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

PRINTED: 09/30/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435082	A. BUILDING ______ B. WING ______	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY LENNOX	404 EAST 6TH AVENUE LENNOX, SD 57039

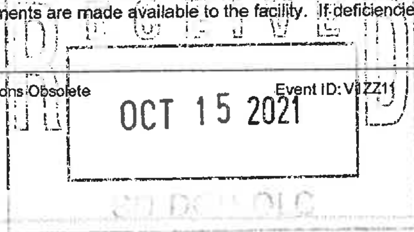
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 29354 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 9/14/21 through 9/16/21. Good Samaritan Society Lennox was found not in compliance with the following requirements: F657, F688, F700, F725, F812, and F880.	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 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 657	1. On 10/7/2021, care plans for residents 14, 16, and 19 were reviewed by the interdisciplinary team and updated to reflect their current conditions. 2. A resident who has experienced a change in condition has the potential to be affected if the care plan does not accurately reflect their condition. By 10/14/2021, the interdisciplinary team will review all resident care plans to ensure they accurately reflect the residents current condition. 3. By 10/14/2021, DNS or designee will re-educated nurses regarding when and how to update care plans. Going forward, within 48 hours of readmission, the interdisciplinary team will review residents care plan to ensure it matches their current condition. 4. To monitor performance, MDS coordinator or designee will audit 5 resident care plans to ensure they are updated and reflect the resident's current conditions. Audits will occur weekly x4, monthly x2, and quarterly x1. Administrator or designee will report findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring.	10/14/2021

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

TITLE: Administrator

(X6) DATE: 10/8/2021

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 657	Continued From page 1 assessments. This REQUIREMENT is not met as evidenced by: Surveyor: 45383 Surveyor: 44928 Based on observation, interview, record review, and policy review, the provider failed to ensure three of fifteen sampled residents (14, 16, and 19) had an updated and revised care plan to reflect their current condition. Findings include: 1. Review of resident 14's medical record revealed his: *Physician diet order on 6/21/21 was for a regular diet, level 3-advanced texture, 2 mildly thick consistency (soft diet with mildly thick liquids). *The care plan was last updated on 9/16/21 and was for a regular diet. -No texture for food was care planned. -No consistency with liquids was care planned. Interview on 9/16/21 at 2:20 p.m. with certified dietary manager (CDM) D regarding resident 14's care plan and physician's order revealed she agreed they had not matched. Review of resident 14's current care plan record revealed he: *Had a a fall on 1/17/21 with a right ankle fracture. *Was non-weight bearing. *Required extensive assistance of one and use of a sit-to-stand [mechanical lift] for transfers. Interview on 9/16/21 at 1:23 p.m. and 2:02 p.m. with certified nursing assistant (CNA) F and registered nurse (RN) E revealed he was full weight bearing and transferred with a mechanical	F 657		

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F 657	Continued From page 2	F 657		

lift.

Surveyor: 43021
2. Observation on 9/15/21 at 9:01 a.m. revealed resident 16 was in her semi-private room eating her breakfast meal. She stated she liked to eat in her room as she was used to being alone. She had no roommate.

Review of resident 16's medical record revealed:
*Diagnosis of unspecified dementia with behavioral disturbance.
*Physician's orders for:
-Heart healthy diet was initiated on 4/29/21.
-Heart healthy diet was discontinued on 8/25/21.
-Regular diet, regular texture was ordered on 8/25/21.
-Daily weight was initiated on 4/29/21.
-Daily weight was discontinued on 6/9/21.
-Weekly weight was initiated on 6/9/21.
-Remeron tablet (mirtazapine) give 7.5 mg by mouth at bedtime for appetite with a start date of 7/23/21.
-House supplement three times a day for weight loss, give 2 ounces with a start date of 7/23/21.
-Her roommate moved out of her room on 8/20/21.

Review of resident 16's 9/16/21 comprehensive care plan revealed:
*"Focus: The resident has potential for a nutritional problem R/T [related to] Alzheimer's Disease and decline in cognitive ability.
*Goal: Resident will consume an average greater than 50% of meals through the review date.
*Interventions:
-Resident has order for a therapeutic diet: Heart Healthy.

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F 657	Continued From page 3 -Weigh daily. -Provide resident with a calm, quite setting at mealtimes with adequate eating time. -Resident to dine in resident room with roommate during meals due to COVID 19 precautions. -Monitor closely/report s/s [signs and symptoms] of chewing/swallowing difficulties, coughing, choking, etc. *Date initiated: 4/29/21." *Her care plan had not been updated to reflect her: -Diagnosis of unspecified dementia. -Current diet order. -Updated weekly weight. -Medication for appetite. -House supplement for weight loss. -Preference to eat in her room. Surveyor: 43844 3. Observation of resident 19 on 9/15/21 at 10:54 a.m. revealed she: *Was sitting in her wheelchair with her head down and the television on. *Appeared to be sleeping. *Did not appear to have a catheter. Review of resident 19's medical record revealed she had: *A significant loss of 11.57% from 2/17/21 through 9/7/21. (168.5 lbs to 149.0 lbs.) -Been monitored by the dietitian each month. -Received Remeron [a prescribed medication] as an appetite stimulant. *A current care plan focus of unplanned/unexpected weight loss. -There had been no goal or interventions for the weight loss. Interview on 9/16/21 on 9:39 a.m. with Minimum	F 657		

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Data Set (MDS) coordinator J regarding resident 19's weight loss care plan revealed she:
*Would have expected the CDM to complete the weight loss care plan.
*Stated "The night nurse sometimes initiated a care plan, but they had not always done it correctly."
*Agreed a care plan goal and interventions were not included in the care plan.

Interview on 9/16/21 at 9:28 a.m. with CDM D regarding initiating a care plan when a resident had weight loss revealed:
*The MDS coordinator would initiate it.
*She would then adjust it as necessary.
*She agreed a care plan goal and interventions for resident 19 were not included in the care plan.

