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
	435104	A. BUILDING _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 SOUTH MADISON NEW UNDERWOOD, SD 57761

(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 11/14/23 through 11/16/23. Good Samaritan Society New Underwood was found not in compliance with the following requirements: F658, F804, F812, F851 and F880.	F 000	This plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Good Samaritan New Underwood does not admit that the deficiencies listed exist, nor does the facility admit to any statement, findings, facts, or conclusions that form the basis for the alleged deficiency. The facility reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review the provider failed to ensure physician orders for pressure ulcer interventions had been implemented in an appropriate amount of time for one of one sampled resident (86). 1. Observation on 11/16/23 at 9:18 a.m. of resident 86 in his room revealed: *He was seated in his recliner with the foot rest in the elevated position. *The heels of his feet were resting on the outer edge of the footrest. -On his feet were red felt booties. *There was a square foam pad positioned between his thighs which caused his legs to spread outward. *His eyes were closed. Review of resident 86's electronic medical record revealed:	F 658	Resident 86 no longer resides at the facility. However upon identification that the physician order was not entered into PCC, it was entered by the Clinical Care Leader at the time of discovery. All residents with new orders have potential to be affected. DON or designee will review residents with new orders in the PAST 30 days to ensure physician orders were entered into PCC timely, and review NEW admit orders ASAP and at morning clinical following admit. DON or designee will educate nurses on process of entering new orders into PCC per policy. DON or designee will develop a check list for nurses to reference for processing new orders including entering into PCC, and provide education to the nurses on the Physician/Practitioner Orders Policy. DON or designee will also educate nurses to the checklist. DON or designee will audit 5 new orders per week to ensure they were entered timely for 4 weeks, then monthly for 2 months. Results of audits will be discussed by the Quality Manager at the QAPI meeting for analysis and recommendation for continuation/discontinuation/revision of audits based on their findings. Results of audits will be discussed by the Administrator or designee at the monthly QAPI meeting with for analysis and recommendation for continuation/discontinuation/revision of audits based on their findings.	12/15/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — LNHA — TITLE: Administrator — (X6) DATE: 12/13/2023

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 658	Continued From page 1 *He was admitted on 11/2/23. *His diagnoses included: heart failure, urinary tract infection, chronic kidney disease, morbid obesity, malignant neoplasm of the prostate. *His 11/3/23 admission skin observation documentation revealed the following wounds: -A pressure ulcer on his right heel that measured 2.2 centimeters (cm) by (x) 1.5 cm by 0.2 cm. -A pressure ulcer on his left heel that measured 1.0 cm x 1.5 cm x with no depth. -An open area on his right buttock that measured 3.0 cm x 2.3 cm. -A dry reddened area with excoriation on his left buttock that measured 3.0 cm x 3.0 cm. *His 11/13/23 wound data collection form revealed the following wounds: -A stage III pressure ulcer (a wound that extends into deeper tissue and fat but does not reach the muscle, tendon, or bone) on his right heel with no measurements. -A pressure ulcer on his left heel that measured 0.5 cm x 0.8 cm with no depth. -Shearing on his right buttock that was improved. -Shearing on his left buttock that was improved. *His 11/2/23 "NEW Nursing Home Physician Orders" noted on 11/15/23 included: -Daily weights and to call his provider if he had a weight increase of 3 pounds (lbs) overnight or 5 lbs in a week. -Heel protectors. -"Low air loss chair/recliner cushion/mattress". *His electronic medical record physician orders revealed the following start dates for the above orders were: -On 11/7/23 the heel protectors. -On 11/15/23 the: --Daily weights and to call his provider if he had a weight increase of 3 pounds (lbs) over night or 5	F 658		

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F 658	Continued From page 2 lbs in a week. --"Low air loss chair/recliner cushion/mattress". Interview on 11/16/23 at 9:24 a.m. with licensed practical nurse D regarding resident 86's pressure ulcers revealed she thought the stage III right heel pressure ulcer was improving based on the information provided to her during change of shift. Interview on 11/16/23 at 10:15 a.m. with certified nursing assistant F regarding resident 86 revealed: *He always slept in his recliner. *She tried to prop his legs up so his heels would not touch the footrest. -She stated it "Is hit or miss" due to his non compliance. *His red slippers were to take the place of grippy socks to prevent falls. *His feet were wrapped with ace wraps due to the wounds. Interview on 11/16/23 at 10:52 a.m. and again at 12:32 p.m. with director of nursing B revealed: *The low loss air mattress that had been physician ordered on 11/2/23 was not ordered from the vendor until 11/7/23. *There was not a low air loss chair or recliner available. *Not all of resident 86's physician orders from 11/2/23 had been recorded in his electronic medical record. -A temporary agency nurse had entered part of the orders. --She had not been aware that all of the orders needed to be entered. Interview on 11/16/23 at 11:15 a.m. with	F 658		

