STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435074	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/4/26 through 8/6/26. Good Samaritan Society De Smet was not in compliance with the following requirements: F552, F605, F657, F688, F755, and F761. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/4/26 through 8/6/26. Areas surveyed included a resident's fall from a mechanical lift, and an allegation of potential resident abuse. Good Samaritan Society De Smet was found to have past noncompliance at F689.	F0000	The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law.	
F0552 SS = E	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by:	F0552	DNS or designee provided education on the risks versus benefits of medications or of alternative treatments to resident 5 on 8/6/2026 and resident 46 on 8/13/2026. DNS obtained signed consents for the use of psychotropic medications for resident 5 on 8/6/2026 and resident 46 on 8/13/2026. On 8/10/2026, DNS or designee reviewed all residents who have an ordered psychotropic medication to ensure residents or their representatives were educated of the risks versus benefits of medications or of alternative treatments and consents were signed. If documentation was not present of education and signed consents at time of review, DNS or designee would educate that resident or representative immediately and obtain a signed consent form.	

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	9/10/2026

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F0552 SS = E	Continued from page 1 Based on record review, interview, and policy review, the provider failed to ensure the staff educated two of five sampled residents (5 and 46) or their representatives of the risks versus benefits of medications or of alternative treatments, and to obtain consents from two of five sampled residents (5 and 23) or their representatives for the use of psychotropic medications (drugs that affects brain activities associated with mental processes and behavior) before they were administered. Findings Include: 1. Review of resident 5's electronic medical record (EMR) revealed she admitted to the facility on 4/9/24. Her Brief Interview for Mental Status (BIMS) assessment score was 2, which indicated her cognition was severely impaired. Her diagnoses included major depressive disorder (a mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities), disorientation, and unspecified dementia (a group of symptoms affecting memory, thinking, and social abilities) with unspecified severity with other behavioral disturbance. She had a 5/12/26 physician's order for hospice care. She had a 5/12/26 physician's order for 0.5 milligram (mg) of Lorazepam (a prescription medication that slows down the central nervous system to treat short-term anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), anxiety-related insomnia, and acute seizures, and to provide sedation before medical procedures) to be administered every four hours as needed for agitation, and a 7/21/26 physician's order for Lorazepam 0.5 mg to be administered every morning for agitation and anxiety. No documentation indicated that resident 5 or her representative was informed of the risks versus benefits of that medication, alternative treatment options, or that they provided their consent for that medication to be administered to resident 5. She had a 4/8/24 physician's order for 25 mg of Sertraline HCl (a prescription medicine that increases serotonin (a natural chemical messenger and hormone) activity in the brain to treat major depressive disorder, obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder, social anxiety disorder, and premenstrual dysphoric	F0552	All LPNs, RNs and nurse leaders will be educated by clinical lead development specialist or designee on psychotropic medications alternatives policy along with the psychotropic medications policy. Education completed for all LPNs, RNs and nurse leaders will be completed by 9/4/2026. All LPNs, RNs, or nurse leaders who do not complete education by 9/4/2026 will be educated by clinical lead development specialist or designee prior to their next scheduled shift. DNS or designee will review all new psychotropic medication orders daily to ensure documentation of informed consent, risks versus benefits, alternative treatment options, and resident/responsible party participation in treatment decisions is completed prior to medication administration. DNS or designee present information to IDT team during daily clinical meeting. A prompt will be added to the daily clinical meeting stand up sheet to ensure IDT team review and oversight. Psychotropic medication documentation, education and consents for all residents with new psychotropic medication orders will be audited weekly x4, every other week x2 and monthly x2 by DNS or designee to ensure risk versus benefits and education related to alternate treatment options are present and facility remains in compliance. DNS or designee will report audit findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring. Substantial compliance will be achieved on 9/11/2026.	9/11/2026

