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	435134	A. BUILDING _____ B. WING _____	11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST MARTIN VILLAGE	4825 JERICHO WAY RAPID CITY, SD 57702

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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 10/31/23 through 11/2/23. Good Samaritan Society - St Martin Village was found not in compliance with the following requirements: F690 and F880.	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690	Resident 112 had her foley catheter removed. All residents that currently have a foley were assessed for proper diagnosis, necessity of catheter, and care plan. All residents have the potential to be effected. Catheter status and care planning if applicable has been added to admission checklist to ensure that catheters are addressed upon admission. All facility staff have been educated by the Director of Nursing, Infection Preventionist or designee on catheter policy. New direct care staff will have catheter care as a part of their orientation modules. Our meeting for review was documented with policy and sign in sheet. All new staff will have it in their online transcripts. Director of Nursing or Designee will audit the new admissions, weekly x3, every other week x3 and monthly x3. Director of Nursing or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary, make any recommendation for improvement. Monitoring results will be reported by the Ancillary manager or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	11.24.23

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

Jana McCroden, RN LNHA

TITLE
Senior Director, Administrator

(X6) DATE
11.29.23

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F 690	Continued From page 1 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (112) had a documented diagnosis and was assessed for the removal of her Foley catheter. Findings include: 1. Observation and interview on 10/31/23 at 12:15 p.m. with resident 112 revealed she: *Admitted after a fall in the community which required orthopedic surgery. *Was non-weight bearing (NWB) on her right leg. *Participated in physical therapy and was making progress with her physical mobility. *Had a Foley catheter bag attached to her wheelchair. -Had not required the use of a catheter before her surgery. Observation on 11/01/23 at 4:50 p.m. of resident 112 revealed she: *Was seated in a wheelchair in the doorway between her bathroom and her room. *Had activated her bathroom call light for staff to help her pull up her pants after she had used the toilet. *Had not waited for staff assistance before she transferred herself from the toilet to her wheelchair independently. *Her catheter bag hung to the side of her wheelchair and contained amber-colored urine.	F 690		

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F 690	Continued From page 2 Interview on 11/1/23 at 4:51 p.m. with licensed practical nurse F regarding resident 112 revealed: *Staff had assisted her onto the toilet a few minutes before she activated her bathroom call light for staff assistance to get off the toilet. -She had not waited for staff to return to help her after she activated her call light before she transferred herself from the toilet to her wheelchair. *LPN F thought resident 112 had a Foley catheter because she had urinary retention and because she was at risk for urinary tract infections (UTIs). Review of resident 112's care plan last revised on 10/30/23 revealed no indication she had a Foley catheter. Review of resident 112's electronic medical record revealed: *A 10/25/23 surgical hospital Discharge Summary: -The resident had an open reduction and internal fixation (ORIF) of her right knee joint on 10/19/23. -She was NWB on her right leg. -"...Keep Foley [catheter] as unable to get OOB (out of bed) yet at this time. Good Foley care and likely be able to dc [discontinue] in next few days." -A physician's order to continue taking an oral antibiotic for the treatment of a UTI. *A 10/25/23 Nursing Home History and Physical completed by her primary care provider revealed: -In addition to the UTI referred to above resident 112 had vaginitis [an inflammation of the vagina] which was being treated with a second antibiotic medication and an antifungal medication. *Review of Systems: "Genitourinary: Positive for vaginal discharge. Had occasional incontinence	F 690		

