will complete education prior to next scheduled 3. Dietary Manager or designeewill audit food temperature logs to ensure food is temped per policy. Audits will be done 3 times weekly for 3 weeks, then once weekly for 3 weeks, then monthly for 3 months	06/09/2021

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 _____	05/13/2021

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 804	Continued From page 29 provider failed to ensure: *Prepared food was served at a temperature that was palatable to the residents. *Both hot and cold foods were served at acceptable temperatures. *Prepared food temperatures were checked throughout the meals to ensure temperature control. *All food temperatures were documented throughout the meal. Findings include: 1. Observation and interview on 5/10/21 from 5:39 p.m. in the dining room with a resident who wished to remain anonymous revealed: *"It [the food] is all cold. It would taste better if it was warm." *"I am losing weight so bad. I don't want to get into trouble. Can I ask for some hot food?" *"Most of the time I don't eat the meals because they are always cold." *Resident asked food service assistant J to have her chicken patty re-heated. -She informed the resident the food was supposed to be cold but she would bring another tray. *At 6:16 p.m. resident had not received another tray. -Resident again asked food service assistant J for a hot chicken patty. -She stated to the resident,"Do you want some more? I'll get you some more." -Resident stated, "I don't want anything [food that is] cold." --Without being served a new tray or offered a hot alternative, the resident left the dining room at 6:30 p.m. without eating any of her supper meal. SURVEYOR 41895	F 804	DIETARY MANAGER OR DESIGNEE WILL COMPLETE THE DIETARY STAFF EDUCATION. - IR 6/09/2021 DIETARY MANAGER OR DESIGNEE WILL COMPLETE DIETARY STAFF EDUCATION. - IR 6/09/2021 DIETARY MANAGER OR DESIGNEE WILL SUBMIT AUDITS TO QAPI. - IR 6/09/2021	

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 _____	05/13/2021

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 804	Continued From page 30 2. Interview on 5/11/21 at 2:56 p.m. with a resident who wished to remain anonymous revealed: *The hot foods are not served hot and the cold foods are not served cold. *They often did not like the food and did not eat. *They did not like to complain so often will not tell the staff they did not like the food nor ask for something different. *They expressed concerned about weight loss. 3. Interview on 5/11/21 at 9:26 a.m. with resident 184 regarding food revealed: *Hamburger and chicken served the prior evening had been cold. *Coleslaw served the prior evening had been warm. *Only have one option and can not get anything else. *She thought the cold salads should not have been on the steam table with the hot food. *No fresh vegetables or salads were offered. *Most food that should have been hot were served cold. *Cold food is not served cold. *She does not eat at times because she is afraid it will make her sick because it appears not to be held at the right temperature. 4. Interview on 5/11/21 at 1:36 p.m. with nutrition and foodservice supervisor C revealed: *She has been working with a cook on proper food temperatures. -That cook did not know that the salads should be kept on an ice bath and he just put ice in the steamer table so it had melted away. 5. Review of the provider's 4/14/21 Food Temperature Monitoring policy revealed:	F 804		

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 _____	05/13/2021

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 804	Continued From page 31 *"Food is cooked, reheated [,] or cooled to ensure proper holding temperatures before each meal service." *"Food temperatures are taken and recorded before each meal services." *"Periodically, temperatures are taken at other times during or at the end of meal service to ensure temperatures are held within acceptable ranges." *"TCS [time/temperature control for safety] hot foods should be served at 135 degrees Fahrenheit or higher." *TCS cold foods will be held at or lower than 41 degrees Fahrenheit and served promptly after being removed from the refrigerator." SURVEYOR 40053 B. Based on observation, interview, record review, and policy review, the provider failed to ensure: *Two of two refrigerators were clean and food was appropriately labeled. *The dry storage area food items were off of the floor and placed onto the shelves. *Opened food items were labeled. *Prepared foods were at the required temperatures. *Dietary staff were aware of the required food holding temperatures for prepared foods. *Food temperatures were monitored per the facility procedure. Findings include:	F 804	list for an appointment. Woundeastist from AMT Wound Care Supplier was able to assess on All residents have potential to be affected by failing to prevent pressure ulcers. 2. Will provide education to nursing staff re: daily skin assessments by 06/09/2021. The facility will educate nursing staff re: policy for pressure ulcer prevention and documentation requirements including at UDAs and comm unications required, including forms GSS230F14 - wound ordered wound care fax for physician. Resident's Braden Scale scores to be reviewed and assess ed for interventions to be put in place for prevention as according to GSS Braden Scale guidelines and care plan updated When skin changes do occur, wound data collection and wound RN assessment will be initiated immediately, PCP notified using GSS230F-4, treatment initiated and care plan 3. DNS or designee will audit 3 care plans a week for 3 weeks, then one weekly for 3 weeks, then monthly for 3 months to reflect appropriate interventions have been implemented based on admitting and quarterly Braden Scale score or presence of pressure ulcers. Each resident will then be reviewed quarterly. Audits will be brought to monthly QAPI meeting to be discussed with IDT for recommendation for continuation/discontinuation/revis visions based on audit findings.	
F 812 SS=D	1. Refer to F812, Findings 3, 4, 5, 8, and 9. Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812	1. Administrator, DNS, and Dietary Manager have reviewed the Food and Temperature Mon itoring policy and Food Supply Storage policy on 05/14/2021	06/09/2021