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F 658	Continued From page 3 administrator A regardin resident 86's physician ordered interventions revealed the provider did not have a low air loss chair or recliner. Review of the provider's Pressure Ulcers Policy revealed: *"Policy -A resident who has a pressure ulcer will receive the necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing. -Residents will receive appropriate assessments and services to promote and maintain skin integrity.	F 658		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review the provider failed to ensure two of two cooks (G and L) on two of two observed opportunities had prepared pureed food for residents with adequate nutritional value. Findings include: 1. Observation and interview on 11/14/23 at 9:00 a.m. with cook G revealed: *Two stainless containers with pureed looking	F 804	No residents were identified. Residents with a pureed diet are at risk for not having food pureed with a liquid of nutritional value. On 12/8/2023, the dietary manager was educated by the administrator to the Textured-Modified Diets Policy stating that pureed foods will be blended with something of nutritive value; not water. Dietary staff were educated by the dietary manager on 12/14/2023 to the Textured-Modified Diets Policy which states that pureed foods will be pureed with a liquid that will enhance the nutritional value of the meal; not water. The administrator, dietary manager or designee will audit 3 pureed meals per week to ensure accurate documentation is in place to ensure pureed food is pureed with a liquid with nutritional value, other than water. Audits will be weekly for 4 weeks and then monthly for 2 months. Results of audits will be discussed by the Dietary Manager or designee at the QAPI meeting for analysis and recommendation for continuation/discontinuation/revision of audits based on their findings.	12/15/2023

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F 804	Continued From page 4 food on the counter. -He stated it was pureed food for residents and they mixed water with it instead of milk/cream due to the amount of phlegm the milk products produced for residents. Observation and interview on 11/14/23 at 11:15 a.m. with cook G regarding pureed food revealed: *He used water to puree the chicken and mix vegetables. *He had been instructed by dietary supervisor O to use water, due to residents coughing and having congestion. -He was not aware water would deplete the nutritional value of the pureed food. 2. Observation and interview on 11/16/23 at 7:31 a.m. with cook L revealed: *She pureed two servings of eggs with one-half cup of water. -The eggs were too runny so she added two squirts of thickener. *She pureed two servings of apple pie filling with one cup of water. -The apples were very runny so she added two squirts of thickener. -Stated some people serve apple sauce instead of pureed apples. *She had been trained by dietary supervisor O to use water. *One of the residents requiring pureed food was allergic to diary products. *Agreed using something with nutritional value would have been a better choice than water. Interview on 11/16/23 at 7:51 a.m. with administrator A regarding the process for resident's pureed food revealed he: *Was not aware that water was being used to	F 804		

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F 804	Continued From page 5 puree the food. *Stated dairy products would provide better nutrition and would make the consistency more appealing than water. *Review of the provider's Texture-Modified Diets Policy revealed: *"Purpose -To ensure safe consumption of food/fluids for those residents who have difficulty chewing/swallowing (dysphagia)." *"Policy -Food and nutrition services provide texture-modified diets that are prescribed by the resident's attending physician. Texture-modified diets are served ...and prepared by methods that conserve nutritive value, flavor, and appearance." Policy review and interview on 11/16/23 at 8:25 a.m. with administrator A revealed that he agreed the policy had not been followed. Dietary Manager O not available for an interview throughout the survey.	F 804		
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	F 812	No residents were identified. Residents are potentially at risk of infection when dietary equipment surfaces are cracked or uncleanable. On 11/20/2023 Maintenance Staff replaced the front of the ice machine. On 12/14/2023, all staff were educated to the Cleaning Schedule for Food and Nutritional Services Policy, and how to report broken or uncleanable surfaces. The administrator, dietary manager or designee will audit the ice machine to ensure the surface is cleanable and not cracked. Audits will be weekly for 4 weeks and then monthly for 2 months. Results of audits will be discussed by the Dietary Manager, Administrator, or designee at the QAPI meeting for analysis and recommendation for continuation/ discontinuation/revision of audits based on their findings.	12/15/2023

