STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435075	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOOD SAMARITAN SOCIETY HOWARD	**300 WEST HAZEL AVENUE HOWARD, SD 57349**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
E 0001 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Establish an Emergency Preparedness Program (EP).** Based on intervew, record review, and policy review, the provider failed to develop and establish a comprehensive emergency preparedness program. Findings include: 1. Interview on 3/12/20 at 1:34 p.m. and review of the provider's emergency preparedness program documentation with administrator A revealed: *They did not have a complete emergency preparedness program. *They had not: -Developed a chain of command with contact information and list of duties. -Developed and maintained a clear communication plan that had included names and contact information for staff, residents, physicians, other long term care facilities, and volunteers. -Developed a tracking system for staff and residents if relocated from the facility. -Developed an alternate way of communication if the phone lines and cell towers had not functioned. Administrator A admitted they had work to do to get the plan better developed. She agreed the plan should be well organized in the event of an emergency so their staff would know what to do and could use the plan for guidance. Review of revised 7/1/19 provider Emergency Management Plan policy and procedure revealed: *Good Samaritain Society policy and procedure requires that all locations have a comprehensive emergency and disaster management plan in place for all service lines provided at a locations.

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

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.