Review of resident 19's medical record revealed:
*Her current care plan included a diet care plan for a heart healthy diet with Level 1 puree foods [smooth and free of lumps] and moderately thick consistency fluids.
*She had an 8/19/21 physician's diet order for a regular diet, regular texture, mildly thick consistency for liquids, and meats cut up into small pieces with gravy or sauce added.
-That physician's order was not reflected in her care plan.

Interview on 9/16/21 at 9:45 a.m. with CDM D regarding resident 19's diet care plan revealed she agreed the care plan had not accurately reflected the physician's orders.

Review of resident 19's medical record revealed:
*Her current care plan included an indwelling catheter related to urine retention.
-Catheter care was to be completed by a CNA on

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F 657	Continued From page 5 every shift. *There was no physician's order for catheter care or changing of the catheter. Interview on 9/16/21 at 10:20 a.m. with MDS coordinator J regarding the catheter use for resident 19 revealed: *Her catheter had been discontinued on 8/3/21. *She agreed the care plan should have been updated at that time. 4. Review of the provider's 10/16/20 Care Plan policy revealed: *"Purpose -To develop a comprehensive care plan using an interdisciplinary team approach..." *"Definitions" -"Comprehensive care plan - Includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. -Person centered care - A focus on the resident as the focus of control and supporting the resident in making his or her own choices and having control over their daily life." *Policy -Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. -Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial and educational needs. Any problems, needs, and concerns identified will be addressed through use	F 657		

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F 657	Continued From page 6 of departmental assessments, the Resident Assessment Instrument (RAI) and review of the physician's orders." -"This plan of care will be modified to reflect the care currently required/provided for the resident. -The care plan will emphasize the care and development of the whole person ensuring that the resident will receive appropriate care and services. It will address the relationship of items or services and facility responsibility for providing these services." *The resident's care plan's did not reflect the care currently rquired/provided for the resident's.	F 657		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on interview, record review, document	F 688	1. On 10/5/2021, residents 16 and 37 were screened for therapy and restorative needs. Day shift staff were educated by administrator and DNS or designee during huddles on 10/7/2021 and 10/8/2021, on ensuring residents are notified when restorative gym is open and encouraging them to attend. 2. By 10/14/2021, DNS or therapy director will screen all residents for decline in ROM or mobility and update restorative plans appropriately. 3. Restorative nursing will be offered 5 days per week to residents with a need or request for restorative nursing program. This will be monitored by DNS or designee. A "Moving and Grooving" activity will be offered weekly. 4. To monitor performance, DNS or designee will audit to ensure restorative nursing interventions are available at least 5 days per week. Audits will occur weekly x4, monthly x2, and quarterly x1. DNS or designee will report findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring.	10/14/2021

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F 688	Continued From page 7	F 688		

review, and policy review, the provider failed to have an ongoing restorative nursing program for two of two sampled residents (16 and 37).
Findings include:

Surveyor 43021
1. Interview on 9/15/21 at 9:01 a.m. with resident 16 in her room while seated in a wheelchair revealed she:
*Was ambulatory, but had not walked much.
*Walked one to two times a week.
*Would like to walk more.
*Felt like she was losing the ability to walk.

Review of resident 16's 9/16/21 care plan revealed:
"*Focus: The resident has a need for restorative intervention due to ADL self-care performance deficit/limited physical mobility R/T [related to] Parkinson's Disease E/B [established by] activity intolerance, fatigue, impaired balance, musculoskeletal impairment."
-Date initiated: 7/8/21
*Interventions initiated on 7/8/21 included:
-"NURSING REHAB #1: AROM [active range of motion]: UE/LE [upper extremity/lower extremity] Extremity(ies) -Nustep at Level 4, X [times] 15 mins [minutes] per day, 1 X times/day, up to 6 days a week."
-"Nursing REHAB #1: Walking with FWW [forward wheeled walker]: X 1 person Contact Guard Assist; using verbal cues and encouragement X distance to tolerance to increase endurance; 1 X times/day; up to 6 days a week."

Review of resident 16's medical records plan of care response history from August 15, 2021 through September 11, 2021 revealed out of 28

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F 688	Continued From page 8 opportunities: *Active range of motion (AROM) had only been provided 7 times. -Only one of the days noted above had recorded the number of minutes spent with AROM. --Fifteen minutes had been documented for 9/10/21. *Training and skill practice with walking had only been provided once. Interview on 9/16/21 at 4:34 p.m. with director of nursing (DON) B regarding staffing revealed and confirmed: *The last three to four months staffing in the facility had been in the "worst crunch." *Restorative nursing had been a big issue the last two months due to staffing. *Twenty-five residents were currently on a restorative nursing program. *She had instructed the restorative aides to focus on 6 to 7 residents every 2 weeks and then change the residents focused on to "share the load." *The facility had recently asked a staff person in the physical therapy department to assist in completing the restorative programs. *The plan of care responses for resident 16 noted above, were accurate. Surveyor 29354 2. Interview on 9/14/21 at 5:03 p.m. with resident 37 in her room revealed: *She had been sitting in a recliner. *She received restorative nursing once a week. *The restorative nursing aide was "pulled to work the floor when they were short staffed." *She felt her restorative nursing program should have occured more often.	F 688		