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F 812	Continued From page 6 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: Based on observation, interview, and policy review, the provider failed to ensure one of one observed counter ice machine was maintained in sanitary condition. Findings include: 1. Observation on 11/14/23 at 12:05 p.m. of the counter ice machine located in the dining room had: *Three cracks extending from the bottom plastic cup holder upwards about three inches high. *Two cracks directly underneath of the ice dispenser. *There was a clear plastic funnel for the dispensing ice to flow through. -That funnel was not in place on the ice dispenser. --It was sitting on the counter next to the ice dispenser. Random observations throughout the survey on 11/14/23 from 11:15 a.m. to 4:00 p.m. and again on 11/16/23 from 7:32 a.m. through 11:00 a.m. revealed the plastic funnel was not in place on the ice dispenser. Interview on 11/16/23 at 8:48 a.m. with administrator A regarding the ice machine revealed: *He was not aware of the unsanitary condition of	F 812		

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F 812	Continued From page 7 the ice machine prior to the surveyor bringing it to his attention. *He stated he would order a new full front for the ice machine. Review of the provider's Ice Machines Use and Maintenance-Food and Nutrition Policy revealed: *"Purpose: -To provide procedures to limit contamination of ice. -To provide procedures for proper maintenance of ice machines." *"Maintaining the Ice Machine -1. Clean, descale and change filters according to manufacturer recommendations. Adjust the frequency based upon the use and conditions related to the ice machine (location, quality of water, etc.). 2. Use an EPA [Environmental Protection Agency] registered disinfectant suitable for use on ice machines according to manufacturers' instructions."	F 812		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who,	F 851	No residents were identified. Residents are potentially at risk of not having accurate nurse staffing data when hours are not reported correctly. On 12/11/2023, the Administrator, DON, and BOM were educated by the GSS Quality Strategist on how to monitor, adjust and submit accurate and timely PBJ data. Administrator, DON or designee will compare the master schedule to PBJ data each pay period. Administrator or designee will audit PBJ data bi-weekly for 12 weeks. Results of audits will be discussed by the Administrator at the QAPI meeting for analysis and recommendation for continuation/ discontinuation/revision of audits based on their findings.	12/15/2023

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F 851	Continued From page 8 through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by	F 851		

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F 851	Continued From page 9 CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on Payroll Based Journal (PBJ) record review, employee timecard review, staffing schedules, and electronic medical record review, the provider failed to submit PBJ data accurately for three of three federal fiscal quarters (Quarter 1, 2023; Quarter 2, 2023; and Quarter 3, 2023). Findings include: 1. Review of PBJ records submitted to the Center for Medicaid and Medicare (CMS) services revealed the provider submitted the following for no licensed nursing coverage 24 hours per day for: -Quarter 1, 2023 for seven days: 10/8/22, 10/9/22, 10/16/22, 10/23/22, 10/30/22, 11/20/22, and 12/04/22. -Quarter 2, 2023 for six days: 1/8/23, 1/14/23, 1/15/23, 1/21/23, 2/12/23, and 3/5/23. -Quarter 3, 2023 for four days: 5/20/23, 6/3/23, 6/24/23, and 6/25/23. Review of the provider's employee timecards, staffing schedules and resident's electronic medical records documentation revealed the provider had licensed nursing coverage 24 hours per day for the period referenced above. Interview with director of nursing (DON) B on 11/16/23 at 10:50 a.m. regarding PBJ online reporting revealed: *The information was automatically obtained from	F 851		

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F 851	Continued From page 10 individual staff timecards by their electronic payroll system. *They would receive a notification if something appeared to have been incorrect. --Incorrect information was usually related to not having hours worked in the correct code. -The administrator was able to sign into the electronic payroll system and update any incorrect information. *At one point in time agency staff hours were not able to be recorded in the provider's electronic payroll system. -Those hours worked would not have been automatically sent to CMS. *When the DON worked as the charge nurse, her hours codes would have needed to be adjusted. -The administrator or the DON would have had to adjust the payroll code information to reflect actual hours worked. Interview on 11/16/23 at 11:15 a.m. with administrator A regarding PBJ online reporting revealed: *The information was automatically obtained from individual staff timecards by their electronic payroll system. *He was aware that incorrect information had been submitted to CMS on occasion. *He was unsure as to why certain employee's time worked was not being electronically transferred correctly. -He had been, "trying to figure out why". *The administrator and the DON should have had access to the electronic reporting system to correct the submission information before sending the information electronically. -They both had started in the facility recently, and did not have the, "working knowledge how to fix it".	F 851		

