PRINTED: 03/19/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		435075	B. WING			03/12/2020	
	ROVIDER OR SUPPLIER  MARITAN SOCIETY HOV	VARD		300	REET ADDRESS, CITY, STATE, ZIP GODE D WEST HAZEL AVENUE DWARD, SD 57349		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	42 CFR Part 483, Sub Long Term Care facili	n survey for compliance with opart B, requirements for ties, was conducted from 20. Good Samaritan Society	F	000			
		UPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

program participation.

Administrator 3/26/2020

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 fromes, the includes stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing fromes, the above triddings 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

MAR 2 6 2020

Facility ID: 0025 SO DOH-OLC If continuation sheet Page 1 of 1

PRINTED: 03/19/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		DATE SURVEY COMPLETED	
		435075	B. WING_			03	/12/2020	
	ROVIDER OR SUPPLIER	VARD		30	TREET ADDRESS, CITY, STATE, ZIP CODE 00 WEST HAZEL AVENUE OWARD, SD 57349			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
E 000	Initial Comments		E	000				
	CFR Part 482, Subpa Emergency Prepared Term Care Facilities, through 3/12/20. Good was found not in comprequirement: E001.	y for compliance with 42 rt B, Subsection 483.73, ness, requirements for Long was conducted from 3/10/20 d Samaritan Society Howard pliance with the following			,			
E 001 SS=E	Establishment of the B CFR(s): 483.73  The [facility, except for must comply with all a and local emergency The [facility] must esta [comprehensive] eme program that meets the section.* The emergemust include, but not letements:  *[For hospitals at §482 comply with all applicational emergency prepared in the program that meets the section, utilizing an all emergency prepared in the program that meets the section, utilizing an all emergency prepared in the program that is \$485.62 with all applicable Fed emergency prepared in CAH must develop an comprehensive emergency program, utilizing an all program, utilizing an all comprehensive emergency prepared in the program, utilizing an all comprehensive emergency program and the pr	rgency preparedness le requirements of this ency preparedness program be limited to, the following  2.15:] The hospital must able Federal, State, and aredness requirements. relop and maintain a gency preparedness le requirements of this hazards approach. The less program must include, he following elements:  25:] The CAH must comply leral, State, and local less requirements. The d maintain a lency preparedness ll-hazards approach. The	EC		All residents have the potential to be affected facility's incomplete emergency preparedness. The facility will ensure Emergency Managem. Plan addresses Chain of Command including assignment of duties in the event of emergenc Communication plan including names and cor information for staff, residents, and physicians other facilities, and volunteer information will be included. Facility will develop tracking system staff and residents in the event of a relocation Facility will ensure plan includes alternate way communication if the phone lines and cell toware not functioning. Facility Emergency Management Plan monthly x4 months to ensure adequate a date policies are in place.  Audits will be completed and taken to QA Comfor further recommendations.	s plan. ent  cy tract for of gens gement and up to amittee	May 1, 2020	
		UPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For hursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiency are cited, an approvedulan discorrection is requisite to continued program participation.

Event ID: 02511

FORM CMS-2567(02-99) Previous Versions Obsolete

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If continuation sheet Page 1 of 3

SD DOH-OLC

PRINTED: 03/19/2020 FORM APPROVED OMB NO. 0938-0391

OFILE	OT OIT MILLDIOF ITTE OF	MEDIO/ND OFICAIOFO				CIVID IV	<u>0. 0000-000 j</u>
	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED			
		435075	B. WING			03	/12/2020
	ROVIDER OR SUPPLIER	VARD		3	STREET ADDRESS, CITY, STATE, ZIP CODE 300 WEST HAZEL AVENUE HOWARD, SD 57349		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 001	but not be limited to, This REQUIREMENT by: Surveyor: 41088 Based on intervew, rereview, the provider frestablish a comprehe preparedness program  1. Interview on 3/12/2 the provider's emergedocumentation with a *They did not have a preparedness program *They had not: -Developed a chain of information and list of the provider's emergency and main communication plant to contact information plant to contact information for physicians, other long volunteersDeveloped a tracking residents if relocated the phone lines and of functioned.  Administrator A admitting the plan better deplan should be well on emergency so their stand could use the plan Review of revised 7/1	ness program must include, the following elements: is not met as evidenced  ecord review, and policy ailed to develop and insive emergency m. Findings include:  0 at 1:34 p.m. and review of ency preparedness program diministrator A revealed: complete emergency m.  f command with contact duties. tained a clear hat had included names and in staff, residents, in term care facilities, and in system for staff and from the facility. The are way of communication if ell towers had not ted they had work to do to weloped. She agreed the reganized in the event of an aff would know what to do	E	001			
	*"Good Samaritain So	ociety policy and procedure ons have a comprehensive					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: D25I11