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F 688	Continued From page 9 Review of resident 37's medical record revealed: *Diagnoses of multiple sclerosis and paraplegia. *There was not a physician's order for restorative nursing. *The 8/17/21 annual Minimum Data Set (MDS) assessment had been coded as: -Brief Interview for Mental Status examination score of fifteen indicating she was cognitive. -She required extensive assistance of two staff members for bed mobility, locomotion, dressing, toileting, and personal hygiene. -She had received active range of motion for at least fifteen minutes in the past seven days. Review of resident 37's care plan revealed: *3/11/21: -"The resident has a need for restorative intervention due to a decline in ADL self-care performance deficit, limited physical mobility R/T multiple sclerosis E/B gait and balance problems, history of falls, muscle weakness. *Resident will maintain current level of ROM and use of bilateral hands through next review date. *Nursing rehab #6: AROM bilateral hands-using the Peg board and/or stacking cones 15 minutes 1x a day up to 6 days a week. *Nursing rehab #7: AROM to bilateral lower legs using 2# weights-15 minutes/day - 1x a day up to 6 days a week." Review of resident 37's POC [point of care] resident response rate report from 6/15/21 through 9/15/21 restorative log revealed she had received restorative nursing 27 times out of 90 days. 3. Interview and document review on 9/15/21 at 11:50 a.m. with occupational therapy assistant N	F 688		

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F 688	Continued From page 10 regarding the restorative nursing program revealed: *She: -Worked five days a week between another long term care facility and here. -Worked with residents who were on Medicare A or B. -Had been assisting with the restorative nursing program. *The nursing department would give her a list of residents who were on the restorative nursing program. *The resident's individual restorative nursing programs were documented on their electronic medical record. *She checked the resident list to see who would be ready to start restorative nursing. *Most of the residents had done therapy in their own rooms. *She had worked with resident 37 three months ago. -Resident 37 had been on Medicare part B. *The physical therapist assisted with starting the residents on a restorative nursing program after they had completed Medicare A or B status. *She had provided the surveyor a list of residents they had assisted with. -Three resident names had been highlighted on the list as having recieved restorative nursing today. -Resident 37 had not been one of them. *On the bulletin board in the therapy room was a hand written note of residents' who were to have received restorative nursing. -The nursing department provided the list to the therapy department. 4. Interview on 9/15/21 at 2:15 p.m. with certified nursing assistant (CNA) O regarding the	F 688		

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F 688	Continued From page 11 restorative nursing program revealed: *She: -Had been a restorative aide for one month. -Would be scheduled to work as a restorative aide. *Her working schedule had been inconsistent when she would work as a restorative aide. -If a staff member called in ill she was removed from the restorative aide position and worked on the floor as a CNA. *Having the restorative aide "pulled to the floor" had been going on for a long time before she started as the restorative aide. *She worked eight hour shifts from 6:00 a.m. through 2:30 p.m. *There was no restorative nursing program on weekends. 5. Interview on 9/15/21 at 2:20 p.m. with DON B regarding the restorative nursing program revealed: *The administrator and she had been working on a plan for the restorative nursing program. *They struggled with staffing. *When they needed extra assistance for resident cares the restorative nursing aide would be assigned to work as a CNA and not as the restorative aide. *They had worked with the therapy department to see what they could do to assist with restorative nursing. *She: -Had provided a list of resident names who required restorative nursing to the therapy department. -Tried to "Q" in on the residents who needed more assistance or were due for an upcoming MDS assessment. *The resident group list would change every	F 688		

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F 688	Continued From page 12	F 688		

week.
*On the list she provided to the therapy department every resident who was on a restorative program received some sort of restorative nursing through out the month.
*In the past month the therapy department had slowed down so therapy was able to assist more with the restorative nursing.
*Each resident on a restorative nursing program had recieved some type of therapy three to four times a week.

6. Interview on 9/15/21 at 2:35 p.m. with administrator A regarding the restorative nursing program and the therapy department revealed they:
*Utilized the therapy department when there was no restotrative nursing available.
*Would send the therapy department an updated list of residents who required therapy.

7. Review of the restorative nursing schedule from 8/29/21 through 9/11/21 and interview on 9/15/21 at 4:27 p.m.with DON B revealed:
*Out of the past fourteen days the:
-Nursing staff had provided restorative nursing five times to the residents.
-Therapy department had provided restorative therapy five times to the residents.
*She confirmed therapy had provided restorative therapy to three to five residents on those days and not to all the residents who had been listed had received restorative nursing.
*They did not have a current performance improvement plan for restorative nursing with their Quality Assurance Performance Improvement (QAPI) program.

A request for the Rehab/Skilled policy had been

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F 688	Continued From page 13 requested from DON B on 9/15/21 at 3:20 p.m. The surveyor had been provided with the 7/22/20 Surveillance - Rehab/Skilled policy. That policy had not included any information on how the restorative nursing program was to function. Surveyor: 43021	F 688		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Surveyor: 45383 Surveyor: 43844	F 700	1. Residents 13 and 32 and their representatives were educated on risk versus benefits of using a side rail/grab bar and informed consent was obtained on 10/7/2021. 2. MDS coordinator or designee will educated all residents or their responsible party on risk versus benefits of using a side rail/grab bar and obtain informed or discontinue use by 10/14/2021. 3. Nurse leadership, social services, and administration will review the policy and procedures related use of side rails/grab bars/assistive devices. Residents need for devices will be reviewed on admission and quarterly. If IDT recommends use, will obtain a physician order and informed consent. Care plans will be updated to reflect resident needs. 4. To monitor performance, DNS or designee will audit 5 resident with side rails/grab bars to ensure use is appropriate, physician order is in place, informed consent obtained, and care plan reflects need. Audits will occur weekly x4, monthly x2, and quarterly x1. DNS or designee will report findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring.	10/14/2021