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F 880 SS=F	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 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:	F 880	For the identification of: *Lack of appropriate hand hygiene by staff while passing fresh water. *Lack of appropriate care and maintenance of oxygen supplies and insulin pens. All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by 12/14/2023 by the DON or designee. ALL residents receiving fresh water have the potential to be impacted with lack of appropriate hand hygiene and those residents' receiving oxygen and insulin via a pen have potential to be impacted if supplies not stored appropriately. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by the DON or designee by 12/14/2023 Root cause analysis was conducted with the Administrator/DON and reviewed with the Quality Improvement Advisor with the Great Plains Quality Innovation Network on 12/08/23. The "5 Whys" related to this deficiency are: 1. Lack of agency orientation/competency 2. Lack of on-going education 3. Lack of supervisor oversight auditing 4. Agency utilization 5. Staff vacancies Administrator, DON, 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 and documentation. Administrator and DON contacted the South Dakota Quality Improvement Organization (QIO) on 12/08/2023 and discussed our processes for O2	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435104	A. BUILDING _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 SOUTH MADISON NEW UNDERWOOD, SD 57761

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F 880	Continued From page 12 (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: Based on observation, interview, record review, policy review the provider failed to ensure: *Hand hygiene was completed per facility policy during two of two observed water passes to all residents. *Oxygen tubing and nasal cannulas had been replaced for two of two sampled residents (1 and 9) on a routine basis. *An insulin pen was stored in a sanitary manner after use for one of one sampled resident (10). *Oxygen tubing was stored in a sanitary manner	F 880	Continued from page 12 tubing, water pass, and hand hygiene and potential process improvements, including contacting ICAR. Administrator, DON, and/or designee will conduct auditing and monitoring of above identified items 2-3 times weekly over all shifts. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. Staff compliance in the above identified area. Any other areas identified through 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 a designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	

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F 880	Continued From page 13 for one of one sampled resident (9) when not in use. 1. Observation on 11/14/23 at 11:04 a.m. of certified nursing assistant (CNA) E during the water pass to residents in the north hall revealed she had: *A push-cart with clean water cups with straws, that had contained ice water, on the top shelf of the cart. -There had been enough cups on the top shelf for every resident in the facility. *Brought clean water cups into a resident's room without performing hand hygiene. *Removed the used water cups from the same room and placed them on the second shelf of the cart. *Not performed hand hygiene before picking up two clean cups from the top of the cart and bring those clean cups into a different resident room. *Continued to pass the remaining resident's water without performing hand hygiene. Observation and interview on 11/16/23 at 10:23 a.m. of CNA E and CNA F during the water pass to residents in the north hall revealed: *They had prepared the water cups in the dining room without first performing hand hygiene. *The ice water cups had been passed in the same matter as the above observation two days before. *CNA E agreed that hand hygiene should have been performed after grabbing the used water cups and before grabbing a new clean water cup for a different resident. Interview on 11/16/23 at 11:35 a.m. with director of nursing (DON) B regarding the above observations revealed:	F 880		

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F 880	Continued From page 14 *She was unable to recall what the facility's procedure for passing water to the residents was. *She had agreed that the staff should have been sanitizing their hands after touching anything in a resident's room and before touching anything that would have been going into another resident's room. Review of the provider's August 2023 Water Pitcher policy revealed that water pitchers would be collected daily, and hands would be washed before distributing clean water pitchers. Review of the provider's March 2022 Hand Hygiene policy revealed: *"POLICY:" *"All employees in patient care areas (unless otherwise noted in their policy) will adhere to the 4 Moments of Hand Hygiene and 2 Zones of hand hygiene. *1. Entering Room *2. Before Clean Task *3. After Bodily Fluid/Glove Removal *4. Exiting Room *5. Zones: Patient zone and Health-care zone" 2. Observation on 11/14/23 at 2:40 p.m. of resident 1's room revealed: *She had been receiving oxygen through nasal cannula tubing. *There was no label on the oxygen tubing that indicated when that tubing had been placed, when it was to have been changed or any staff initials of whom had placed the oxygen tubing. Interview on 11/15/23 at 1:40 p.m. with DON B regarding the above observation revealed that the bath aide had "taken it upon herself to change the	F 880		