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F 690	Continued From page 3 at home. Foley catheter was placed for immobility." *A 10/25/23 physician's order summary: "Foley Catheter Cares each shift. ALLERGIC to LATEX." Interview on 11/2/23 at 10:10 a.m. with clinical care coordinator C revealed: *She was an admission nurse and the Infection Preventionist. -She assisted with resident 112's nursing home admission on 10/25/23 and was aware the resident had a Foley catheter. *A "Catheter Diagnosis Request" was expected to have been completed and sent to the resident's primary care provider (PCP) the day of her admission or the day after admission. -The purpose of that request was for the PCP to have identified the medical diagnosis(es) which had required resident 112 to have had a Foley catheter. *No completed Catheter Diagnosis Request was found for resident 112. *"Immobility" referenced in the 10/25/23 History and Physical referred to above was not an appropriate diagnosis for the use of a catheter. *If there had been no appropriate medical diagnosis for the use of the resident's catheter a plan for the removal of that catheter was expected to have been discussed with the PCP) *"Anytime we have the ability to discontinue a catheter we should." "Catheters cause a lot of UTI's." "We don't want it [the catheter] for too long." -Eight days had been too long for resident 112 to have had her Foley catheter without having initiated a plan for its removal. Review of the 11/28/22 Urinary Catheter policy	F 690		

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F 690	Continued From page 4 revealed: *Insertion: "1. An order and indication is required for an indwelling foley insertion." *Removal: "1. Remove Foley catheter when no longer indicated."	F 690	We are not able to go back and correct deficient practices that have already happened. All residents have the potential to be effected by the deficient practice that includes For the identification of: Lack of appropriate hand hygiene and glove use with potential for blood exposure, lack of appropriate care of glucose meter cover, lack of appropriate handling of resident eye drops, lack of appropriate regard for plated food, lack of water management program. All facility staff who provide or are responsible for the above cares will be educated/re-educated by 11.30.23 by the infection control nurse or designee. All glucose meters have had all covers replaced and now are in a protective plastic barrier that can be cleaned. All new staff will have hand hygiene, and glove use in their general orientation courses with the infection control topics. These will be documented on their transcripts. Dietary will have an orientation pathway that will address platted food handling that is is signed and documented. . Each person passing medication will have a pathway that includes medication administration and is a signed document. Maintenance will have the water management program on their orientation pathway that is documented. All residents served a meal have potential impact for lack of appropriate process and follow through for the above identified items. Policy education/re-education about roles and responsibilities for the above identified	11.30.23
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 possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		

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F 880	Continued From page 5 (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: Based on observation, interview, record review, and policy review, the provider failed to ensure infection prevention and control practices were implemented for the following:	F 880	assigned care and services will be provided by the Dietary manager or designee by 11.30.23. Root cause analysis conducted by Administrator and QIN. the 5 Why's came down to education, return demonstration and ensuring we have annual competencies. 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 contacted the South Dakota Quality Improvement Organization on 11.22.23 and QIN will be providing information for facility to participate in an infection control ICAR along with the root cause of the process breakdown as stated above. 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. (if any) 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 6 *Appropriate glove use by one of one licensed practical nurse (LPN) (F) during skincare treatments for two of two sampled residents (36) and (44). *A water management program (WMP). *Appropriate handling of a glucometer in a cloth case by one of one LPN (F) during a blood sugar check for one of one sampled residents (20). *Appropriate handling of an eye drop bottle by one of two LPN (F) during medication administration for one of two sampled residents (20). *Appropriate handling of plated food during food service. Findings include: 1. Observation on 10/31/23 at 12:40 p.m. in resident 44's room revealed: *Certified nurse aide (CNA) L and occupational therapist M assisted the resident to sit at the edge of her bed to prepare her for a wheelchair transfer. -CNA L noticed blood on the resident's back which the resident stated had been caused by scratching her back. -The back of the resident's shirt had small tears which appeared to have been caused by her nails. *LPN F was called into the resident's room and: -With gloved hands he cleansed the open areas on her back and patted them dry with a gauze pad. -The gauze pad was light red in color from the blood on her back. -Without changing his gloves, or performing hand hygiene, and putting on a new pair of gloves he applied a clean bandage to the resident's back. 2. Observation and interview on 10/31/23 at 3:46	F 880		