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F 700	Continued From page 14 Based on observation, interview, record review, and policy review, the provider failed to ensure two of two sampled residents (13 and 32) had received risk versus benefits education and obtained informed consent for bed rail/side rail/assist bar usage. Findings include: 1. Observation on 9/14/21 from 3:00 p.m. through 6:00 p.m. and on 9/15/21 from 7:45 a.m. through 4:00 p.m. revealed: *Eight of eight resident beds had side rails installed on them. -All of these beds had the side rails in the up position. 2. Observation and interview on 9/14/21 at 3:46 p.m. with resident 13 revealed: *There was a side rail on the upper left half of her bed. *She did not sleep in her bed. *She slept in her recliner. 3. Observation and interview on 9/15/21 at 7:55 a.m. with resident 32 revealed: *There were side rails on the upper half of her bed that were in the up position. *She used the side rails to help her get in and out of bed. 4. Interview on 9/15/21 at 4:22 p.m. with Minimum Data Set coordinator J regarding the use of bed rail/side rail/assist bars revealed: *She thought all forty-three residents had been using side rails/assist bars. *She had completed side rail safety assessments for all forty-three residents. *Risk of use versus benefits of use of side rails education had not been provided to the residents or their representatives.	F 700		

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F 700	Continued From page 15 -She had not been aware these should have been completed. *Informed consents had not been signed by residents or their representatives. Surveyor 44928 Interview on 9/16/21 at 9:00 a.m. with administrator A and maintenance director L regarding the use of side rails on residents' beds revealed they had been aware the beds had side rails installed on them. Review of the provider's 6/16/21 Bed Safety including Bed Rails, Side Rails, Assist Bars policy revealed: *"Purpose: -To promote bed safety. -To promote appropriate use of bed rails for resident safety when being used for a medical provider-identified medical necessity. -To reduce entrapment risk by providing appropriate resident assessment and use of less restrictive alternatives. to side rails." "Policy......Bed rail/side rail/assist bar usage will occur only when" " Informed consent is obtained from resident and/or responsible party and then documented in the medical record." "Procedure....." "7. If a device will be in use inform the resident and/or the resident representative about the risks and benefits of the chosen device. Using the FDA [Food and Drug Administration] Brochure 'A Guide to Bed Safety......'" 8. Documentation of this informed consent may be done in the Teaching-Resident/Family PN [progress note] and should include the following: -What assessed medical needs would be addressed by the use of bed rail or assist bar;	F 700		

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F 700	Continued From page 16 -The resident's benefits from the use of bed rail or assist bar and the likelihood of these benefits; -The resident's risks from the use of the bed rails or assist bar [and] how these risks will be mitigated; and -Alternatives attempted that failed to meet the resident's needs and alternatives considered but not attempted because they were considered to be inappropriate."	F 700		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge	F 725	1. Social worker met with resident 13 on 10/7/2021, to discuss expectations on call light response time. Staff were educated during huddles on 10/7/2021 and 10/8/2021, by administrator and DNS, on timely responses to requests for transfer assistance and call light response expectations during peak times. Resident 46 was discharged prior to survey. 2. All residents have the potential to be affected by delayed response to call lights. 3. Administrator or designee will provide on-going education weekly x4, then monthly for all-staff regarding responding appropriately to call lights depending on specific circumstances at the time of the call light. SW or designee will discuss response times and how needs are being met during monthly resident council meetings. 4. To monitor performance, Administrator or designee will audit call light response times, interview 5 residents to ensure needs are meet timely, and observe staff for timely response. Audits will occur weekly x4, monthly x2, and quarterly x1. Administrator or designee will report findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring.	10/14/2021

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F 725	Continued From page 17 nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Surveyor 43844 Based on observation, interview, record review, call light log response time review, and policy review, the provider failed to ensure call lights were answered in an appropriate time frame for one of one sampled resident (13), one of one closed resident record (46), one of one confidential resident interview, and confidential interviews during resident group. Findings include: 1. Interview on 9/14/21 at 3:46 p.m. with resident 13 regarding call light response time revealed: *"My call light is not always answered within a reasonable time, it takes one-half hour to 45 minutes. -Everyone is stressed out, they are understaffed, they all are working so hard." -The staff often say 'I am so tired I am the only one working today'; it makes me feel bad." -She did not want to identify who the staff had been. 2. Interview and review of resident 13's call light log response time with social worker (SW) C revealed: *On: -9/10/21 at 12:30 p.m. she had waited 56 minutes before her call light had been answered. -9/14/21 at 10:17 p.m. she had waited 93 minutes before her call light had been answered. *SW C knew it sometimes took over one-half hour before call lights had been answered. Surveyor 44928:	F 725		

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F 725	Continued From page 18 3. Closed record review of resident 46 revealed in her progress notes on: *8/25/21 at 10:26 a.m. "resident's daughter met SW C asking to discharge her mother from the facility. Family is concerned about call light wait times." *8/25/21 at 11:01 a.m. her daughter signed against medical advice paperwork and had her discharged from the facility. Interview on 9/16/21 at 3:44 p.m. with SW C regarding resident 46's call light log response time revealed: *On: -8/24/21 at 7:33 p.m. she had a call light wait time of 38 minutes. -8/25/21 at 7:14 a m. she had a call light wait time of 38 minutes. *Out of 6 total call light wait times she averaged a wait time of 13 minutes. Surveyor 43021 4. Confidential interview with a resident on 9/15/21 at 9:01 a.m. in his/her room with the door closed for privacy regarding call lights revealed: *The nights here were "horrid." *The resident "dreads the nights." *"Only two staff were during working the night and it took a while for the staff to answer his/her call light." 5. Confidential interview on 9/15/21 at 11:00 a.m. with a group of 12 residents during resident council regarding questions asked "Do you get the help and care you need without waiting a long time and did staff respond to their call light timely?" revealed: *The groups response was "not always." *Consensus was mornings were okay, evenings	F 725		

