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
	435087	A. BUILDING _____ B. WING _____	03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY CANISTOTA	700 WEST MAIN ST CANISTOTA, SD 57012

(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: 41088 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/21/22 through 3/23/22. Good Samaritan Society Canistota was found not in compliance with the following requirements: F685 and F812.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Surveyor: 41088 Based on observation, interview, record review, admission packet review, and policy review, the provider failed to ensure one of one sampled resident (36) with a visual impairment had received services to ensure he had eye glasses in good repair to maintain his vision. Findings include: 1. Observation and interview on 3/22/22 at 3:27 p.m. with resident 36 revealed he: *Had been a resident at the facility since	F 685	Resident 36 is scheduled for eye appointment on 4/19/22. To identify other residents having the potential to be affected by the deficient practice, the DNS or designee will audit all residents to ensure vision services have been provided or offered by 4/29/22. To ensure systemic change by 4/29/22, DNS or designee will educate nursing staff on encouraging residents to wear their glasses, reporting broken or missing glasses, and documenting a resident's refusal to use assistive devices or go to appointments. Each resident will be offered an eye doctor appointment quarterly with their care conference going forward. To monitor performance, DNS or designee will audit 3 residents by observation and interview to ensure staff encourage and assist resident to wear their glasses, appropriately report broken or missing glasses, document refusal of glasses or services, and that an eye doctor appointment is offered during care conference. Audits will occur weekly x2, every other week x2 and monthly x1. DNS or designee will report audit finding to QAPI committee monthly. The QAPI committee will determine ongoing interventions and monitoring.	4/29/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alexis Luke	Administrator	4/15/22

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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GOOD SAMARITAN SOCIETY CANISTOTA	700 WEST MAIN ST CANISTOTA, SD 57012

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F 685	Continued From page 1	F 685		

November 2020.
*Squinted during the conversation with this surveyor who was seated approximately three feet from him.
*Was able to see me but said my image was very fuzzy.
*Had glasses when he was admitted to the facility but had not had them for a long time.
*Was unsure of what had happened to his glasses but thought they were lost or stolen.
*Wanted to see an eye doctor so he could get a new pair of glasses.
*Had not seen an eye doctor since he had come to the nursing home.
*Wanted improved vision.

Interview on 3/23/22 at 9:09 a.m. with Minimum Data Set (MDS) coordinator D revealed she was familiar with resident 36 and:
*Had completed the MDS assessments for him since his admission.
*Had thought his vision was good without glasses.
*Had him read from a newspaper when she completed the MDS assessments; he did so without difficulty.
-Had not thought to have him wear glasses when she assessed him even though he had glasses when admitted to the facility.
*She had not considered his vision could have been poor from a distance or that her assessment of his vision may not have been accurate.
*Had no knowledge of what happened to his glasses.

Interview on 3/23/22 at 10:08 a.m. with licensed social worker (LSW) E revealed she:
*Had worked for the provider for a couple of

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F 685	Continued From page 2	F 685		

months.
*Was unaware that resident 36 had glasses when he was admitted to the facility.
*Thought his vision was fairly good as he was able to make eye contact with her when she met with him.
*Had not thought to ask about his vision.
*Agreed that this should have been caught during his care conferences when all areas of his care are reviewed and with the MDS assessment.

Interview on 3/23/22 at 1:42 p.m. with administrator A revealed:
*She was unaware of what had happened to resident 36's glasses or location.
*An appointment had been made for the resident to see an eye doctor and he had refused to go.
*No supporting documentation had been provided to support that an appointment had been made, the resident had refused to attend the appointment, or that a new appointment had been attempted.
*She agreed there should have been follow-up to ensure the resident had the best possible vision.

Review of the provider's admission packet Resident's Rights for Skilled Nursing Facilities document revealed:
"The resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside of the facility. A facility must protect and promote the rights of each resident, including each of the following rights:
*A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.

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F 685	Continued From page 3 The facility must protect and promote the rights of the resident. *The facility must provide equal access to quality care regardless of diagnosis, severity of condition or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge and the provision of services under the State plan for all residents regardless of payment source." Review of the provider's 4/6/21 Eye care- Culture, Eyeglasses, Prosthesis, Services- Rehab/Skilled, Therapy and Rehab policy revealed: *Procedure for eyeglass care: ...8. Report to charge nurse any problems with glasses such as broken or missing lens. 9. Encourage resident to wear glasses whenever necessary.	F 685		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §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	F 812	By 3/30/22, CDM and administrator educated all dietary staff on cleaning expectations and maintaining kitchen and store room floors in sanitary condition. On 4/6/22, all equipment was removed and floors thoroughly cleaned. To ensure systemic change, on 4/6/22 CDM implemented new cleaning logs to include kitchen and storeroom floors to be swept twice daily and all equipment to be removed and floors to be cleaned monthly. To monitor performance, Administrator or designee will audit cleaning logs and observe kitchen and store room floors to ensure both are maintained in sanitary condition. Audits will occur weekly x2, every other week x2, and monthly x1. CDM or designee will report audit findings to QAPI committee monthly. The QAPI committee will determine ongoing interventions and monitoring.	04/29/22