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F 880	Continued From page 7 p.m. with LPN F in resident 36's room revealed he: *Performed hand hygiene, put on a new pair of gloves, and cleansed opened areas on the inner aspect of her left ankle, her left lower leg, and her right breast. -He had not changed his gloves, or performed hand hygiene, and put on a new pair of gloves after he had cleansed each of the skin areas referred to above but agreed he should have. -The same practice should have been observed during the skin care observation referred to above with resident 44. Interview on 11/1/23 at 12:30 p.m. with clinical care coordinator (CCC) C regarding the skin treatments performed by LPN F referred to above revealed she: *Was the infection preventionist. *Expected LPN F to have removed his gloves, performed hand hygiene, and put on a clean pair of gloves after cleansing resident 44's back and before applying a new bandage. *Expected LPN F to have removed his gloves, performed hand hygiene, and put on a clean pair of gloves: -After he cleansed resident 36's foot and before he cleansed her left leg. -After he cleansed her leg and before he cleansed her right breast. *Changing gloves after cleansing the skin and before applying a clean dressing reduced the risk of an infection occurring. Review of the 3/29/22 Hand Hygiene policy revealed: *Glove use: -"Change gloves when moving from a dirty to a clean or sterile activity performing hand hygiene	F 880		

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F 880	Continued From page 8 in between changing gloves." 3. Interview on 11/2/23 at 11:45 a.m. with maintenance director D regarding the WMP revealed: *He had been in his current position for six weeks. *The provider used a computer-based program called "TELS" which included a WMP prevention program. -That program had not been implemented by the previous maintenance director. *Maintenance director D had not yet implemented that system either but was aware he needed to. Interview on 11/2/23 at 12:05 p.m. with senior director A regarding the WMP revealed she had: *Expected the TELS system to have been used as the provider's WMP. -Not been aware the previous maintenance director had not followed that expectation. -"Trusted" that process was occurring but had not ensured it was implemented. Review of the undated Water Management Plan Process Summary revealed: *"The Good Samaritan Society has moved from a reactive WMP to a prevention [controlled] WMP" that included scheduled review, monitoring, and/or maintenance of the following: -Domestic water temperatures. -Cold water main temperatures and chlorine residual testing. -Commercial water temperatures. -Flushing of water systems in unoccupied rooms. -Ice machines. -An annual site WMP. 4. Observation and interview on 11/01/23 at 9:27 a.m. with LPN F during glucometer use and a	F 880		

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F 880	Continued From page 9 medication administration observation for resident (20) revealed: *The glucometer was in a black cloth zipper case and was taken from the medication cart into the resident's room and placed on her dresser. *The glucometer was removed from its cloth case and placed on a barrier. *After the glucometer use was completed, it was taken out of the resident's room wrapped in the used barrier and placed on top of the medication cart along with its cloth case. *The glucometer was cleaned and placed back into its cloth case and placed back into the medication cart. *The eye drop bottle was taken out of its box, placed in his scrub top pocket, and taken into the resident's room. *He used hand sanitizer, placed a pair of gloves on his hands, and then removed the eye drop bottle from his scrub top pocket then administered the resident's eye drops. *After the eye drop administration, he returned the eye drop bottle into his scrub top pocket and returned to the medication cart. *The eye drop bottle was returned to its box and placed into the med cart. *He agreed he should not have taken the cloth glucometer case into the resident's room, or he should have placed it onto the barrier as it was a non-wipeable surface. *The nurse agreed his scrub top pocket was not a clean surface and he should not have transported the resident's eye drop bottle in his scrub top pocket and removed the eye drop bottle from his scrub top pocket after he performed hand hygiene and placed gloves before he administered the resident's eye drops. Interview on 11/02/23 at 10:07 a.m. with CCC C	F 880		