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 _____	05/13/2021

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 812	Continued From page 32 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Surveyor: 40053 Based on observation, interview, record review, and policy review, the provider failed to ensure: *Two of two refrigerators were clean and food was appropriately labeled. *The dry storage area food items were off of the floor and placed onto the shelves. *Opened food items were labeled. *Prepared foods were at the required temperatures. *Dietary staff were aware of the required food holding temperatures for prepared foods. *Food temperatures were monitored per the facility procedure. Findings include: 1. Observation on 5/10/21 at 6:00 p.m. of the kitchen revealed:	F 812	a. Kitchen Aid side-by-side fridge has been cleaned on 05/12/2021. b.Opened products, foods/condiments, juices in aftermarket containers have been labeled and dated as of 05/14/2021. c. Dried storage area boxes have been removed from floor and product has been stored in designated areas as of 05/12/2021. d. Cook D and Cook M have been educated on proper serving temperature for hot and cold foods on 05/12/2021. e. All dietary staff will be educated on temperature logs for private dining room refrigerator at dietary inservice by 06/09/2021. f. All dietary staff will be educated on proper labeling and dating of perishable items at dietary inservice by 06/09/2021. 2.All dietary staff will receive education with topics related to: food handling and preperation techniques, food borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements by 06/09/2021. Any staff unable to attend will complete education prior to next scheduled shift. 3. Administrator, Dietary Manager, or designee will audit cleaning schedule, date and label of non-perishable items, food serving temperature logs, and refrigerator temperature logs 3 times a week for 3 weeks, then weekly for 3 weeks, then monthly for 3 months. Audits will be brought to monthly QAPI meeting to be discussed with IDT for recommendation for continuation/discontinuation/revisions based on audit findings. DIETARY MANAGER OR DESIGNEE WILL EDUCATE ALL DIETARY STAFF. - IR 06/09/2021 DIETARY MANAGER OR DESIGNEE WILL ENSURE EDUCATION IS COMPLETED BY THOSE UNABLE TO ATTEND THE ORIGINAL TRAINING. - IR 6/09/2021 DIETARY MANAGER OR DESIGNEE WILL SUBMIT AUDITS TO QAPI. - IR 6/09/2021	

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 _____	05/13/2021

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 812	Continued From page 33 *A Kitchen Aid side-by-side refrigerator to the left of the prep area. *Inside the freezer compartment appeared a brown-colored, sticky substance from the top to the bottom of the freezer. --It resembled splattered chocolate ice cream. *The top shelf had a container of sherbert which had been opened and three-quarters of it was gone. -It did not have a label indicating the date it had been opened. *The bottom of the freezer had a mesh wired pull-out basket. -That basket was empty. -Underneath the basket was the same brown colored sticky material. -There were also pieces of tan and white hard material that resembled food particles. Continued observation of the kitchen revealed: *The walk in cooler had an opened cardboard box of quart sized creamer on the floor as well as a box of ham patties sitting on the floor. *The shelves to the left side of the walk-in refrigerator door contained metal shelves that held: *Apple and orange juices in one gallon plastic pitchers with no label indicating the date it had been put into those pitchers. *Plastic squeeze bottles which contained: -Ranch. -Thousand island. -Oil and vinegar mixture. -Mustard. -Ketchup. *None of the above squeeze bottles were labeled or dated. *Yellow single cheese slices in a plastic container with no label or date on it.	F 812		