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F 812	Continued From page 4 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Surveyor: 41088 Based on observation, interview, job description, and policy review, the provider failed to ensure kitchen floors and storeroom floors were maintained in a sanitary condition for one of one kitchen. Findings include: 1. Observation and interview on 3/21/22 at 4:00 p.m. with certified dietary manager (CDM) B during the initial kitchen tour revealed: *She had worked for the facility for three years and served in her current position for a year. *All floors under and behind equipment, shelving, and service tables had an accumulation of dust balls and food debris. *The floors under the stove, food preparation (prep) table, and the steam table had what appeared to have been an accumulation of dust, grease, and food crumbs. *There was dirt built-up along the edges of the walls and in the corners wherever those areas were exposed and could be seen. *The area under the pipes of the two-compartment sink had particles of food and paper scraps that had collected underneath. *They had normally had a service company come in and power wash the floors, but that had not happened due to the pandemic. *The dietary staff had cleaning checklists that they were to complete, and she reviewed those forms. *There had been daily cleaning checklists for the following dietary staff to complete: -Cooks. -Early assistant (6:00 a.m. to 2:30 p.m.).	F 812		

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F 812	Continued From page 5 -Day assistant (7:30 a.m. to 4:00 p.m.). -Evening assistant (after 4:00 p.m.). *Kitchen cleanliness was something that they had been working on. *The p.m. dietary staff were responsible to ensure the floor is scrubbed and cleaned each night. *The checklist had been marked off and initialed as completed for that task. *She agreed that the condition of the floor was not up to standards. Observation on 3/22/22 at 8:00 a.m. of the kitchen and storage areas revealed the floors appeared to remain in the same condition with food and dirt particles as the above observation. Observation and interview on 3/22/22 at 10:50 a.m. with cook C. *The floors appeared to not have been swept and were in a similar state as the above 3/21/22 observation. *The storage rooms appeared to have been unswept, with food and dirt particles throughout the areas. *There were pieces of aluminum foil, individual packets of pepper, scraps of cardboard, and *She stated this had been the usual condition of the floors. *The dietary staff spot cleaned between the breakfast and lunch meals. *She was unsure who was assigned to the task for the day but thought someone had already done this. Observation on 3/22/22 at 11:43 a.m. of the kitchen and storage room floors revealed floors in a similar condition as the above observations. Observation and interview on 3/23/22 at 12:45	F 812		

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F 812	Continued From page 6 p.m. with CDM B revealed: *Her agreement that the floors had not appeared to be clean and should have been. *Review of that days checklist revealed the floor had been cleaned. *Although the checklists had been initialed as completed, the condition of the floor had not been acceptable. Interview on 3/23/22 at 1:40 p.m. with administrator A revealed: *She had been aware of issues with cleanliness in the kitchen. *They had been working on this as a performance improvement plan for several months. *They had revised the kitchen cleaning checklists to improve kitchen cleanliness. *She would expect the storeroom floors and kitchen floors to remain clean. *She agreed CDM B was responsible to ensure the kitchen is maintained in a sanitary condition and had not done so. Review of the provider's Food and Nutrition Supervisor job description responsibilities revealed: "This position will be held accountable for complying with all related laws, regulations, company policies and procedures pertaining to his or her position and for fulfilling his or her obligations under the [provider name]'s Corporate Compliance Program." Review of the provider's 3/7/22 Person in charge-Food and Nutrition Services policy revealed: "The director of food and nutrition services (DFN) or senior living dining director is the person in charge while on duty and is certified as a food protection manager by ServSafe or equivalent. The DFN is responsible for all aspects of the food	F 812		

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F 812	Continued From page 7 and nutrition department including but not limited to daily operations, food safety, food production, sanitation and infection control, personnel training and quality assurance. The DFN will ensure that federal, state, and local guidelines and regulatory requirements are being followed."	F 812		

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E 000	Initial Comments Surveyor: 41088 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 3/21/22 through 3/23/22. Good Samaritan Society Canistota was found in compliance.	E 000		

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

Alexis Luke | Administrator | 4/15/22

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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	435087	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/22/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY CANISTOTA	**700 WEST MAIN ST CANISTOTA, SD 57012**

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K 000	INITIAL COMMENTS Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/22/22. Good Samaritan Society Canistota (building 01) was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 3/23/22. Please mark an F in the completion date column for K241 and K374 deficiencies identified as meeting the FSES, in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 241 SS=C	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation and record review, the provider failed to maintain at least two conforming exits from each floor of the building. One of two floors (basement) did not have two conforming	K 241		F