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F 880	Continued From page 10 revealed: *She was the infection preventionist. *She agreed that LPN F should not have taken the glucometer case that was cloth and a non-wipeable surface into a resident's room placed it on the dresser without a barrier and then returned it to the medication cart. It was a breach of infection control. *She agreed that transporting an eye drop bottle in a scrub top pocket into a resident's room and removing it from the scrub top pocket was a breach of infection control. *She reported she planned to remove the glucometers from their cloth cases, place the glucometers in zip lock bags that were changed out weekly, and provide staff education that the glucometers were to have been removed from the baggies while at the medication cart and not taken into the resident rooms. Review of the provider's 9/22/2023 Blood Glucose Monitoring, Disinfecting and Cleaning policy revealed: *"Purpose" -"To provide proper cleaning methods for glucose meters and to avoid cross-contamination issues." --"2. Cleaning and disinfecting can be completed by using a commercially available EPA-registered disinfectant or germicide wipe." 5. Observation on 11/1/23 at 12:10 p.m. during the noon meal with food service assistant G revealed: *Without sanitizing her hands she: -Touched the paper menu. -Grasped the top of the plate with her hand to serve food. -Touched the inside of a bowl with her thump, and then served the soup.	F 880		

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F 880	Continued From page 11 Interview on 11/1/23 at 12:15 p.m. after food service with lead cook I revealed: *The food service process was for the server to pick up menus to view resident's preferences and then serve the food. *They do not sanitize between menus and flatware. *Servers were not to touch the eating surface of flatware or bowl when serving resident's food. Interview on 11/1/23 at 2:00 p.m. with nutrition and food service supervisor E revealed: *Touching the eatable surface of flatware or bowls during resident food service was not acceptable. *They have no process in place for sanitizing employees hands after touching the resident's menus and then touching the serving dishes. Review of revised July 21, 2023 Dining Service Standards-Food and Nutrition Services policy revealed: *Procedure: -"Follow procedures for prevention of foodborne illness when serving meals (e.g., never touching ready-to-eat foods with bare hands; never touch the eating surface of utensils and dishware).	F 880		

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

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E 000	Initial Comments An emergency preparedness survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 10/31/23 through 11/2/23. Good Samaritan Society - St Martin Village was found not in compliance with the following requirements: E004, E006, and E039.	E 000		
E 004 SS=D	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness	E 004	Annual meeting will be held on 11.27.23 for review and update of the EP plan. We documented the meeting on our "Emergency Management Planning Document Review/Change History" form. All employee information has been updated to reflect currents staff. All residents have the potential to be effected. All annual meetings will be placed on a calendar for review. Ancillary Manager educated by Senior Director on requirement of annual meeting and EP program. Ancillary Manager or Designee will audit the EP plan to ensure annual meeting and information is current, weekly x3, every other week x3 and monthly x3. Ancillary Manager or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary, make any recommendation for improvement. Monitoring results will be reported by the Ancillary manager or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	11.27.23

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

Jana McCroden, RN LNHA | Senior Director, Administrator 11.29.23

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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	435134	A. BUILDING _____ B. WING _____	11/02/2023

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E 004	Continued From page 1 requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on interview and document review, the provider failed to have a current emergency management plan (EMP) that should have been reviewed and revised annually. Findings include: 1. Interview on 11/2/23 at 1:30 p.m. with senior director A revealed: *The emergency contact list within the EMP were out of date and many of the employees listed were no longer employed with the company. *There was no information that the plan was reviewed annually. *The previous maintenance director had kept most of the EMP documents. *She was unsure where the previous maintenance director had stored the other EMP documents. *She had not verified or followed through with ensuring the documents were updated with the	E 004		