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F 880	Continued From page 15 tubing weekly". Interview on 11/16/23 at 7:50 a.m. with CNA N regarding changing oxygen tubing revealed she: *Had been the CNA who completed resident baths weekly from Sunday through Thursday. *Had explained that she did not change the oxygen tubing and it had been the previous bath aide that had changed the oxygen tubing. *Would have changed the oxygen tubing of any resident she was bathing if the label had been outdated or if "the tubing around the face looks old and brittle". Interview on 11/16/23 at 8:12 a.m. with CNA K revealed the night shift staff was to have changed the oxygen tubing but was not aware of the day of the week that it was to have been changed. Interview on 11/16/23 at 8:17 a.m. with DON B regarding the process for changing oxygen tubing revealed: *The previous bath aide had been in charge of changing the oxygen tubing, but she was no longer employed at the facility. *She had explained that the task of changing resident oxygen tubing had been a new task for the night shift staff. *She had been told by the night staff that the residents' oxygen tubing had been getting changed. *The facility had no way to document and track that the tubing had been changed but she had been working on a task list for the overnight staff that would include changing the oxygen tubing weekly. *She was unaware that the resident's oxygen tubing was not getting labeled with the date and staff initials.	F 880		

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F 880	Continued From page 16 *Her expectation would have been that when the oxygen tubing was changed, the date the tubing needed to have been changed and the staff initial of who had changed the tubing would have been written on a label placed on the oxygen tubing. Review of the provider's June 2023 Oxygen Administration, Safety, Mask Types policy revealed that "disposable equipment should be changed weekly or according to manufacturer's instruction and marked with date and initials." 3. Observation and interview on 11/15/23 from 7:30 a.m. to 8:05 a.m. with licensed practical nurse (LPN) H while performing resident's medication administration revealed: *She had been employed with the facility for about a month. *She had prepared resident 10's oral medications and removed the resident's insulin pen from the medication cart. *She placed resident 10's insulin pen in her scrub shirt pocket, picked up the medication cup containing the resident's medications and brought them to the resident who was eating breakfast in the dining room. *After she had given the resident her oral pills she told the resident that she would give her insulin after she was done eating breakfast. *She had then prepared another resident's medications and administered them to the resident in the resident's room. -She still had resident 10's insulin pen in her scrub pocket. *She performed another resident's medication administration in a third resident's room while resident 10's insulin pen was still in her scrub pocket. *She was not aware that the insulin pen was still	F 880		

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F 880	Continued From page 17 in her pocket, and she agreed that the insulin pen should have been returned to the medication cart after she realized that resident 10 was in the dining room eating breakfast. Interview on 11/16/23 at 11:35 a.m. with DON B regarding the above observation revealed: *Her expectation would be that the nursing staff not put resident insulin pens into their scrub shirt pockets. *She had explained that the facility had trays that the nursing staff could use during medication administration if their hands were full. *She would not expect a nurse to keep the insulin pen in her pocket while going into other resident's rooms. Review of the provider's infection control policies did not account for the above situation. Review of the provider's March 2023 Medication Administration policy revealed: *"PROCEDURE" *"4. Follow the "Six Rights": Right mediation, right dose, right resident, right route, right time and right documentation." 4. Observation and interview on 11/15/23 at 3:29 p.m. with resident 9 regarding oxygen (02) usage revealed: *He was sitting in his recliner. *He had an O2 nasal cannula placed in his nostrils and was attached to his O2 concentrator. -The O2 concentrator had been set to administer 3 liters of O2 per minute. *He used O2 at all times. -A portable O2 tank was used when in his w/c. -An O2 concentrator was used when in his room. *He was not sure when the O2 tubing and nasal	F 880		