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F 725	Continued From page 19 were longer waits, but nights were dreaded. *Facility staffing at night was a subject that brought many responses that included the following individual resident participant responses: -"Nights suck." -"Terrible" -"One C.N.A for fourty-four residents, I don't see how that's appropriate." --The current census was forty three residents. Surveyor 29354 6. Interview on 9/16/21 at 10:00 a.m. with SW C regarding call light response time revealed: *Their policy did not have a specific time for staff response. *The appropriate call light response time varied based on each residents' needs. *The average call light response time was ten to fifteen minutes. 7. Interview on 9/16/21 at 11:15 a.m. with DON B regarding call light response time and staffing for the night shift revealed: *They staffed one nurse and two CNAs for the overnight shift. *Sometimes they only had one CNA depending if someone had "called in." *She was aware they had a staffing issue. *Administrator A and she had been looking into different call light systems. *They did not have a current performance improvement plan for call light response times. Surveyor 43021 8. Interview and nursing schedule review from 4/30/21 through 9/15/21on 9/16/21 at 1:10 p.m. with DON B regarding night staffing revealed: *The night shift hours were from 10:00 p.m.	F 725		

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F 725	Continued From page 20 through 6:00 a.m. *There were a total of one hundred thirty-nine night shifts of work during the above time frame. *She had highlighted the nights when only one CNA had worked. *On five nights one CNA worked from 10:00 p.m. through 2:00 a.m., the second CNA worked from 2:00 a.m. through 6:00 a.m. which was half the night shift. *37.5 of the above night shifts had been staffed with one CNA out of 139 nights. *27% of the above time frame in the past 3 months had been staffed with one C.N.A. on the night shift. Surveyor 43844 9. Review of the provider's 7/1/21 Call Light policy revealed: *"Purpose -To ensure resident always has a method of calling for assistance -To promptly answer resident's call light Procedure 1. New admission - explain and demonstrate the use of call light system. 2. When a resdient's call light is observed/heard, go the resident's room promptly. Respond to request as soon as possible. Turn call light off and inquire about resdient's request in a friendly manner. 3. Respond to request as soon as possible. Turn call light off and inquire about resident's request in a friendly manner...." Surveyor: 43021 Surveyor: 45383	F 725		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

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F 812	Continued From page 21 §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: 45383 Surveyor: 43844 Based on observation, interview, and policy review, the provider failed to ensure: *Food stored in a sanitary condition and labeled. *Proper hand hygiene and glove use by one of one cook (I) during meal service. *One of one activity freezer temperatures was monitored. Findings include: 1. Observation on 9/14/21 at 2:45 p.m. through 3:30 p.m. revealed: *The pantry storage area had the following: -A box of cucumbers stored on the floor that had	F 812	1. On 10/5/2021, CDM inspected all kitchen refrigerators, freezers, and storage areas to ensure sanitary storage and labeling. On 10/5/2021. Administrator educated activity director on need for temping activity fridge. On 10/11/2021, cook 1 will be educated by CLDS on hand hygiene and glove use. Cook 1 completed online learning module "Safe Food Handling" by 10/8/2021. 2. All residents have the potential to be affected by improper food handling. 3. Dietary staff will complete the Safe Food Handling learning module by 10/14/2021. Kitchen daily checklist has been updated to include verifying all leftovers are properly labeled and dated; weekly checklist updated to include expiration date checks. CDM will conduct weekly audits X4, and report findings to QAPI committee. Activity coordinator will monitor refrigerator temperature daily. 4. To monitor performance, CDM or designee will audit dietary 3 staff for proper hand hygiene and glove use, inspect food storage areas for compliance, and review documentation of refrigerator temperatures. Audits will occur weekly x4, monthly x2, and quarterly x1. CDM or designee will report findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring.	10/14/2021 here

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F 812	Continued From page 22 turned yellow in color and had mold on them. -Three boxes of thickened apple juice concentrate that expired on 7/30/20. -One box of thickened apple juice concentrate that a had been expired on 8/2/20. -An undated tray of six donuts covered in saran wrap. -A Rubbermaid container with cookies in it with no label or date on it. -Four packages of vanilla pudding with a use by date of 6/16/21. -An open canister of Kool-aid with no open or use by date. *The tall refrigerator in the main kitchen had the following stored in it: -A glass bowl with ruffled edges with flowers in it. -A small plastic dish with what appeared to be applesauce in it, covered and with no label or date. *The counter top located next to the steam table had a chip out of the right top side measuring approximately four inches by two inches, making it an uncleanable surface. *The counter top located next to the pots and pans had a crack in the left front of it, making it an uncleanable surface. *The walk in freezer had a package of what appeared to be breaded chicken or fish that had been opened and had no label or date. *Stored on the floor, next to the walk-in cooler, was a large box of foam cups. *In the walk-in cooler there had been a plastic container with what appeared to be hamburger with a date of 9/9 and no use by date. Interview on 9/15/21 at 2:21 p.m. with certified dietary manager (CDM) D revealed: *Her expectation for food items would have a label and a date and not be expired.	F 812		

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F 812	Continued From page 23 *She agreed with the above observation that there had been: -Expired food. -Food with no date or label. 2. Observation on 9/14/21 at 5:44 p.m. of cook I during the meal service revealed the following: *CDM D instructed cook I to use tongs instead of gloves when picking up the cold sandwiches. *Cook I with a pair of vinyl gloves on: -Opened a hot dog bun package. *With the same pair of now contaminated gloves on she: -Picked up a hot dog bun and placed it on a plate. -Placed a hot dog on the bun using a pair of tongs. -Opened a drawer and took out a black serving spoon. -Opened another drawer and took out a serving scoop. --Put those items on the steam table. -Opened the refrigerator door and had not taken anything out of it. -Went into the walk-in refrigerator to get a container of salad. -Opened the salad. -Opened drawer and took out another serving scoop. --Used a scoop to put salad on a plate. -Opened a cupboard door and then closed it. -Picked up a luncheon meat sandwich and placed it on a plate with the same contaminated gloves. *Cook I had not removed the gloves or performed hand hygiene during the above time frame. Interview at the time of the above observation with CDM D revealed: *She agreed cook I had touched ready-to-eat foods with contaminated gloves.	F 812		

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	435082	A. BUILDING ______ B. WING ______	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY LENNOX	404 EAST 6TH AVENUE LENNOX, SD 57039

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F 812	Continued From page 24	F 812		

-Cook I had a history of doing this.
-She had provided education to cook I on proper serving of food on more than one occasion.