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E 004	Continued From page 2 current information related to the EMP. Review of the EMP revealed the plan had last been reviewed on April 3, 2020. Review of the July 22, 2022, Emergency Management Plan policy revealed "All plans for all locations are required to be updated as required by Centers for Medicare/Medicaid, state or local jurisdictions, or as situations change."	E 004	Facility risk assessment was updated and dated. Community risk assessment was obtained. All employee information has been updated to reflect currents staff. All residents have the potential to be effected. Facility and community risk assessment review will be placed on a calendar to ensure compliance. Ancillary Manager educated by Senior Director on requirement of risk assessments. Ancillary Manager or Designee will audit the risk assessments to ensure information is current, weekly x3, every other week x3 and monthly x3. Ancillary Manager or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary, make any recommendation for improvement. Monitoring results will be reported by the Ancillary manager or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	
E 006 SS=D	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The	E 006		11.27.23

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E 006	Continued From page 3 plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on interview and Emergency Management Plan (EMP) review, the provider	E 006		

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E 006	Continued From page 4 failed to include a community-based risk assessment that utilized an all-hazards approach. Findings include: 1. Interview on 11/2/23 at 1:30 p.m. with senior director A revealed there were no community-based risk assessments obtained or performed. Review of the April 3, 2020, EMP revealed: *A. Community Coordination: -"It is extremely important that your location be actively involved with your local community in preparing and planning for emergencies/disasters that may occur in your local area. Involvement with planning should extend to your state agencies as well. City, County, and State Emergency Management Services..." *No community-based risk assessment was identified in the plan.	E 006	Table top drill was completed on 11.27.23. Will participate in the next community drill available. All residents have the potential to be effected.	
E 039 SS=D	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:	E 039	A community drill, and a facility drill will be placed on a calendar to ensure compliance. Ancillary Manager educated by Senior Director on requirement of risk assessments. Actual event activations of the emergency plan will be documented on the Event_AAR template. The drills will be reviewed and analyzed in QAPI on the following month. Our safety committee per our plan is compromised of Ancillary Manager, Administrator, Director of Nursing, Dietary Manager and Senior Living Manager. Ancillary Manager or Designee will audit the drills to ensure compliance monthly x3 then quarterly x2.	11.27.23

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E 039	Continued From page 5 (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is	E 039	Ancillary Manager or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary, make any recommendation for improvement. Monitoring results will be reported by the Ancillary manager or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	

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E 039	Continued From page 6	E 039		

community based every 2 years; or
(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of

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E 039	Continued From page 7 the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual,	E 039		

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E 039	Continued From page 8 facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.	E 039		

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E 039	Continued From page 9 (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.	E 039		

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E 039	Continued From page 10 (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or	E 039		

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E 039	Continued From page 11 (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435134	A. BUILDING _____ B. WING _____	11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST MARTIN VILLAGE	4825 JERICHO WAY RAPID CITY, SD 57702

(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
E 039	Continued From page 12 (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOOD SAMARITAN SOCIETY - ST MARTIN VILLAGE	4825 JERICHO WAY RAPID CITY, SD 57702

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E 039	Continued From page 13 least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and Emergency Management Plan (EMP) review, the provider failed to conduct emergency peparedness exercises/drills to test the emergency plan at least twice per year using the emergency procedures. Findings include: 1. Interview on 11/2/23 at 1:30 p.m. with senior director A revealed: *She had participated in a community-wide tornado drill in 2023. -She had no documentation of that participation for the community-wide tornado drill. *There were no table-top, facility-wide, community-wide, announced or unannounced emergency preparedness exercises documented for years 2022 and 2023. *There was no quality assurance safety committee established as outlined in the EMP. Interview on 11/2/23 at 1:30 p.m. with maintenance director D revealed: *There was actual emergency events that had occured such as power outages and fire alarm activations over the last few months. -Those power outages and fire alarm activations were not documented..	E 039		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	435134	A. BUILDING _____ B. WING _____	11/02/2023