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 _____	05/13/2021

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 812	Continued From page 34 *A five pound opened plastic bag of grated yellow cheese with no label or opened date on it. *A cardboard box of what appeared to be fresh rhubarb. -It was wilted and bent almost in half when picked up out of that box. *Bread, muffins, and buns were all open and were not dated. 2. Observation of the dried storage area revealed boxes of dried foods had been left sitting on the floor in their original cardboard boxes and not opened and placed on the available shelving. 3. A meal tray was requested on 5/10/21 at 6:20 p.m. and received at 6:37 p.m. *That meal tray consisted of and was tempted at: -Chicken patty 106.9 degrees. -Cheeseburger 103.5 degrees. -Pea salad 78.1 degrees. -They had run out of coleslaw which had also been served during this meal. *Those temperatures did not fall within the regulation of hot food to be served at or above 135 degrees and cold foods to be served at or below 41 degrees. 4. Interview and record review on 5/10/21 at 6:45 p.m. with cook D while in the kitchen revealed: *He had cooked the above meal. *He had used the three-section steam table to serve hot and cold foods. -Hot items were on the far right, the center had empty pans, and the far left held the pea salad and coleslaw. *He stated he did not keep lids on the foods to keep them hot or cold. *He stated he had put ice into the far-left side of the steam table before placing the two salads in	F 812		

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 _____	05/13/2021

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 812	Continued From page 35 there. *He stated he had placed the ice in there at approximately 5:10 p.m. and had tempted the two salads. -The temperature log review indicated the pea salad tempted at 57 degrees. -The coleslaw tempted at 54 degrees. --That had been above the recommended temperature of 41 or below for cold items. *He stated he tries to keep cold foods below room temperature, "65 degrees or below." *He tempted the foods only one time per meal when they go onto the steam table. *He removed the pan from the steam table and there was no ice below the metal pans where the two salads had been after he had finished serving the meal. 5. Interview on 5/10/21 at 6:45 p.m. with resident 3 concerning the evening meal revealed he stated: *He did not like the chicken patty. "It was barely warm." *He thought the cheeseburger was "Okay" but did not have any taste. *"Food is usually always cold." 6. Observation on 5/11/21 at 11:05 a.m. of the private dining room refrigerator revealed: *Temperature log forms were taped to the left side of that refrigerator but no month, dates, or temperature had been documented. *The refrigerator contained: -Five Boost supplement drinks and various canned soft drinks. *The inside refrigerator thermometer read 46 degrees. 7. Interview on 5/11/21 at 9:34 a.m. with cook M	F 812		

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 _____	05/13/2021

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 812	Continued From page 36 concerning the labeling of food items revealed she knew that they had a problem with dating and labeling of food items. "I know it needs to be done" just haven't been doing it. 8. Observation and interview on 5/11/21 at 11:25 p.m. with cook M and nutrition and food service supervisor (NFSS) C in the kitchen revealed: *One item on the lunch menu was a noodle type bake. -It consisted of items used in making lasagna but replaced the lasagna noodles with spaghetti noodles. -The cheese mixture consisted of cottage cheese, sour cream, and mozzarella cheese. *The pan of that noodle bake was removed from the oven and the item was tempted. -The right side temperature was 200 degrees while the left side temperature at its lowest was 110 degrees. *Cook M stuck in and removed the thermometer from that meal a minimum of 40 times trying to get a higher temperature reading on the left side of that noodle bake. -She stated "There must be a cold pocket." *She stated the oven was a convection oven and sometimes she heard the fan on while other times she had not heard it working. *Nutrition and food service supervisor C stated she had heard rumors about the oven not working properly but was waiting for confirmation by other employees. *There was a shallow pan of breadsticks sitting on top of the oven range that had been previously baked. -They were part of that lunch meal. -The breadsticks on the right side of that pan were a perfect gold brown color. -The breadsticks on the left side had a light tan to	F 812		