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F 880	Continued From page 18 cannula were replaced. *He would place the cannula from the O2 concentrator on the bed when using the portable 02 tank. *The cannula to the portable O2 tank was laying on his wheelchair seat which had crumbs on it. *There was nothing attached to O2 concentrator or the portable O2 tank to store the cannula when it was not in use. Interview on 11/16/23 at 9:24 a.m. with licensed practical nurse D regarding resident 9's O2 cannula storage revealed: *The nasal cannula was to have been stored in a plastic bag that was attached to the O2 concentrators and the portable 02 tanks. *When the nasal cannula was placed on an unclean surface it should have been replaced. Interview on 11/16/23 at 10:15 a.m. with certified nursing assistant F regarding resident 9's O2 cannula storage revealed: *The cannula was to have been stored in a plastic bag that was attached to the O2 concentrators and the portable O2 tanks. *She confirmed resident 9 had no plastic bag attached to his O2 concentrator or his portable O2 tank. *When an O2 cannula was found on an unclean surface she would have wiped it down with an alcohol wipe and continued to use it. Interview on 11/16/23 at 10:52 a.m. with DON B regarding O2 nasal cannula infection control process revealed: *The cannula was to have been stored in a plastic bag that was attached to each resident's O2 concentrator or portable O2 tank. *If a nasal cannula was dropped on the floor, it	F 880		

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F 880	Continued From page 19 should have been replaced with a new one. *She was not aware the concentrator and portable O2 tank that resident 9 had used had no plastic bag attached do it. *She was not aware the nasal cannula was being placed on the bed or chair when not in use. *She confirmed that when a nasal cannula was placed on an unclean surface it should have been replaced. Review of the provider's Oxygen Administration, Safety, Mask Types Policy revealed: *"Procedure" -"Guidelines" --11. When oxygen is not in use, store cannula face mask or face tent and tubing in a zip-lock bag/plastic bag secured to oxygen cylinder or concentrator."	F 880		

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

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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 11/14/23 through 11/16/23. Good Samaritan Society New Underwood was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 12/11/2023

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	435104	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/14/2023

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing healthcare occupancy) was conducted on 11/14/23. Good Samaritan Society New Underwood was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing healthcare occupancies upon correction of the deficiencies identified at K211, K324, K355, and K522 in conjunction with the providers commitment to continued compliance with the fire safety standards.	K 000	This plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Good Samaritan New Underwood does not admit that the deficiencies listed exist, nor does the facility admit to any statement, findings, facts, or conclusions that form the basis for the alleged deficiency. The facility reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.	
K 211 SS=D	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: Based on observation and interview, the provider failed to maintain the required exit corridor width in the 100-wing at one location (at the nurses station). Findings include: 1. Observation on 11/14/23 at 12:40 p.m. revealed the 100-wing had three chairs and a side table in the corridor across from the nurse's station. The chairs and side table were not affixed in place and extended into the corridor 24 inches from the wall.	K 211	No immediate correction can be made for failing to maintain the required exit corridor width in the 100-wing. Residents in that smoke compartment are at risk of having impeded egress exit ability. On 12/06/2023, Maintenance removed the chairs and table from this area permanently or until such time we're able to affix them so they do not impede the corridor exit. Maintenance or designee will audit this corridor area weekly for 4 weeks then monthly for 2 months to ensure the corridor exit width is maintained unobstructed. Results of audits will be discussed by Maintenance or designee at the QAPI meeting for analysis and recommendation for continuation/discontinuation/revision of audits based on their findings.	12/15/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12/11/2023

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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	435104	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/14/2023**

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K 211	Continued From page 1 Interview with the ancillary service manager at 12:45 p.m. on that same day confirmed that finding. He stated he was unaware the chairs needed to be affixed to the corridor wall. The deficiency has the potential to affect egress exit ability for all occupants of that smoke compartment.	K 211		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324	No immediate correction can be made for failing to have the 6-month inspection on the facility's cooking ductwork exhaust system, complete. Residents are potentially at risk of having poor cooking ventilation. On 12/8/2023, GreaseKings completed cooking exhaust repairs including installation of a hinge kit. On 12/11/2023, Swiftec is scheduled to complete electrical repairs, at which time GreaseKings will return and complete the 6-month inspection. The Administrator, maintenance or designee will enter inspections into TELS. Audits of inspections will be completed by the Administrator monthly for 6 months. Results of audits will be discussed by the Administrator at the QAPI meeting for analysis and recommendation for continuation/ discontinuation/revision of audits based on their findings.	12/15/2023

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GOOD SAMARITAN SOCIETY NEW UNDERWOOD	**412 SOUTH MADISON** **NEW UNDERWOOD, SD 57761**