Facility ID: 0025

If continuation sheet Page 2 of 3



### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/19/2020 FORM APPROVED

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES					<u>OMB NO</u>	<u>. 0938-0391</u>	
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		435075	B. WING				03/ <sup>-</sup>	12/2020	
NAME OF P	ROVIDER OR SUPPLIER				DRESS, CITY, STATE, ZIP COD	DE			
GOOD SA	MARITAN SOCIETY HOV	NARD			HAZEL AVENUE SD 57349				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION (ROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIA	HOULD BE COMPLETE		
E 001		e 2 ster management plan in nes provided at a locations."	E	001	DEFICIENCY				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: D25i11

Facility ID: 0025

If continuation sheet Page 3 of 3



PRINTED: 03/19/2020 FORM APPROVED OMB NO. 0938-0391

REGULATORY OR LSC IDENTIFYING INFORMATION)  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 3/10/20. Good Samartan Society Howard 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 deficiencies identified at K281, K916, and K823 in conjunction with the provider's commitment to continued compliance with the fire safety standards.  K 281 Illumination of Means of Egress CFR(s): NFPA 101  Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention.  18.2 8, 19.2 8  This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to ensure adequate illuminiation of means of egress was provided at two randomly observed locations (boiler room and exit stair enclosure). Findings include:  1. Observation at 1:05 a.m. on 3/10/20 revealed the stair enclosure from the basement boiler room had a double lamp fixture that was not it.		DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	STREET ADDRESS, CITY, STATE, ZIP CODE  300 WEST HAZEL AVENUE  HOWARD, SD 57349  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X3) DATE SURVEY COMPLETED	
SOURCE   NOTE   NOTE			435075	B. WING_			03	1/10/2020
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  ROUGHLAND REGULATORY OR LSC IDENTIFYING INFORMATION)  ROUGHLAND REGULATORY OR LSC IDENTIFYING INFORMATION)  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 31/10/20. Good Samaritan Society Howard 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 deficiencies identified at K281. K916, and K923 in conjunction with the provider's commitment to continued compliance with the fire safety standards.  K 281  Illumination of Means of Egress  Illumination of Means of Egress  Illumination of Means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention.  1.8.2.8, 19.2.8  This REQUIREMENT is not met as evidenced by; Surveyor: 18087  Based on observation and interview, the provider failed to ensure adequate illumination of means of egress was provided at two randomly observed locations (boller room and exit stair enclosure), Findings include:  1. Observation at 1:05 a.m. on 3/10/20 revealed the stair enclosure from the basement boller room had a double lamp fixture that was not it.			VARD		30	00 WEST HAZEL AVENUE		
Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/10/20. Good Samaritan Society Howard was found not in compliance with 42 CPR 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 deficiencies identified at K281, K916, and K923 in conjunction with the provider's commitment to continued compliance with the fire safety standards.  K 281 Illumination of Means of Egress  Illumination of Means of Egress  Illumination of Means of Egress  Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention.  18.2.8, 19.2.8  This REQUIREMENT is not met as evidenced by:  Surveyor: 18087  Based on observation and interview, the provider failed to ensure adequate illumination of means of egress was provided at two randomly observed locations (boller room and exit stair enclosure). Findings include:  1. Observation at 1:05 a.m. on 3/10/20 revealed the stair enclosure from the basement boiler room had a double lamp fixture that was not iit.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
the stair enclosure from the basement boiler room had a double lamp fixture that was not lit.	K 000	INITIAL COMMENTS  Surveyor: 18087 A recertification surve Life Safety Code (LSC occupancy) was cond Samaritan Society Ho compliance with 42 Cr for Long Term Care Fr  The building will meet 2012 LSC for existing upon correction of def K916, and K923 in co commitment to continus afety standards. Illumination of Means CFR(s): NFPA 101  Illumination of means discharge, is arranged shall be either continu capable of automatic of intervention. 18.2.8, 19.2.8 This REQUIREMENT by: Surveyor: 18087 Based on observation failed to ensure adequ of egress was provide locations (boiler room Findings include:	y for compliance with the C) (2012 existing health care ucted on 3/10/20. Good ward was found not in FR 483.70 (a) requirements acilities.  The requirements of the health care occupancies iciencies identified at K281, njunction with the provider's ued compliance with the fire of Egress  of Egress of Egress of egress, including exit in accordance with 7.8 and ously in operation or operation without manual is not met as evidenced  and interview, the provider late illumination of means dat two randomly observed and exit stair enclosure).	K	0000	All residents have the potential to be affected by facility failing to provide adequate illumination of means of e. An electrician hard wired the lamp fit so it was not able to be turned off on March 17, 2020. Environmental Servor designee to audit monthly x1 to eight	gress. xture	
Interview with the maintenance supervisor  ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE  (X6) DATE	ABORATORY I	the stair enclosure froi room had a double lan Interview with the main	m the basement boiler np fixture that was not lit. ntenance supervisor			TITLE		(X6) DATE