Interview on 9/14/21 at 5:52 p.m. with cook I and CDM D revealed:
*Cook I confirmed she had touched hamburger buns and several unclean items with her gloved hands.
*Cook I normally did not wear gloves when serving.
*Cook I was not sure why she was wearing them during the above meal service.
*Cook I took her gloves off and had not performed hand hygiene.

Continued observation on 9/14/21 at 5:53 p.m. of cook I during the meal service revealed with her bare hands she:
*Touched a package of hot dog buns and opened it.
*Touched the mask covering her face, pulling it down and back up.
-With that now contaminated hand she:
--Put soup in a bowl, and placed it on a tray.
--Picked up a sandwich and placed it on a plate.
--Picked up a hot dog bun, used tongs to put a hot dog in it, and placed it on a plate.
---She did this three more times.
--Laid her right hand on a potholder that had dried food on it.
--Picked up a hot dog bun and opened it with both hands.
*She had not performed hand hygiene during this observation.

Review of the provider's 4/8/21 Hand Washing and Glove Use policy revealed:
*"Purpose To provide guidelines regarding hand

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	435082	A. BUILDING ______ B. WING ______	09/16/2021

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F 812	Continued From page 25 hygiene, glove use and foodborne illness when serving highly susceptible populations." "Barriers Acceptable barriers include utensils, deli papers and appropriately used disposable gloves (single task, uncontaminated). Hand washing and hand sanitizer are not acceptable barriers." "....Bare-hand contact with any food is prohibited....." "Policy Employees do not touch any food with bare hands - ready-to-eat or otherwise." "Employees wash their hands as required and wear gloves only when appropriate to protect any food from contamination that may be present on hands. Employees limit the cross-contamination by using gloves correctly and only when appropriate." "Proper Use of Gloves..... 2. Use utensils and single service deli papers whenever possible instead of gloves when touching any food; ready to eat or otherwise." "4. Gloves are not worn when serving food, during food preparation or when completing more than one task. Utensils are used when completing multiple tasks. 5. Gloves are changed as follows: a. Before handling ready-to-eat foods. b. When coming in contact with something that may be contaminated, such as handling pots/pans/tray/utensils, opening a trash can or touching a doorknob or faucet. c. Whenever employee changes an activity, the type of food being worked with or whenever he or she leaves the workstation. d. After sneezing, coughing or touching the face or hair." "f. After touching hair, skin or clothing. g. Any time contamination is suspected." 3. Observation and interview on 9/16/21 at 9:31	F 812		

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F 812	Continued From page 26	F 812		

a.m. with activity director (AD) K regarding the activity refrigerator/freezer revealed:
*There had been liquid coffee creamer in the refrigerator that did not have an open date.
*She had not been aware that an open date was required.
*In the freezer there had been ice cream bars, a small container of ice cream, and six icepacks that belonged to the nursing department.
-She had not been aware that non-food items could not be stored with food items.

Interview on 9/15/21 at 2:33 p.m. with AD K regarding the activity refrigerator/freezer revealed she:
*Monitored the temperature of the activity refrigerator on a weekly basis.
*Documented the temperatures on a flip note pad.
*Had not monitored the freezer temperatures.

4. Review of the provider's 6/23/21 Food-Supply Storage policy revealed:
*"Purpose - to ensure that food is stored properly......"
"Policy:
-Food from approved food sources is stored in sanitary conditions and is not exposed to prolonged periods of excessive heat.
-Personal food is not considered approved food and is not stored in the food preparation kitchen or location refrigerators and storage areas."
"Procedure.......
6. Storeroom layout:
a. All food/supply items are stored six inches off the floor...."
"7. Foods that have been opened or prepared are placed in an enclosed container, dated, labeled and stored properly."

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F 812	Continued From page 27 "14. Internal temperatures of all refrigerators and freezers in the food and nutrition department dining room and nourishment areas are recorded twice daily......." "18. The internal temperatures of all refrigerators and freezers used to store food in locations such as activities, medication and employee lounge are recorded once daily..."	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880	1. Time cannot be turned back to a time prior to the identification of lack of: *Appropriate wearing of personal protective equipment by staff during COVID-19 testing. The administrator and DON in consultation with the medical director and infection control nurse will review, revise, create as necessary policies and procedures about: *Appropriate wearing of personal protective equipment by staff during COVID-19 testing. *Necessary infection control and prevention plan that includes effective compliance. All staff who provide above services to staff and residents will be educated/re-educated by 10/1/2021 by Clinical Learning and Development Specialist. Identification of Others: 2. ALL residents have the potential to be affected if staff do not adhere to: *Appropriate wearing of personal protective equipment during COVID-19 testing. ALL staff completing this assigned task have potential to be affected. Policy education/re-education about roles and responsibilities for the above identified assigned task will be provided by 10/1/2021 by Clinical Learning and Development Specialist. System Changes: 3. Root cause analysis conducted answered the 5 Whys: RCA was completed on 10/7/21 with Administrator, Director of Nursing, RN- Infection Preventionst, and Nurse Consultant. Found a competing priorities led to insufficient training and IP not understanding what PPE was needed while conducting testing. A prioritized training schedule was created to correct this problem.	