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E 039	Continued From page 14 Review of the April 3, 2020, Emergency Management Plan revealed: *IV. INFORMATION, TRAINING AND EXERCISE: -"C. Identify a schedule for conducting exercises/drills of all or portions of the disaster plan on an annual basis or other applicable schedule per service line and governing regulations." -"D. Establish procedures for correcting deficiencies noted during training exercise, i.e., through the quality assurance safety committee." Review of the revised July 22, 2022, Emergency Management Plan policy revealed "Current Centers for Medicare and Medicaid Services regulations require two drills to be conducted in a 12-month period testing your emergency management plan."	E 039		

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	435134	A. BUILDING **01 - SERENITY PLACE** B. WING _____	**10/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST MARTIN VILLAGE	**4825 JERICHO WAY RAPID CITY, SD 57702**

(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 10/31/23. Good Samaritan Society - St Martin Village 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 deficiency identified at K321, K363, and K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
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)	K 321	The door hingers were replaced with spring hinges on 11/27/23. All residents have the potential to be effected. Doors will be audited to ensure doors are able to self close if they have been identified as needing to be self closing. Ancillary Manager educated by Senior Director on requirement of self closing doors. Ancillary Manager or Designee will audit self closing door to ensure it latches, weekly x3, every other week x3, and monthly x3.	11.2.23

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

Jana McCroden, LNHA, RN | Senior Director, Administrator 11.27.23

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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	435134	A. BUILDING **01 - SERENITY PLACE** B. WING _____	**10/31/2023**

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K 321	Continued From page 1 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: Based on observation, testing, and interview, the provider failed to maintain one randomly observed hazardous area (kitchen pantry) as required. Findings include: 1. Observation on 10/31/23 at 2:00 p.m. revealed the kitchen pantry was over 100 square feet and had copious amounts of combustibles (boxed items, canned goods, and cooking oils) stored in it. There was not a door installed to separate the pantry from the kitchen. Further observation revealed the kitchen had two doors exiting into the egress corridors. The doors were each equipped with four spring hinges. Testing of the doors revealed they would not self-close with the spring hinges. Further observation revealed each door had previously been equipped with a closer at the top of the door as well. There were holes in the upper part of each door and frame and pieces of swing arm still in place from closer installations. The pantry was therefore not provided with self-closing and latching doors. Interview with the ancillary service manager at the times of the observations confirmed those findings. The deficiency affected one of numerous requirements for hazardous storage rooms and	K 321	Ancillary Manager or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary, make any recommendation for improvement. Monitoring results will be reported by the Ancillary manager or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	

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K 321	Continued From page 2 had the potential to affect 100% of the occupants of the smoke compartment.	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 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,	K 363	The door on room 39 was fixed on 11/20/23 so there is no longer a gap in the doors. All residents have the potential to be effected. Doors will be audited to ensure doors do not have a gap. Ancillary Manager educated by Senior Director on requirement of doors. Ancillary Manager or Designee will audit the bariatric doors for a gap, weekly x3, every other week x3 and monthly x3 weeks. Ancillary Manager or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary, make any recommendation for improvement. Monitoring results will be reported by the Ancillary manager or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	11.20.23

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K 363	Continued From page 3 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: Based on observation and interview, the provider failed to maintain a smoketight door separation from one randomly observed location (U39 bariatric suite). Findings include: 1. Observation on 10/31/23 at 2:30 p.m. revealed the U39 bariatric suite had a dual-door configuration to the corridor (active leaf and a slave leaf). The gap between the doors measured 3/4 inch at the bottom and 3/8 inch at the top. Interview with the ancillary service manager at the time of the observation confirmed that finding. He stated he was a new employee within the past year and was unaware of the door gap. The deficiency had the potential to affect 100% of the smoke compartment occupants.	K 363		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.	K 918	The generator back up batteries were replaced on 11.6.23. All residents have the potential to be effected. Generator back up batteries have been replaced and now on a rotation to ensure batteries are valid for use. Ancillary Manager educated by Senior Director on requirement of back up batteries. Ancillary Manager or Designee will audit the generator back up batteries, weekly x3, every other week x3 and monthly x3 weeks. demonstrates sustained compliance then as determined by the committee.	11.6.23

