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
	435117	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DEUEL COUNTY	913 COLONEL PETE STREET CLEAR LAKE, SD 57226

(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: 26632 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 4/27/21 through 4/29/21. Good Samaritan Society Deuel County was found not in compliance with the following requirement: F675.	F 000		
F 675 SS=D	Quality of Life CFR(s): 483.24 § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 16385 Surveyor: 43844 Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (20) had been: *Accurately assessed and received appropriate dental care to prevent oral pain from extensive tooth decay. *Accurately assessed to reflect her current dietary needs. Findings include: 1. Observation on 4/27/21 at 12:12 p.m. of resident 20 revealed visible cracks and dark	F 675	Most current oral assessment was complete 5/19/2021 which reflected resident having obvious or likely cavity and/or broken natural teeth, as well as having mouth pain and/or difficulty chewing. The dental a ppointment is scheduled for 5/20/2021. The current care plan reflects oral care to be provided AM and HS with assistance by the CNA. To monitor pain and dental discomfort or difficulty chewing. The dietitian continues to monitor intake and diet as well as resident preferences or refusal of NDD2 and thickened liquids at times. For all other potentially affected residents - The facility must ensure appropriate dental assessments are completed and oral hygiene and dental care is provided with daily cares as reflected in the plan of care. The facility must ensure dental needs are addressed in a timely manner, including addressing mouth pain and chewing difficulties. The facility will schedule appointments as needed with dental providers to provide dental health to each resident. In-Service/Training: Education provided by the Director of Nursing or designee 5/19 to nursing department related to oral and dental hygiene, oral health assessment UDA. Oral/Dental policy and procedure as well as facility process for scheduling appointments. Audits: The Director of nursing and or designee will audit the oral health assessment UDAs for completion weekly x 4 weeks and monthly x 4 months to ensure all residents have been assessed. Through the audit process residents identified with possible cavities, broken teeth, ill- fitting dentures, as well as complaints of mouth pain will be addressed per the review as to last dental appointment, provider orders for dental needs and scheduling appointment for dental care with the providers. Audit findings will be reported to the quality committee monthly for further recommendations. Resident has orders for scheduled tylenol in am for pain. Resident is also prescribed PRN pain medication. Routine pain assessments are completed by nursing department. Non-pharmaceutical pain interventions are utilized within the facility. Assessments and audits will be presented at QA Committee on 6/8/2021.	6/8/2021

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

MBA, LNHA

TITLE: Administrator

(X6) DATE: 5/26/2021

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.

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F 675	Continued From page 1 colored areas were visible on her lower front teeth when she spoke. Observation and interview on 4/28/21 at 10:30 a.m. with resident 20 revealed she: *Had visible cracks and dark colored areas on her lower front teeth. *Had oral pain due to her teeth. *Had problems with chewing. *Thought she had been to the dentist in a February, but she was not sure of the year. -She was only missing one tooth at that time. -Her dentist wanted to fix her teeth. Interview on 4/28/21 at 2:31 p.m. with licensed social worker C regarding resident 20 revealed: *The last time she had been to the dentist was on 9/23/19. *Her dentist had recommended at that time all her teeth be removed due to decay. *She would have liked implants put in. Interview on 4/28/21 at 4:20 p.m. with licensed practical nurse (LPN) E regarding resident 20 revealed: *She had complained of pain in her mouth. *She had reported to another staff member that she had mouth pain last weekend. Observation and interview on 4/28/21 at 4:25 p.m. with resident 20 and registered nurse/Minimum Data Set assessment coordinator (RN/MDS) D during an oral assessment revealed: *RN/MDS D: -Stated there was brown coloring on a back tooth that appeared to be either tooth decay or plaque. -Asked her if she wanted a dental appointment. -Agreed the condition of her teeth may have contributed to her being on a mechanical soft	F 675		

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F 675	Continued From page 2 diet. *Resident 20: -Stated she had pain in her mouth and pointed to her lower right jawline. -Confirmed she wanted dental appointment. Interview on 4/28/21 at 4:34 p.m. with LPN E revealed resident 20 reported mouth pain in February 2021. Interview on 4/28/21 at 4:35 p.m. with certified nursing assistant (CNA) F regarding resident 20 revealed: *Sometimes she had been unable to hold her toothbrush because of her disease process. *They tried to use pink oral care swabs instead of her toothbrush because of the poor condition of her teeth. Review of resident 20's medical record revealed: *She was admitted on 2/26/19. *A 9/23/19 dentist note revealed "Dr. rec. [recommends] all teeth to be removed due to deep decay." *Her MDS assessments dated 11/21/19, 8/20/20, 11/19/20, and 2/18/21 all revealed: -She had been on a mechanically altered diet. -She had no obvious or likely cavity or any broken natural teeth. *Oral assessments dated 2/20/20, 5/21/20, 8/20/20, 11/18/20, and 2/18/21 revealed she had no obvious or likely cavity or any broken natural teeth. *A dining assessment dated 2/18/21 revealed no signs or symptoms of possible swallowing disorder. *A nutritional status progress note dated 2/24/21 revealed: -Diagnosis of malnutrition.	F 675		