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F 880	Continued From page 28 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: 43844	F 880	Administrator, DON, infection control nurse, medical director and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency. Administrator contacted the South Dakota Quality Improvement Organization (QIN) on 10/4/2021 and included discussion of contributing factors to IP error, and QIN providing education on creating a culture of safety with partnering to heal, auditing and strategies for improving infection prevention in nursing homes, and review of communication and performance tracking tools. Monitoring: 4. Administrator, DON, infection control nurse, and whomever else determined necessary will conduct auditing and monitoring for areas identified above. Monitoring of determined approaches to ensure effective infection control and prevention include at a minimum 3-5 times weekly for 4 weeks, administrator, DON, and/or infection prevention nurse making observations across all shifts to ensure staff compliance with: *Necessary infection control and prevention plan that includes compliance in the above identified areas. *Any other areas identified thru the Root Cause Analysis. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by administrator, DON, and/or infection control person, or whomever else is determined necessary, to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director.	10/7/2021

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F 880	Continued From page 29 Surveyor: 45383 Surveyor: 29354 Based on observation, interview, training checklist review, and procedure card review, the provider failed to ensure appropriate personal protective equipment (PPE) was used by one of one sampled registered nurse (RN)/infection control previonist (ICP) (P) during facility wide COVID-19 testing. Findings include: 1. Observation and interview on 9/16/21 at 9:45 a.m. in the hallway with RN/ICP P revealed: *She had on a surgical mask, gloves, and goggles. *There was a three tiered red cart with BinaxNow COVID-19 Ag Cards. -On the cart were documents, nasal swabs, a cooler, and specimen containers. *RN/ICP P said she was collecting nasal samples for COVID-19 testing. -The facility was in out break testing. -She was working on completing one hallway and would finish up the other hallway. -All staff and residents were being tested. -They were testing biweekly on Monday and Thursdays. *They had a positive COVID-19 staff member who had been diagnosed outside of the facility. 2. Interview and document review on 9/16/21 at 10:30 a.m. with RN/ICP P and director of nursing (DON) B regarding the infection control (IC) program revealed: *RN/ICP P: -Worked sixteen hours a week as the ICP. -Had outside resources for IC issues.	F 880		

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F 880	Continued From page 30 3. Interview on 9/16/21 at 2:20 p.m. with RN/ICP P regarding her Abbott Binax Now COVID-19 Ag Card training checklist revealed: *The card was dated 4/21. *She: -Confirmed the training had been completed on 4/21/21. -Had not worn a N-95/KN-95,gown, or face shield during the COVID-19 testing. -Was not aware she was to have worn the PPE listed in the training check list. *No residents or staff had tested positive for COVID-19 today. 4. Interview on 9/16/21 at 2:35 p.m. with DON B regarding the above observation and interview with RN/ICP P revealed: *They would use the Abbott Binax Now COVID-19 Ag Card training checklist as their policy. -They did not have a written policy for COVID-19 testing. -RN/ICP P should have worn the appropriate PPE during testing. *100% of the residents had been vaccinated for COVID-19. Review of RN/ICP P's 4/21 Abbott Binax Now COVID-19 Ag Card -Training checklist revealed: *"BinaxNow COVID-19 Ag CARD - Kit Overview: -"Wear appropriate personal protection equipment and gloves when running each test and handling patient [resident] specimens. -Change gloves between handling of specimens suspected of COVID-19. *"Specimen Collection, Storage and Handling. -The user acknowledges being shown; sample collection and storage conditions in the package insert:	F 880		

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F 880	Continued From page 31 --Perform Hand Hygiene and don gloves, N-95/KN-95; gown, and Face Shield." *The individual completing the Abbott binax Now COVID-19 Ag Card testing was to have worn a N-95/KN-95 mask, gown and face shield.	F 880		

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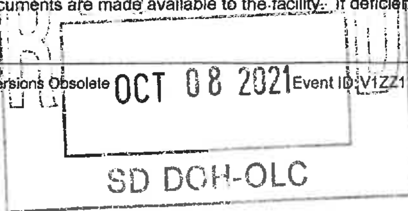
E 000	Initial Comments Surveyor: 29354 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 9/14/21 through 9/16/21. Good Samaritan Society Lennox was found in compliance.	E 000		

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

TITLE: Administrator

(X6) DATE: 10/8/2021

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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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435082	A. BUILDING 01 - MAIN BUILDING 01 B. WING ________	09/15/2021

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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 9/15/21. Good Samartian Society Lennox 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 upon correction of deficiencies identified at K211, K321, and K363 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 211 SS=C	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: 27198 Based on observation, testing, and interview, the provider failed to provide operable egress doors as required at three randomly observed exit door location (west dining room exit, east basement exit, and north basement exit). Findings include: 1. Observation beginning on 9/15/21 at 2:53 p.m. revealed the west exit door out of the dining room was unable to be easily opened. Testing of the	K 211	It is the policy of the facility to maintain all fire rated doors and assemblies are in safe working condition. Corrective Action will include: 1. The Environmental Services Director and/or designee will conduct fire door inspection per NFPA 101 7.2.1.1.5 through NFPA 101 7.2.1.15.8 requirements. 2. West Exit Door leading out of the dinning room was adjusted and repaired to allow for proper operation 3. North Exit Door leading out of the basement was adjusted and repaired to allow for proper operation. Assurance of On-Going Compliance 1. The facility administrator will monitor and verify fire rated doors and assemblies inspections are completed and documented per assigned PM scheduling. 2. The facility safety committee will review and oversee documentation that shows fire rated doors and assemblies are maintained and completed. Every 6 months for one year.	10/14/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	10/8/2021

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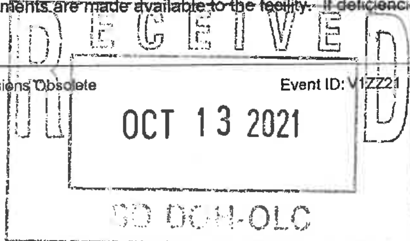
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435082	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/15/2021