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 _____	05/13/2021

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 812	Continued From page 37 white color and did not look as appetizing as the breadsticks from the right side of the pan. 9. Ongoing observation and interview revealed at 11:35 a.m. cook M had opened a can of three bean salad and placed the contents of that can into a tall plastic container and set it on the counter next to the steam table. *When questioned she stated that salad was to have been served cold but she had forgotten to put it into the refrigerator. -She did not attempt to put it in a shallow pan and place that over ice to cool the salad down before lunch service. -She left it on the counter and served it at room temperature. *Meal service began at 12:00 a.m. which meant the room temperature three bean salad sat on the counter for 25 minutes instead of being placed in the refrigerator to be cooled down. *She placed the noodle bake on the steam table and began serving lunch to the residents. *She stated she did not put lids onto the foods to keep them warm while serving. *She believed they were supposed to temp the food before, during, and after service to ensure items were being served at the correct temperatures but "We haven't been doing that." *She stated "Everything hot must temp at 160 degrees" before serving. 10. Observation and interview on 5/11/21 at 11:48 a.m. with NFSS C concerning the above observations and interviews revealed she: *Stated the inside of the Kitchen Aide refrigerator and freezer combination in the kitchen "Should not look like this" referring to the brown sticky spots and remnants of food particles. *Stated she reminds the cooks that the kitchen	F 812		

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 _____	05/13/2021

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 812	Continued From page 38 needs to be kept clean. *Knew all open items in the refrigerator and freezers should have been labeled. *Stated the food items on the floor and now place on the shelves were "On me" and she should have them up off the floor, but, it was really a team effort and everyone should be keeping the items off the floor and putting items on the shelves where they belonged. *Believed all hot foods needed to be 145 degrees before serving. 11. Interview on 5/12/21 at 2:20 p.m. with administrator A concerning the above observations and interviews revealed: *He agreed all refrigerators and coolers needed to be kept clean, items should not be stored on the floors and all opened items needed to be labeled with a date. *The fresh rhubarb should have been discarded. *Agreed that all dietary staff should be aware of the correct serving temperatures for all food items. 12. Interview on 5/13/21 at 3:00 p.m. with the director of nursing B revealed her expectation would have been that all hot and cold foods were served at the required temperatures. 13. Review of the provider's 4/14/21 Food Temperature Monitoring Policy revealed: *"Food is cooked, reheated or cooled to ensure proper holding temperatures before each meal service." *"Food temperatures are taken and recorded before each meal services." *"Periodically, temperatures are taken at other times during or at the end of meal service to ensure temperatures are held within acceptable	F 812		

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 _____	05/13/2021

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 812	Continued From page 39 ranges." *"TCS [time/temperature control for safety] hot foods should be served at 135 degrees Fahrenheit or higher." *TCS cold foods will be held at or lower than 41 degrees Fahrenheit and served promptly after being removed from the refrigerator." 14. Review of the providers 10/22/2020 last edited Supervisor, Nutrition and Food Services Job Description revealed: *"JOB PROFILE SUMMARY -Ensures department meets all regulatory requirements. *ESSENTIAL FUNCTIONS -Adheres to established procedures and dietary guidelines in food storage and menu planning. Monitors progress, provides feedback, support, and course correction as necessary. *Dietary Guidelines -Knowledge of applicable laws, rules and regulations governing dietary guidelines: ability to apply these theories to design, develop and maintain a healthy diet." 15. Review of the providers 4/2/21 last edited Cook Job Description revealed: *"JOB DESCRIPTION -Adheres to food quality standards of appearance, taste, temperature and sanitation. Maintains labeling and storage of food, equipment, and machinery. Prepares and provides the highest quality and safest food possible to patients/residents, co-workers, team members, and guests."	F 812		

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 _____	05/13/2021

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
E 000	Initial Comments Surveyor: 40053 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 5/10/21 through 5/13/21. Good Samaritan Society New Underwood was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Aden Ramey
TITLE: Administrator
(X6) DATE: 06/09/2021

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.

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 **01 - MAIN BUILDING 01** B. WING _____	**05/12/2021**

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
K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 5/12/21. 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 health care occupancies upon correction of the deficiency identified at K918 in conjunction with the providers commitment to continued compliance with the fire safety standards.	K 000		

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

Aden Ramey | Administrator | 06/07/2021

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.