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F 675	Continued From page 3 -Diet is National Dysphagia Diet 2 (NDD2) (diet for individuals with chewing and swallowing challenges) and spoon thickened liquids. -High nutrition risk. Review of resident 20's care plan dated 3/24/21 revealed: *Focus area related to activities of daily living and self-care deficit: -Interventions: --She required NDD2 diet. --She required spoon/pudding consistency thickened liquids. --She had her own teeth and required assistance for oral cares. *Focus area related to nutritional problem or potential nutritional problem, moderate protein-calorie malnutrition, choking episodes, and swallowing problem. Review of resident 20's progress notes revealed: *3/31/21 at 2:53 a.m., she received Tylenol 500 milligram (mg) for right lower jaw pain. -She rated her pain at eight out of ten with ten being highest pain level. *4/8/21 at 4:13 p.m., she received Tylenol 500 mg for tooth pain. *4/11/21 at 7:03 a.m., she received Tylenol 500 mg for pain in right lower jaw. *4/25/21 at 11:30 p.m., she stated "She had a chipped tooth and the steel was stuck in her throat." "Resident also didn't have any c/o [complaints of] tooth or mouth pain." -There was no documentation of any assessment of the chipped tooth or her complaint of steel stuck in her throat. *4/28/21 at 10:49 p.m., she received Tylenol 500 mg for complaints of right lower wisdom tooth pain.	F 675		

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F 675	Continued From page 4 -She rated her pain an eight out of ten. -Stated she would like to see a dentist. Interview on 4/29/21 at 8:57 a.m. with administrator A revealed: *Dental needs of residents were provided by a local dental office. *Staff would schedule dental appointments through the residents' providers. *His expectation for any resident that needed dental care would have been for: -A CNA or nurse to report dental care needs to the charge nurse. -The charge nurse would determine if the director of nursing or physician should be notified. -Appointments would be scheduled as needed. Review of the provider's 4/23/21 Oral Hygiene, Dental Health Assessment, Dental Services-Rehab/Skilled policy revealed: *Purpose: -To observe the oral cavity for abnormalities. -To provide appropriate oral/dental assessment on a resident. -To ensure good oral hygiene. -To provide comfort and well-being. -To maintain healthy condition of teeth and oral cavity. -To ensure dental needs of all residents are met in a timely manner to maintain good oral hygiene. *Policy: -"The purpose of these assessments is for early identification and evaluation of any dental/oral health problems in order for treatment by a dentist or other professional to begin as early as necessary." -"Referral will be made to appropriate specialized care as needed, as well as assistance given in obtaining appropriately fitting appliances."	F 675		

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E 000	Initial Comments Surveyor: 26632 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 4/27/21 through 4/29/21. Good Samaritan Society Deuel County was found in compliance.	E 000		

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

MBA, LNHA

TITLE: Administrator

(X6) DATE: 5/18/2021

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	435117	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/28/2021

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K 000	INITIAL COMMENTS Surveyor: 40506 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 4/28/21. Good Samaritan Society Deuel Nursing Home 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 K211, K362, K363 and K754 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the provider failed to provide exits free of obstruction as required at one of four exit corridors. Findings include: 1. Observation beginning on 4/28/21 at 10:00 a.m. revealed the 100 Corridor had excessive storage within the exit corridor. Two large patient lifts, two mobile nurse work stations, and two 50	K 211	It is the policy of the facility to maintain egress in accordance with NFPA standards and requirements. And accept this, facilities credible allocation of compliance and correct the citation K211. Corrective action will include: The Environmental Services Director and or designee will remove excessive storage, large patient lifts, mobile nurse workstations, and two 50 gallon receptacles from the 100 corridor clearing an unobstructed path of egress. Facility preventative maintenance program will be updated to include weekly egress inspections. To protect residents, the Environmental Services Director and or designee will conduct weekly egress inspection to meet this requirement. Assurance of On-Going Compliance: The Environmental Services Director and or designee will conduct ongoing weekly inspections to ensure egress inspections to meet this requirement and as identified in our preventative maintenance program. The facility safety committee will review and oversee documentation that shows that the aforementioned inspections are performed weekly as required for a period of 3 months. The facility administrator will monitor and verify weekly egress inspections are completed and documented per assigned PM scheduling.	6/8/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5/21/2021