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K 211	Continued From page 1 door by applying greater than fifty pounds of force in the direction of the path of egress revealed it would not open. The deficiency affected 100% of the smoke compartment occupants. 2. Observation beginning on 9/15/21 at 3:19 p.m. revealed the east exit door out of the basement was unable to be easily opened. Testing of the door by applying greater than fifty pounds of force in the direction of the path of egress revealed it would not open. The deficiency affected 100% of the smoke compartment occupants. 3. Observation beginning on 9/15/21 at 3:45 p.m. revealed the north exit door out of the basement was unable to be easily opened. Testing of the door by applying greater than fifty pounds of force in the direction of the path of egress revealed it would not open. Interview at the time of those observations with the maintenance supervisor confirmed those conditions. He stated he was unaware those doors were not able to be opened. Failure to provide working egress doors as required increases the risk of death or injury due to fire. The deficiency affected 100% of the smoke compartment occupants. Ref: 2012 NFPA 101 Section 19.2.2.2.1, 7.2.1.4.5.1(2)	K 211		

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	435082	A. BUILDING **01 - MAIN BUILDING 01** B. WING	09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 321	Continued From page 2	K 321		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation and interview, the provider failed to maintain one randomly observed hazardous area (clean linen storage room) as required. Findings include:	K 321	It is the policy of the facility to maintain hazardous areas to contain combustible materials in proper storage capacities and enclosure fire barrier doors close properly without blockage. Corrective Action 1. The Environmental Services Director and/or designee will conduct walk throughs weekly X 4 weeks then monthly X 4 months and report findings to safety committee to assure all doors equipped automatic door closure are not blocked or tied off to restrict the door from closing such as the Kitchen Pantry Storage Room Door. 2. Maintenance Technician was educated on havardous materials in proper storage capacities and enclosure fire doors policies. Assurance of On-Going Compliance The Safety Committee will conduct rounds monthly X 6 months to assure all storage room doors are not obstructed to prevent closure.	10/14/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435082	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY LENNOX	**404 EAST 6TH AVENUE** **LENNOX, SD 57039**

(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 321	Continued From page 3 1. Observation on 9/15/21 at 2:50 p.m. revealed the kitchen pantry storage room was over 100 square feet and contained combustible items. The pantry door was equipped with a closer but was held open with a lift sling wrapped around the door handle. Interview with the maintenance supervisor at the times of the observations confirmed that finding. The deficiency affected one of numerous requirements for hazardous storage rooms.	K 321		
K 363 SS=D	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 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	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: 1) The Environmental Services director and or designee will remove the coaxial TV cable restricting resident room 211 door from proper closure. . Assurance of On-Going Compliance 1. The Environmental Services Director will perform annual door inspections per NFPA requirements and monthly preventative maintenance schedule X 4 months. 2. The Environmental Services Director and or Designee will present findings to the facilities safety committee monthly X 4 months. 3. The facility administrator will randomly monitor and verify resident room doors inspections are completed and documented per assigned scheduling. Will report findings to safety committee monthly X 4 months.	10/14/2021

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
	435082	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**09/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY LENNOX	**404 EAST 6TH AVENUE** **LENNOX, SD 57039**

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K 363	Continued From page 4 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: 27198 Based on observation, testing, and interview, the provider failed to maintain impediment free closing for one randomly observed corridor door (room 211) as required. Findings include: 1. Observation on 9/15/18 at 2:40 p.m. revealed the corridor door to resident room 211 had a coaxial tv cable hanging between it and the door frame. Testing of that door revealed the cable would bind the door before it could latch into the frame. Interview with the maintenance supervisor at the time of the observation and testing confirmed that finding. The deficiency had the potential to affect 100% of the occupants of the smoke compartment.	K 363		

South Dakota Department of Health

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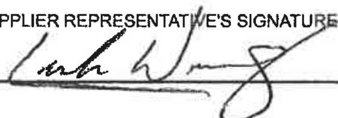
	10642 S	A. BUILDING: ______ B. WING ______	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY LENNOX	**404 E 6TH AVE LENNOX, SD 57039**

(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 9/14/21 through 9/16/21. Good Samaritan Society Lennox was found not in compliance with the following requirement: S157.	S 000		
S 157	44:73:02:13 Ventilation Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 27198 Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation in three randomly observed rooms (room 116, shower room toilet, and room 115). Findings include: 1. Observation on 9/15/21 at 12:25 p.m. revealed the exhaust ventilation for the toilet room in resident room 115 was not functioning. Testing of the grille with a paper towel at the time of the observation confirmed that finding. 2. Observation on 9/15/21 at 12:38 p.m. revealed the exhaust ventilation for the toilet room in the shower room suite was not functioning. Testing of the grille with a paper towel at the time of the observation confirmed that finding. 3. Observation on 9/15/21 at 12:42 p.m. revealed the exhaust ventilation for the toilet room in	S 157	It is the policy of the facility that ventilation systems are maintained in good working order and accept this facilities credible allocation of compliance and correct citation of S157. Corrective Actions: 1. Power roof ventilators supporting Resident rooms 115, 116 and Shower Room Suites is scheduled to be repaired (in house). 2. The preventative maintenance program will be updated to include monthly PRV (Power Roof Ventilation) inspection. 3. The preventative maintenance program will be updated to include monthly exhaust fans Inspection to assure systems operations. Assurance of On-Going Compliance: 1. The Environmental Service Director or designee will per for monthly preventative maintenance inspections to assure proper ventilation. The facility administrator will monitor and verify monthly exhaust inspections are completed and documented per assigned PM scheduling.	10/26/2021

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



TITLE: Administrator

(X6) DATE: 10/8/2021

South Dakota Department of Health

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	10642 S	A. BUILDING: ______ B. WING ______	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY LENNOX	404 E 6TH AVE LENNOX, SD 57039

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S 157	Continued From page 1 resident room 116 was not functioning. Testing of the grille with a paper towel at the time of the observation confirmed that finding. Interview with the maintenance supervisor at the same time confirmed the ventilation wsa not working in those rooms. He also revealed he was unaware the exhaust ventilation was not properly working at those locations. He further stated he believed the fan for the exhaust for that end of the corridor had issues causing those conditions.	S 157		