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:
	435104	A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	**5/12/2021**

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 918	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on record review and interview, the provider failed to document generator battery conductivity monthly (no documentation was done in October, November, and December 2020). Findings include: 1. Record review on 5/12/21 at 1:45 p.m. revealed there was not any documentation of the battery conductivity in the monthly maintenance logs for the generator for October, November, and December of 2020. Interview with the administrator at 3:15 p.m. on 5/12/21 revealed the provider was without a maintenance supervisor since the end of September 2020. He stated he was unaware of the monthly battery conductivity documentation requirement. The deficiency affected 100% of the building occupants.

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

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
	10657	A. BUILDING: _____ B. WING _____	05/13/2021

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 Surveyor: 40053 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 5/10/21 through 5/13/21. Good Samaritan Society New Underwood was found not in compliance with the following requirements: S206, S236, and S301.	S 000		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and. (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section.	S 206	1. Employee E, D, and G will complete all unfinished education related to: Fire prev ention and response; Emergency procedures and preparedness; infection control and pre vention; Accident prevention and safety pro cedures; Proper use of restraints; Resident rights; Confidentiality of resident information; Incidents and diseases subject to mandatory reporting and the facility's reporting mechani sms; Care of residents with unique needs; Dining assistance, nutritional risks, and hydration needs of residents; and Abuse, neglect, misappropriation of residents pro perty and funds, and mistreatment by 06/09/2021 or prior to next shift. All residents are at risk for being affected by staff not completing education on required subjects annually. 2. New hires will be expected to complete the GSS5900 General Orientation Checklist within the first 30 days of being hired. Facility Administrator or designee will eval uate monthly education exemption reports to identify anyemployee with past due education. Employee's with education past due over 21 days will not be able to work until education is up to date.	06/09/2021

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

TITLE: Administrator

(X6) DATE: ~~06/03/2021~~

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
	10657	A. BUILDING: _____ B. WING _____	05/13/2021

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 206	Continued From page 1 Additional personnel education shall be based on facility identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 42558 Based on interview, record review, and policy review, the provider failed to ensure: *Required annual training was completed for one of one sampled employees (E). *Required new employee orientation training was completed timely for two of two sampled employees (D and G). Findings include: 1. Review on 5/12/21 and 5/13/21 of personnel files revealed: *Employee E was hired on 8/12/19 and had not completed the annual 2020 required training on the topics of: -Fire prevention/response. -Emergency procedures/preparedness. -Proper use of restraints. -Resident rights. -Dining assistance, nutritional risks, hydration. 2. Review on 5/12/21 and 5/13/21 of personnel files revealed: *Employee D was hired on 7/28/20 and had not completed the required orientation training on the topics of: -Proper use of restraints. -Resident rights. -Confidentiality of resident information. -Incidents/diseases reporting. -Dining assistance, nutritional risks, hydration. *Employee G was hired on 2/9/21 and had not completed the required orientation training on the topics of:	S 206	3. Facility Administrator or designee will audit 10 employee's education files monthly for 3 months to ensure monthly education requirements are being met. Audits will be brought to monthly QAPI meeting to be discussed with IDT for recommendation for continuation/discontinuation/revisions based on audit findings. ADMINISTRATOR WILL ENSURE EDUCATION IS COMPLETED BY THOSE UNABLE TO ATTEND THE ORIGINAL TRAINING. - IR 6/09/2021 ADMINISTRATOR WILL SUBMIT AUDITS TO QAPI. - IR 06/09/2021	

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 _____	05/13/2021

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 206	Continued From page 2 -Fire prevention/response. -Emergency procedures/preparedness. -Dining assistance, nutritional risks, hydration. Interview on 5/13/21 at 9:35 a.m. with administrator A regarding new employee and annual orientation revealed: *Employee mandatory education was completed through a Sanford national data-base system. -This was conducted by computer based training and was automatically entered into the Sanford Success Center program. *He stated many of the mandatory education topics are embedded under differently named Sanford topics. -He had contacted the Sanford corporate office in attempt to retrieve the mandatory education information. -He had not been able to locate the mandatory education on some of the sampled employees. *There was not a facility employee assigned to ensure employees had the mandatory training education completed. -He agreed it would be beneficial to have an assigned employee to ensure mandatory training education was completed. Review of the provider's Sanford October 2019 Annual Assignments New Hire and Training Compliance Reporting Information policy revealed: *Policy: Annual Assignments: -"The federal government and Good Samaritan Society policy require [requires] that employees at all locations must be trained on [a] specific topic on an annual basis. At the beginning of each year, Learning and Development assigns annual training courses to all employees based on the setting, department[,] and/or job in which they work. Only employees who are active on January	S 206		