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K 918	Continued From page 4 Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to document generator battery age. Findings include: 1. Record review on 10/31/23 at 2:15 p.m. revealed there was not any documentation of the battery ages in the maintenance logs for the 150 kw diesel generator or the 250 kw diesel generator. The only dates recovered indicated a date of 2017 for the 250 kw generator batteries. Generator batteries were recommended to be replaced every 24-30 months. Interview with the ancillary service manager at the	K 918	Ancillary Manager or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary, make any recommendation for improvement. Monitoring results will be reported by the Ancillary manager or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that	

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K 918	Continued From page 5 time of the record review revealed the generator confirmed that finding. He stated he would mark the batteries and update the preventive maintenance logs with the load testing. The deficiency affected 100% of the building occupants.	K 918		

South Dakota Department of Health

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	68237	A. BUILDING: _____ B. WING _____	11/02/2023

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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 10/31/23 through 11/2/23. Good Samaritan Society - St Martin Village was found not in compliance with the following requirement: S301.	S 000		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview and policy review the provider failed to ensure annual training was completed for two of four sampled employees (J and K). Findings include: 1. Review of cook J's personnel file revealed: *He was hired on 11/9/21 and had not completed annual dietary training for the following topics: -Food safety. -Handwashing. -Food handling/preparation techniques. -Serving and distribution procedures. -Leftover food handling policies. -Time and temperature controls for food preparation and service. -Sanitation requirements. 2. Review of dietary aide K's personnel file	S 301	All employees will completed past due learning to ensure they are up to date by 11/30/23. All residents have the potential to be effected. Dietary Manager was educated by the Senior Director that all mandatory education must be completed annually. Dietary Manager educated on how to pull compliance reports on 11.13.23. Dietary Manager or Designee will run a compliance report on the third Friday of each month. All staff found not to be in compliance will be given work time to complete all assigned learning during scheduled shifts. Dietary Manager or designee will audit monthly learning on the last Friday of the month times 4 months to ensure all learning has been completed. Dietary Manager or designee will report to the QAPI committee on a monthly basis the audits of the online learning. The QAPI committee will review the audit and if necessary make any recommendations for improvement. It will be continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	11.30.23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Jana McCroden, LNHA, RN

TITLE
Senior Director, Administrator

(X6) DATE
11.22.23

South Dakota Department of Health

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S 301	Continued From page 1	S 301		

revealed:
*She was hired on 4/12/22 and had not completed annual dietary training for the following topics.
-Food safety.
-Handwashing.
-Food handling/preparation techniques.
-Serving and distribution procedures.
-Leftover food handling policies.
-Time and temperature controls for food preparation and service.
-Sanitation requirements.

3. Interview on 11/1/23 at 11:30 a.m. with senior director A regarding annual dietary training revealed:
*Employee mandatory education was assigned and was to have been completed through online Sandford Success Center.
-Notification emails are sent to senior director A if staff were overdue on their annual training, and she would forward the notifications to the supervisor of those employees.
-On 10/27/23 she notified nutrition and food service supervisor E that dietary staff J and K had not completed the annual training.
-Annual training was expected to have been completed prior to the due date.

4. Interview on 11/1/23 at 2:00 p.m. with nutrition and food services supervisor E regarding annual dietary training revealed:
*Senior director A would email her the notifications of staff overdue annual training.
*She would print off the emails and give them to the employee.
*She had not followed up with the dietary staff on any overdue annual training.

5. Review of provider's revised 5/22/23

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S 301	Continued From page 2 Competency and Mandatory Education Requirements policy revealed: *Ongoing mandatory education: -"Every department/clinic is expected to ensure ongoing competencies and mandatory education requirements that apply to their employees are completed within the designated timeframe and documented."	S 301		
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 10/31/23 through 11/2/23. Good Samaritan Society - St Martin Village was found in compliance.	S 000		