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K 324	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to conduct an adequate six-month inspection of the facility's cooking ductwork exhaust system for the range hood for the calendar year 2023. Findings include: 1. Record review on 11/14/23 at 1:45 p.m. revealed the contractor's cleaning report dated 8/18/23 stated the exhaust fan could not be cleaned due to the lack of a hinge kit to allow access to the fan. The fan could neither be inspected for grease buildup or cleaned with that existing condition. Interview with the ancillary service manager at 1:55 p.m. on 11/14/23 revealed he was unaware of the ductwork cleaning issue. The deficiency affected one the requirements for the kitchen range hood exhaust system.	K 324		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to perform monthly checks of one randomly observed ABC fire extinguisher in the kitchen. Findings include:	K 355	No immediate correction can be made for failing to have the fire extinguisher in the kitchen checked or logged in Sept or Oct 2023. Residents are at risk if fire extinguishers are not kept in working order and checked monthly. On 11/27/2023, Maintenance completed the monthly check and log for the extinguisher in the kitchen, and was re-educated on the need to check and log each extinguisher monthly. Administrator or designee will audit monthly fire extinguisher checks and logs. Audits of inspections will be completed by the Administrator monthly for 3 months.	12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435104	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY NEW UNDERWOOD	**412 SOUTH MADISON** **NEW UNDERWOOD, SD 57761**

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K 355	Continued From page 3 1. Observation on 11/14/23 revealed the ABC fire extinguisher mounted in the kitchen did not have any sign-offs for September and October 2023. Extinguishers must be checked and logged monthly. Interview with the ancillary service manager at the time of the observation confirmed that condition. The deficiency affected one of numerous requirements for installing and maintaining fire extinguishers.	K 355	Continued from page 3 Results of audits will be discussed by the Administrator at the QAPI meeting for analysis and recommendation for continuation/ discontinuation/revision of audits based on their findings.	
K 522 SS=E	HVAC - Any Heating Device CFR(s): NFPA 101 HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain combustion (fresh) air in one randomly observed area (laundry). Findings include: 1. Observation 11/14/23 at 12:45 p.m. revealed two commercial propane-fired dryers in the laundry room. There was a motorized louver in the wall behind	K 522	No immediate correction can be made for failing to maintain the combustion (fresh) air motorized louvers in the Laundry Room. Residents are potentially at risk when the combustion ventilation is not working. On 11/20/2023, Climate Control repaired the combustion (fresh) air motorized louvers. Administrator or designee will audit the functionality of the motorized louvers weekly for 4 weeks and monthly for 2 months. Results of audits will be discussed by the Administrator at the QAPI meeting for analysis and recommendation for continuation/ discontinuation/revision of audits based on their findings.	12/15/2023

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

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	435104	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/14/2023

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K 522	Continued From page 4 the two propane-fired dryers. Testing of each dryer independently of each other revealed the louver would not activate to open to provide combustion air from the exterior of the building. Interview with the ancillary service manager at the time of the observations confirmed those findings. The deficiency affected one of several requirements for fuel-fired devices.	K 522		

South Dakota Department of Health

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	10657	A. BUILDING: _____ B. WING _____	11/16/2023

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GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 S MADISON POST OFFICE BOX 327 NEW UNDERWOOD, SD 57761

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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 11/14/23 through 11/16/23. Good Samaritan Society New Underwood was found not in compliance with the following requirements: S206 and S210.	S 000	This plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Good Samaritan New Underwood does not admit that the deficiencies listed exist, nor does the facility admit to any statement, findings, facts, or conclusions that form the basis for the alleged deficiency. The facility reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.	
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and. (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section.	S 206	No specific resident was identified. Residents are at potential risk when staff are not staying current on annual trainings. Prior to their next shift, staff members H, I, K will have completed Emergency Preparedness education. Prior to their next shift staff member J will have completed Resident Rights and Restraints education. Prior to their next shift, staff member H will have completed Dining Assistance, Nutritional Risks, and Hydration education. All staff were educated on 12/14/2023 that managers will review the monthly Training Exception report and allow staff "work time" to get assigned trainings completed within 4 weeks of the due date. Administrator and DON or designee will run a compliance report every 3rd Friday, and then audit for compliance on the 4th Friday. Staff will need to complete assigned trainings by the due date, or before their next shift following 4 weeks past due. The Administrator, DON or designee will audit all new hires for the past 6 months to ensure all new hires have completed this education. The Administrator or DON will audit all new hires for education and training for 3 months. Results of audits will be discussed by the Administrator or DON or designee at the QAPI meeting for analysis and recommendation for continuation/ discontinuation/revision of audits based on their findings.	12/15/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12/13/2023