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 _____	05/13/2021

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 206	Continued From page 3 1 of the current year are assigned to the annual required training topics." -"The Online Annual Training Program is designed to provide employees with consistent training, in a flexible manner. Completion of annual training topics can only be completed online. Completion of online training is automatically tracked in the Learning Center. In addition, standard support materials (i.e. communication posters; registration, annual calendar template, etc.) are available to all participating locations." -"Please note the service setting documents only include training topics required by the federal government or through Society policy. It is up to each location to know their state-specific and location-specific training requirements and provide annual training accordingly." *New Hire Training: -"New employees hired throughout the current year (January 2 or after) will not be assigned to annual required training topics, as they are to be trained on these topics during general and department orientation. However, it is recommended that all new employees get on the same training schedule with all other employees immediately following the completion of general and department orientation. This may mean that new employees are trained on the same topic twice in their first year of employment. This process ensures that employees meet both calendar year and anniversary year reporting requirements. In addition, it allows for an efficient way for training to be provided to both current and new employees. " *Training Compliance Reporting: -"By assigning the annual required training courses to employees who are active on January 1 of the current year, the Society has developed a process that will help each location track and	S 206		

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 _____	05/13/2021

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 206	Continued From page 4 monitor training compliance on a regular basis. Designated Learning Center training administrators at each location can pull training compliance reports at any time in the Learning Center Report Manager. -"The Learning and Development Sub-system runs training compliance reports for the Society's Board of Directors two times per year. Typically those reports are run in September (reporting year to date compliance) and in January (reporting compliance for the entire previous year). Before the reports are distributed to the Board of Directors, administrators, executive directors and executive managers will receive the reports from their respective regional vice president."	S 206		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12	S 236	1. Employee E has completed the TB testing through a blood test and employee G will begin the 2-step when she returns from leave. All residents are at risk for being affected by staff not completeing the TB skin test within 14 days. 2. DNS and QAPI Coordinator have been re-educated on TB testing, including reading of the 2nd step must be completed before the 14th day on 05/20/2021. QAPI Coordinatorwill conduct audits on all employees to ensure the 2-step TB skin test has been completed for all staff by 06/09/2021. Facility has implemented procedure to ensure new hires receive first step TB test on first day of orientation.	06/09/2021

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 _____	05/13/2021

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 236	Continued From page 5 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 42558 Based on interview, record review, and policy review, the provider failed to ensure four of five randomly sampled employees (C, D, E, and G) had a two-step tuberculin (TB) skin test completed within fourteen days of hire. Findings include: 1.*Employee C had been hired on 1/14/20. -Her initial TB skin test was performed on 1/21/20. -The second step was completed 139 days later on 6/9/20. 2.*Employee D had been hired on 7/28/20. -His initial TB skin test was performed on 8/6/20. -The second step was completed 27 days later on 9/2/20. 3.*Employee E had been hired on 8/12/19. -There had not been a two-step performed or completed. 4. *Employee G had been hired on 2/9/21. -There had not been a two-step performed or completed. Interview on 5/13/21 at 9:35 a.m. with administrator A revealed:	S 236	3. Facility Adminstrator or designee will audit new employees monthly for 6 months to ensure TB skin test require ment is being met. Audits will be brought to monthly QAPI meeting to be discussed with IDT for recommendation for continu ation/discontinuation/revisions based on audit findings. WE ARE UNABLE TO CHANGE THE OUTCOME FOR STAFF MEMBER C AND D- IR 6/9/2021	

