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
	435074	A. BUILDING ______ B. WING ______	02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 2/7/23 through 2/9/23. Good Samaritan Society De Smet was found in compliance.	F 000		

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

Jody Becker Administrator 2/24/23

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
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/14/2023
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
	435074	A. BUILDING ______ B. WING ______	02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	**411 CALUMET AVENUE NW** **DE SMET, SD 57231**

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E 000	Initial Comments 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 2/7/23 through 2/9/23. Good Samaritan Society De Smet was found in compliance.	E 000		

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

Jody Becker Administrator 2/24/23

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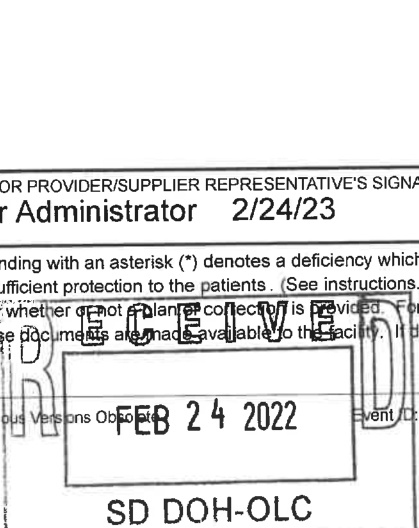

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING 01 - MAIN BUILDING 01 B. WING ____	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 2/7/23. Good Samaritan Society De Smet 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 K226 and K271 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 226 SS=E	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain the two-hour fire resistive rating of the corridor separation. The frame for the 90-minute cross-corridor door leading to the Rehab area appeared to have warped and no longer provided a smoke separation. Findings include: 1. Observation on 2/7/23 at 10:05 a.m. revealed the bottom of the east door of the pair of	K 226	Fire rated/clear anodized aluminum door sweep with neoprene rubber extrusion ordered and installed on 3/3/23. Door company contacted for consultation/fixing of a permenant solution. Audits will be preformed by QAPI or designee to all 90 minute cross corridor doors done weekly for 4 weeks, then monthly for 3 months to ensure all doors provide adequate smoke separation.	3/3/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jody Becker Administrator 2/24/23 | TITLE | (X6) DATE

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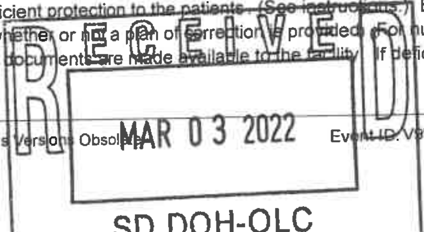
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	435074	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**02/07/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	**411 CALUMET AVENUE NW** **DE SMET, SD 57231**

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K 226	Continued From page 1 cross-corridor doors into the Rehab unit was approximately two-inches above the floor. Since a horizontal exit must also provide a smoke separation (reference NFPA 101 7.2.4.3.9), this door does not comply with the Life Safety Code. The deficiency had the potential to affect all residents of the smoke compartment.	K 226		
K 271 SS=F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to provide a clear egress discharge path to the public way. Three of nine exit discharge paths (assisted living wing, patio, and north dining room door) were not cleared of snow. Findings include: 1. Observation on 2/7/23 at 10:00 a.m. revealed the south exit discharge, commonly known as the old assisted living exit, was not cleared to the public way. Measuring revealed approximately two inches of snow was on the egress path. Interview with the environmental services director at the time of the observation confirmed that condition. 2. Observation on 2/7/23 at 10:30 a.m. revealed	K 271	All exit discharge paths will be free from snow to ensure a clear safe exit can be done by everyone in the building. observation audits will be performed by QAPI or designee of exit discharge paths to ensure they are free from snow. Audits will be done weekly for 4weeks by Administrator. Audit findings will be brought to QAPI commitee, any negative findings will be reviewed and corrected immediately.	2/8/23

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	435074	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**02/07/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	**411 CALUMET AVENUE NW** **DE SMET, SD 57231**

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K 271	Continued From page 2 the patio exit was not cleared to the public way. Measuring revealed approximately two inches of snow was on the egress path. Interview with the environmental services director at the time of the observation confirmed that condition. 3. Observation on 2/7/23 at 10:50 a.m. revealed the north dining room exit was not cleared to the public way. Measuring revealed approximately two inches of snow was on the egress path. Interview with the environmental services director at the time of the observation confirmed that condition. These deficiencies had the potential to affect 100% of the occupants of each smoke compartment .	K 271		

South Dakota Department of Health

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	10614	A. BUILDING: ______ B. WING ______	02/09/2023

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GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVE NW DE SMET, SD 57231

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/7/23 through 2/9/23. Good Samaritan Society De Smet was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 2/7/23 through 2/9/23. Good Samaritan Society De Smet was found in compliance.	S 000		

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

Jody Becker Administrator 2/24/23