MBA, LNHA

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K 211	Continued From page 1 gallon receptacles were within the corridor. The clutter level remained stable through the end of survey at 2:00 p.m. Patient movement was impeded throughout. Interview at the time of the observation with the Director of Environmental Services confirmed those conditions. He stated their process was to keep items accessible. Failure to provide unobstructed egress as required increases the risk of death or injury due to fire. The deficiency affected 100% of the smoke compartment occupants.	K 211		
K 362 SS=D	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout	K 362	It is the policy of the facility to perform fire/smoke wall penetration NFPA standards and requirements. And accept this, facilities credible allocation of compliance and correct the citation K362. Corrective action will include: The Environmental Services Director and or designee will make all necessary repairs to the storage closet walls across from the Frienship Room. To meet NFPA code requirements. The Environmental Services Director and or designee will make all necessary repairs to the records storage room walls across from the Friendship Room. To meet NFPA code requirements. Facility preventative maintenance program will be updated to include semi-annual Smoke and Fire Barrier Penetration inspections. Assurance of On-Going Compliance: The facility safety committee will review and oversee documentation that shows that the aforementioned inspections are performed semi-annual as required for a period of 12 months. The facility administrator will monitor and verify semi-annual fire and smoke ceiling/wall inspections are completed and documented per assigned PM scheduling.	6/8/2021

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K 362	Continued From page 2 the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the provider failed to maintain corridor separation from two randomly selected walls. Findings include: 1. Observation on 4/28/21 at 10:30 a.m. of the storage closet across from the Friendship Room revealed one layer of gypsum was removed. The removed portion was a rectangular shape approximately 14" x 18" cut to install building services equipment. Numerous openings for piping also impacted the capability of the wall to provide adequate corridor separation. 2. Observation on 4/28/21 at 11:30 a.m. of the records storage room revealed an opening on the room side of the corridor wall approximately 4.5" in diameter that will impact the capability of the wall to provide adequate corridor separation. Interview with the director of environmental services at the time of the observations confirmed the finding. The deficiency had the possibility of affecting all occupants of the smoke compartments.	K 362		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for	K 363	It is the policy of the facility to perform fire/smoke door inspections per NFPA standards and requirements. And accept this facilities credible allocation of compliance and correct the citation K363. Corrective action will include: The Environmental Services director and or designee will make all the necessary adjustment to assure the gaps between cross corridor doors 100, 200, 300 and the dinning doors are adjusted to NFPA requirements. The Environmental Services director and or designee will make all the necessary adjustment to assure corridor 103 (Resident room two leaf door) limits the	

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K 363	Continued From page 3 at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the provider failed to provide corridor doors as required. Findings include:	K 363	passage of smoke penetration per NFPA code requirements. The facility preventative maintenance program will be updated to include annual smoke door & fire doors inspections as scheduled. Assurance of On-Going Compliance: The Environmental Services Director will perform annual door inspections per NFPA requirements and preventative maintenance schedule. The Environmental Services Director and or Designee will present findings to the facilities safety committee. The facility administrator will monitor and verify doors inspections are completed and documented per assigned scheduling.	6/8/2021

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K 363	Continued From page 4 1. On 4/28/21, from 9:50 until noon, the cross-corridor doors were not installed to limit the passage of smoke as required. The gap between cross-corridor doors at the 100 Corridor, 200 Corridor, 300 Corridor and the Dining Room were all approximately 0.33 inches. 2. On 4/28/21 at 10:15 a.m, corridor door 103 did not limit the passage of smoke as required. This resident room is a two leaf door with a one-half inch gap between the leaves. These findings have the possibility of affecting 100% of residents within the facility.	K 363		
K 754 SS=D	Soiled Linen and Trash Containers CFR(s): NFPA 101 Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 This REQUIREMENT is not met as evidenced by: Surveyor: 40506	K 754	It is the policy of the facility to maintain and handle soiled linen container per NFPA 101 requirements. And accept this, facilities credible allocation of compliance and correct the citation K754. Corrective action will include: The Environmental Services director and or designee will take the existing 50 linen containers out of service. The Environmental Services director and or designee will replace the 50 gallon linen containers with 32 gallon linen containers per NFPA 101 requirements. The facility preventative maintenance program will be updated to include linen container inspections as scheduled. Assurance of On-Going Compliance The Environmental Services Director will perform monthly linen container inspections per NFPA requirements and preventative maintenance schedule. The Environmental Services Director and or Designee will present findings to the facilities safety committee.	6/8/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435117	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DEUEL COUNTY	913 COLONEL PETE STREET CLEAR LAKE, SD 57226

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K 754	Continued From page 5 Based on observation and interview, the provider failed to maintain proper storage of soiled linen receptacles. Findings include: 1. Observation on 4/28/21 at 10:00 a.m. revealed the 100 Corridor having two 50 gallon covered receptacles marked soiled linen in the exit corridor. The containers remained in the same location all morning. Interview with the director of environmental services at the time of the observation confirmed that finding. He commented that their process would leave the covered containers in the corridor until they became full, when they would be moved to soiled laundry. The deficiency had the potential to affect 100% of the occupants of the smoke compartment.	K 754		

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
	10608	A. BUILDING: _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DEUEL COUNTY	913 COLONEL PETE ST CLEAR LAKE, SD 57226

(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: 26632 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 4//27/21 through 4/29/21. Good Samaritan Society Deuel County was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 26632 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 4/27/21 through 4/29/21. Good Samaritan Society Deuel County was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: MBA, LNHA | TITLE: Administrator | (X6) DATE: 5/18/2021