Krista Swoboda Administrator 3/25/2020

PRINTED: 03/19/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 11 - MAIN BUILDING 01		ATE SURVEY DMPLETED	
		435075	B. WNG			03	/10/2020	
	ROVIDER OR SUPPLIER	VARD		3	TREET ADDRESS, CITY, STATE, ZIP CODE 00 WEST HAZEL AVENUE IOWARD, SD 57349			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
K 923 SS=D	fixture were burned of He further stated the of the generator, but the and the basement bod switch in the main core emergency egress cashall be provided such still provided in the evis lost. That lighting shaproviding one and one lighting upon loss of multiple of the above obsected in the was not was not in compliance requirements.  This deficiency affector requirements for emergency equipment - Cylin Greater than or equal Storage locations are ventilated in accordant 5.1.3.3.3.  >300 but <3,000 cubic Storage locations are within an enclosed into limited- combustible cogates outdoors) that cogases are not stored we separated from combusprinklered) or enclosed	pact fluorescent lights in the ut and needed replacement. entire building was run by lights in the stair enclosure ler room were run by a ridor. Lighting for in not be switched. Lighting in that minimum lighting is ent a single lighting source hall also be capable of e-half hours of emergency formal power.  Intenance supervisor at the ervation confirmed that aware that egress lighting with the minimum lighting exit with the minimum lighting ander and Container Storage to 3,000 cubic feet designed, constructed, and ce with 5.1.3.3.2 and are error space of non- or construction, with door (or an be secured. Oxidizing with flammables, and are ustibles by 20 feet (5 feet if			All residents have the potential to be affected the facility failing to protect medical gas storag oxygen cylinder storage room. Oxygen conceiver removed from the room immediately and self-closing hinge was placed on the door as a 3/19/2020. Environmental Services to audit Oxroom weekly x4 and monthly x3 to ensure prooxygen storage.	je in htrators l a of kygen	May 1, 2020	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: D25I21

Facility ID: 0025

If continuation sheet Page 2 of 4

Krista Swoboda Administrator 3/25/2020

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	·	(X3) DATE SURVEY COMPLETED	
		435075	B. WING_		_	03	/10/2020
	ROVIDER OR SUPPLIER	VARD		STREET ADDRESS, CITY, ST 300 WEST HAZEL AVENUE HOWARD, SD 57349			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 923	1/2 hr. fire protection Less than or equal to In a single smoke con cylinders available for care areas with an ag or equal to 300 cubic stored in an enclosure handled with precauti A precautionary sign i each door or gate of a where the sign include minimum "CAUTION: STORED WITHIN NO Storage is planned so of which they are rece Empty cylinders are s cylinders. When facili integral pressure gauge considered empty is e are marked to avoid o in the open are protect 11.3.1, 11.3.2, 11.3.3, This REQUIREMENT by: Surveyor: 18087 Based on observation failed to protect medic one oxygen cylinder s storage and concentra  1. Observation at 1:25 combustible materials five feet of oxygen cyli cylinder storage room. separation between co storage was not maint contained seven oxyge cannot be stored with	rating. 300 cubic feet inpartment, individual r immediate use in patient gregate volume of less than feet are not required to be c. Cylinders must be ons as specified in 11.6.2. readable from 5 feet is on a cylinder storage room, es the wording as a OXIDIZING GAS(ES) SMOKING." cylinders are used in order sived from the supplier. egregated from full ty employs cylinders with ge, a threshold pressure stablished. Empty cylinders onfusion. Cylinders stored ted from weather. 11.3.4, 11.6.5 (NFPA 99) is not met as evidenced  and interview, the provider al gas storage in one of torage room (combustible ators). Findings include:  p.m. on 3/10/20 revealed were found stored within inders in the oxygen The minimum five feet of ombustibles and oxygen	KS	23			

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Event ID: D25f21

Facility ID: 0025

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PRINTED: 03/19/2020 FORM APPROVED