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	10657	A. BUILDING: _____ B. WING _____	11/16/2023

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S 206	Continued From page 1 Additional personnel education shall be based on facility identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on review of employee personnel records, interview, and policy review, the provider failed to ensure training was completed for the following: *Emergency preparedness for three of five sampled employees (H, I, and K). *Resident rights and restraints for one of five sampled employees (J). *Dining assistance, nutritional risks, and hydration for one of five sampled employees (H). Findings include: 1. Review of employee personnel records revealed: *Employee H was hired on 10/2/23. *Employee I was hired on 10/17/23. *Employee J was hired on 5/24/23. *Employee K was hired on 1/10/23. Review of employee training records revealed there was no documentation to support the following: *Employees H, I, and K had received emergency preparedness training. *Employee J had received resident rights training. *Employee H had received dining assistance, nutritional risks, and hydration training. Interview on 11/16/23 at 10:52 a.m. with director of nursing B regarding employee training revealed: *They used an online training program and in-person trainings. *She confirmed there was no documentation to support: *Employees H, I, and K had received emergency	S 206		

South Dakota Department of Health

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S 206	Continued From page 2 preparedness training. *Employee J had received resident rights training. *Employee H had received dining assistance, nutritional risks, and hydration training. Review of the provider's 5/22/23 Competency and Mandatory Education Requirements Policy revealed: *"Definitions:". -"Mandatory Education: --Education that is required for specific roles, departments, or for all employees. Mandatory education and other ongoing education maintains and improves competency." *"Ongoing Mandatory Education". -"Competency Achievement and mandatory education requirements are required to be documented and are reviewed as part of the performance appraisal process."	S 206		
			On 12/8/2023 the DON completed a new health questionnaire for employee J.	12/15/2023
S 210	44:73:04:06 Employee Health Program The facility shall have an employee health program for the protection of the residents. All personnel shall be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Any personnel absent from duty because of a reportable communicable disease which may endanger the health of residents and fellow employees may not return to duty until they are determined by a physician or physician's designee, physician	S 210	Residents are at potential risk when employees health screenings are not completed. Admininstrator, DON or designee will review all new hires in the past 6 months to verify the Health Questionnaire has been completed. This isolated occurrence happened in May, 2023. Our process changed Oct 1, 2023. All new hire Health Questionnaires are being completed during general orientation and reviewed by a licensed health professional at St. Martin's Village. Administrator, DON or designee will audit new hire health screening documentation weekly for 12 weeks. Results of audits will be discussed by the Administrator or DON or designee at the QAPI meeting for analysis and recommendation for continuation/discontinuation/revision of audits based on their findings.	

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S 210	Continued From page 3 assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and procedure review, the provider failed to complete employee health screenings within fourteen days of being hired for one of four employee health records (J) that were reviewed. Findings include: 1. Review of employee J's personnel file revealed: *Her hire date was 5/24/23. *There was no documentation to support an employee health screening had been completed. Interview on 11/16/23 at 10:52 a.m. with director of nursing B regarding employee health screenings revealed she: *Was aware health screenings were required to have been completed for new employees within 14 days of hire. *Was responsible to ensuring the employee health screenings were completed. *Confirmed there was no documentation to support a health screening had been completed for employee J. *She thought the health screening might not have been done as employee J had worked as a temporary agency certified nursing assistant for the provider prior to her hire date as an employee. Interview on 11/16/23 at 12:50 p.m. with administrator A regarding employee health screenings revealed: *He was aware health screenings were required	S 210		

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S 210	Continued From page 4 to have been completed for new employees within 14 days of hire. *There was no policy to the completion of health screenings for employees. *He provided a procedure document titled "Employee File Submission". *He confirmed there was no documentation to support a health screening had been completed for employee J. Review of the provider's undated Employee File Submission Procedure revealed: *"Documents to submit to Human Resources" -"Medical History Questionnaire".	S 210		
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 11/14/23 through 11/16/23. Good Samaritan Society New Underwood was found in compliance.	S 000		