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Alexis Luke | Administrator | 4/15/22

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K 241	Continued From page 1 exits. Findings include: 1. Observation on 3/22/22 at 11:31 a.m. revealed there was only one exit provided from the basement boiler room. The only exit was a stair enclosure that discharged into the vestibule on the main level. Review of previous survey data also identified that condition. The building meets the FSES. Please mark an F in the completion date column to indicate the provider's intent to correct deficiencies identified in K000. That deficiency would only affect one or two maintenance personnel if in the basement during a fire emergency.	K 241		
K 374 SS=C	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Surveyor: 27198	K 374		F

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K 374	Continued From page 2 Based on measurement and document review, the provider failed to maintain at least thirty-two inches of clear width for two of two smoke barrier doors (100 and 200 wings). Findings include: 1. Measurement on 3/22/22 at 1:11 p.m. revealed the cross-corridor doors to the 100-wing measured thirty-one inches of clear width. Further measurement revealed the cross-corridor doors to the 200-wing adjacent to the nurses' station measured thirty inches of clear width. Review of the previous life safety code survey confirmed those findings. The building meets the FSES. Please mark an F in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K 374		

South Dakota Department of Health

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	10603	A. BUILDING: _____ B. WING _____	03/23/2022

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GOOD SAMARITAN SOCIETY CANISTOTA	700 W MAIN STREET CANISTOTA, SD 57012

(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: 27198 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/21/22 through 3/23/22. Good Samaritan Society Canistota was found not in compliance with the following requirement: S296.	S 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation,this response and plan of correction constitutes the center's allegationof compliance in accordance with section 7305 of the State Operations Manual.	
S 296	44:73:07:11 Director of Dietetic Services A full time dietary manager who is responsible to the administrator shall direct the dietetic services. Any dietary manager that has not completed a Dietary Manager's course, approved by the Association of Nutrition & Foodservice Professionals, shall enroll in a course within 90 days of the hire date and complete the course within 18 months. The dietary manager and at least one cook must shall successfully complete and possess a current certificate from a ServSafe Food Protection Program offered by various retailers or the Certified Food Protection Professional's Sanitation Course offered by the Association of Nutrition & Foodservice Professionals, or successfully completed equivalent training as determined by the department. Individuals seeking ServSafe recertification are only required to take the national examination. The dietary manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each resident are met. If the dietary manager is not a dietitian, the facility shall schedule dietitian consultations onsite at least monthly. The dietitian shall approve all menus, assess the nutritional status of residents with problems identified in the assessment, and review and revise dietetic policies and procedures during scheduled visits. Adequate staff whose working hours are	S 296	Cooks involved in the deficient practice were educated by Certified Dietary Manager and Administrator on 3/30/22. Employee C was registered for ServSafe Food Protection Program certificate on 4/1/22 and will be completed with course on or before 4/29/22. To monitor our performance to ensure that solutions are sustained, audits for adherence ServeSafe Food Protection Program certificate audits will be conducted by administrator or designee weekly X 2, bi-weekly X2, and monthly X 1. Administrator or designee will report audit findings to QAPI committee monthly. The QAPI committee will determine ongoing interventions and monitoring.	04/29/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Alexis Luke — TITLE: Administrator — (X6) DATE: 4/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10603	A. BUILDING: _____ B. WING _____	03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY CANISTOTA	700 W MAIN STREET CANISTOTA, SD 57012

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S 296	Continued From page 1 scheduled to meet the dietetic needs of the residents shall be on duty daily over a period of 12 or more hours in facilities. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 41088 Based on record review, interview, and policy review, the provider failed to ensure at least one cook possessed a current ServSafe Food Protection Program certificate. Findings include: 1. Interview on 3/23/22 at 12:15 p.m. with certified dietary manager (CDM) B revealed she: *Had worked at the facility for three years and in her current position for a year. *Was the only staff person in the kitchen that had a current ServSafe certificate. *Review of her certificate revealed it was good through 7/16/25. *Had been aware the dietary manager and at least one cook working in the kitchen had needed to have a current ServSafe certificate. Interview on 3/23/22 at 1:40 p.m. with administrator A revealed: *There needed to have been at least one cook that had a current ServSafe certificate. *Confirmed there were no cooks that were currently ServSafe certified. Review of the provider's 3/7/22 Person In Charge- Food and Nutrition Services policy revealed: *"The director of food and nutrition services (DFN) or senior living dining director is the person in charge while on duty and is certified as a food protection manager by ServSafe or equivilant. The DFN is responsible for all aspects of the food and nutrition department including but not limited	S 296		

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
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S 296	Continued From page 2 to daily operations, food safety, food production, sanitation and infection control, personnel training and quality assurance. The DFN will ensure that federal, state and local guidelines and regulatory requirements are being followed."	S 296		