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CENTER	3 FOR WEDICARE &	MEDICAID SERVICES				OMR M	<u>0. 0938-0391</u>	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		435075	B. WING			03	/10/2020	
	ROVIDER OR SUPPLIER MARITAN SOCIETY HOV	VARD		3	STREET ADDRESS, CITY, STATE, ZIP CODE 100 WEST HAZEL AVENUE HOWARD, SD 57349			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
K 923	Continued From page observation confirmed Ref: 2012 NFPA 99 S The deficiency affects compartments.	d those findings.	K	923				

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Event ID; D25l21

Facility ID: 0025

If continuation sheet Page 4 of 4

ozimene i on	MEDICINE & MEDICIND BERTICES			A FORW						
STATEMENT OF IS	OLATED DEFICIENCIES WHICH CAUSE	PROVIDER#	MULTIPLE CONSTRUCTION	DATE SURVEY						
NICATIA DA CHUTTU C	NILVA DOTENDIAL DOD MINIBAAL HADA		A. BUILDING: 01 - MAIN BUILDING 01	<b></b>						
	NLY A POTENTIAL FOR MINIMAL HARM		A. BOILDING: 01 - WAILA BUIEDING 01	COMPLETE:						
FOR SNFs AND NF	s	125075		2/10/2020						
		435075	B. WING	3/10/2020						
NAME OF PROVID	CD OD CHINI IED	STREET ADDRESS (	ITY, STATE, ZIP CODE							
INAME OF FROVIL	ER OR SOFFLIER	· ·								
GOOD SAMAI	RITAN SOCIETY HOWARD	300 WEST HAZE	LAVENUE	i						
		HOWARD, SD								
ID										
PREFIX										
TAG	SUMMARY STATEMENT OF DEFICIENCIES	S								
K 916	Electrical Systems - Essential Electric Syste									
	CFR(s): NFPA 101									
	CI K(3). 141 IV 101			,						
	The state of the s									
	Electrical Systems - Essential Electric System									
	A remote annunciator that is storage battery p	powered is provided	I to operate outside of the generating room in							
	a location readily observed by operating pers	onnel. The annunci	ator is hard-wired to indicate alarm							
	conditions of the emergency power source. A	centralized compu	ter system (e.g., building information system)							
	is not to be substituted for the alarm annuncia		, (6-,,							
	6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)									
	, , ,									
	This REQUIREMENT is not met as evidence	ed by:		1						
	Surveyor: 18087									
	Based on observation, interview, and record a	review, the provider	failed to perform preventive maintenance							
	for the remote annunciator at one of one local	tion (nurses station)	. Findings include:							
		` ,	•							
	1. Observation at 1:25 p.m. on 3/10/20 reveal	ed the annunciator	for the congretor was mounted in the corridor							
	outside the nurses station. Interview with the	-								
	the Onan diesel generator provided emergenc			i						
	revealed there was no documentation showing	g the alarm functior	is on the annunciator had been tested. Further							
	interview with the maintenance supervisor re-	vealed there was no	documentation available to show the							
	annunciator could be tested to function as req									
				ļ						
	This deficiency has the material to a 60 at 100	10/ -C4l	- 041 - 1							
	This deficiency has the potential to affect 100	0% of the occupants of the building.								
		•								
				i						
	All residents have the potential to be affected.  The facility has contacted Butter Cat to provide	l by facility failing to	perform preventative maintenance for the remote tenance to remote annunciator along with annual	annunciator at facility.						
	Environmental Services or designee will audi	t completion of prev	entative maintenance annually x1 and bring findin	generator inspection.						
	QA Committee for further Recommendations		with a second of the	90 10 110						
	Date of Completion: May 1, 2020									
				į						
				j						
				1						
	· · · · · · · · · · · · · · · · · · ·									

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other statements are protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether of not a plan of correction 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 deticiencies are often away 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 deticiencies are often away 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 deticiencies are often away 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. The above isolated deficiencies pose no actual harm to the residents

Krista Swoboda

031099

Administrator 3/25/2020

Event ID: D25I21

MAR 2 5 2020

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If continuation sheet 1 of 1

South Dakota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		10631	B. WING		03/	12/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DORESS, CITY, ST	ATE, ZIP CODE			
GOOD SA	MARITAN SOCIETY HOV	VARD	ZEL AVE 9, SD 57349				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
\$ 000	Surveyor: 41088 A licensure survey for Administrative Rules 44:73, Nursing Facilit	compliance with the of South Dakota, Article ies, was conducted from 20. Good Samaritan Society	S 000				
S 000	Surveyor: 41088 A licensure survey for Administrative Rules 44:74, Nurse Aide, retraining programs, wa	compliance with the of South Dakota, Article quirements for nurse aide s conducted from 3/10/20 d Samaritan Society Howard	S 000				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Krista Swoboda Administrator 3/26/2020

TITLE

(X6) DATE

STATE FORM