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 _____	05/13/2021

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 236	Continued From page 6 *Employee health information was maintained through a Sanford computer program called Sanford One Source Workday. *He had been unable to locate two-step TB skin test information on employees E and G. *He stated there had not been an assigned facility staff member ensuring employee TB skin testing had been completed and entered into the computer program. *Agreed TB skin testing was not performed within 14 days of hire on four of five sampled employees. Review of the provider's July 2020 Tuberculosis Control Plan and Screening for Employees-Infection Control policy revealed: *"Policy:" -"A tuberculosis risk assessment will be done annually (or per any applicable state regulation) by each location. For assisted living, the assessment must be consistent with state laws and regulations. The TB control plan will be based on these assessments. " -"New employees will have a baseline TB screening according to current CDC recommendations and guidelines." -"Routine follow-up tuberculin skin test (TST) screening during employment will be based on the annual risk assessment and any state-specific regulations. When annual screening is indicated based on the risk assessment or state requirements, it will be done during the month of the employee's anniversary date." *"Procedure:" "1. New employees will have baseline tuberculosis (TB) screening using the tuberculin skin test (TST) two step [two-step] method. This involves administering the initial TST to be read in 48 to 72 hours by a nursing professional or	S 236		

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 _____	05/13/2021

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 236	Continued From page 7 physician/practitioner. The second test is administered in one to two weeks and is read 48 to 72 hours after administration by a nursing professional or physician/practitioner. This TST will be administered in the volar aspect of the forearm." "a. The TST method described above will be used unless: 1) The employee has documentation of a past positive test 2) The employee has received Bacillus Calmette-Guerin (BCG) vaccination in the past 3) The employee has an allergy to purified protein derivative (PPD) or any components of the formulation 4) The employee has severe eczema" "5. Results of tuberculin skin tests should be recorded in the individual employee's Employee Candidate Mantoux Questionnaire (GSS #832), which can be found under the Society Forms button on the Web Portal. Any chest x-ray results also will be maintained in the employee's confidential medical record." "Note: Tuberculin skin testing is considered both valid and safe throughout pregnancy. Untreated TB is a greater hazard to a pregnant woman and her fetus than its treatment. "	S 236		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements.	S 301	1. All dietary staff will receive training with topics related to: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribu tion procedures, leftover food handling poli cies, time and temperature controls for food preparation and service, nutrition and hydra tion, and sanitation requirements by 06/09/2021 or prior to next shift. All residents are at risk for being affected by dietary employees not being educated food policies and procedures.	06/09/2021

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
	10657	A. BUILDING: _____ B. WING _____	05/13/2021

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 301	Continued From page 8 This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 40053 Based on interview and record review, the provider failed to ensure eight of the nine required dietary training's (food safety, handwashing, food handling/prep, food-borne illness, serving and distribution, leftovers, time/temp controls, and nutrition/hydration) were completed by four of four (C, D, K, and L) sampled dietary staff. Findings include: 1. Interview and record review on 5/12/21 at 8:20 a.m. and 5/13/21 at 8:30 a.m. with Nutrition and Food Service Supervisor C revealed: *She had been hired into that position on 1/14/2020. *Dietary training was to have been conducted on-line. *She had not been aware of the required nine dietary training's which needed to be completed annually. -She could not locate any other training records for the above mentioned training's. *A Monthly Competency Planner listed In-Service Competency Topic(s) for January through September for 2021. -She stated she had not completed dietary training with staff for January, February, or March and will move those missed training's to the end of the year. *She had completed a training in April titled "Sanitizing Food and Contact Surfaces." -She was unable to produce a sign in sheet or documentation of who had attended that training. *She stated she was aware she is missing training for the employees. *She stated "I'm suppose to be training them but who's supposed to be training me?"	S 301	2. Dietary Manager will be educated on re quired dietary education to ensure dietary staff is educated on the nine annual diet ary trainings. Education will be completed by 06/09/2021 or prior to employees next scheduled shift. 3. Facility Administrator or designess will audit 3 dietary employees' education files for 3 months to ensure monthly dietary re quirement is complete. Audits will be brought to QAPI meeting to be discussed with IDT for recommendation for continua tion/discontinuation/revisions based on audit findings. ADMINISTRATOR WILL SUBMIT AUDITS TO QAPI. - IR 6/09/2021	

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 _____	05/13/2021

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 301	Continued From page 9 Review of the revised 10/1/19 Annual Assignments New Hire Training Compliance Reporting Information Policy revealed: *"PROCEDURE: -The federal government and Good Samaritan Society policy require that employees at all locations must be trained on specific topics on an annual basis..."	S 301		
S 000	Compliance/Noncompliance Statement Surveyor: 40053 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 5/10/21 through 5/13/21. Good Samaritan Society New Underwood was found in compliance.	S 000		