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F0552 SS = E	Continued from page 2 disorder) to be administered every morning for major depressive disorder. No documentation indicated that resident 5 or her representative was informed of the risks versus benefits of that medication, alternative treatment options, or that they provided their consent for that medication to be administered to resident 5. 2. Interview on 8/6/26 at 9:03 a.m. with contracted travel Minimum Data Set (MDS) coordinator/licensed practical nurse (LPN) F revealed that the charge nurses obtained the psychotropic consents from the resident or the resident's representative when a new psychotropic medication was started. She expected the consents to be completed before the medication was administered to the resident. 3. Interview on 8/6/26 at 9:52 a.m. with director of nursing (DON) B revealed that she expected the charge nurses to obtain the psychotropic consents for all residents on psychotropic medications, including those receiving hospice care. She confirmed that resident 5 and her representative were not informed of the risks versus benefits of Lorazepam and Sertraline, alternative treatment options, or that they provided their consent for those medications to be administered. 4. Review of resident 46's EMR revealed he admitted to the facility on 7/17/26. His 7/17/26 BIMS assessment score was 13, which indicated his cognition was intact. His diagnoses included depression, anxiety, and insomnia (a sleep disorder characterized by persistent difficulty sleeping). He had a 7/17/26 physician's order for Buspirone HCl (an anti-anxiety medication) 30 mg to be administered by mouth two times a day for anxiety and depression. No documentation indicated that the resident or the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or that they provided their consent for that medication to be administered to resident 46. He had a 7/17/26 physician's order for Chlorpromazine HCl (an antipsychotic medication;) 100 mg to be administered by mouth at bedtime for anxiety. No documentation indicated that the resident's representative was informed of the risks versus benefits of that medication, alternative	F0552		

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F0552 SS = E	Continued from page 3 treatment options, or provided their consent for that medication to be administered to resident 46. He had a 7/17/26 physician's order for Clonazepam 0.5 mg (a benzodiazepine medication used to treat anxiety) to be administered by mouth two times a day for anxiety. No documentation indicated that the resident or the resident's representative was informed of the risks versus benefits of that medication or alternative treatment options before that medication was to be administered to resident 46. He had a 7/17/26 physician's order for Duloxetine HCl (an antidepressant medication) 90 mg to be administered by mouth in the morning for depression. No documentation indicated that the resident or the resident's representative was informed of the risks versus benefits of that medication or alternative treatment options before that medication was to be administered to resident 46. He had a 7/17/26 physician's order for Olanzapine (an antipsychotic medication) 10 mg to be administered by mouth at night for anxiety. No documentation indicated that the resident's representative was informed of the risks versus benefits of that medication, alternative treatment options, or provided their consent for that medication to be administered to resident 46. He had a 7/17/26 physician's order for Trazodone HCl (an antidepressant medication) 300 mg to be administered by mouth at bedtime for insomnia. No documentation indicated that the resident or the resident's representative was informed of the risks versus benefits of that medication or alternative treatment options before that medication was to be administered to resident 46. He had a 7/17/26 physician's order for Zolpidem Tartrate (a hypnotic medication used to treat insomnia) 5 mg to be administered by mouth as needed once every 24 hours as needed at bedtime for insomnia. That physician's order did not have an end date, and resident 46 needed to be seen by a physician to have that medication reordered on 7/31/26. No documentation indicated that the resident or the resident's representative was informed of the risks versus benefits of that	F0552		

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F0552 SS = E	Continued from page 4 medication or alternative treatment options before that medication was to be administered to resident 46. 5. Review of resident 23's EMR revealed he admitted to the facility on 11/21/25. His diagnoses included depression, senile degeneration of the brain (severe age-related mental decline), and dementia with anxiety. He had a 11/25/25 physician's order for lorazepam 0.5 mg to be administered every four hours as needed for agitation, restlessness, depression, senile degeneration of the brain, and dementia with anxiety. Resident 23's 11/21/25 consent for the lorazepam did not indicate what the medication was to be administered for or alternative treatment options. He had a 12/24/25 physician's order for risperidone (an antipsychotic medication) 0.25 mg to be administered two times a day for dementia with anxiety. Resident 23's 12/24/25 consent for the risperidone did not indicate what the medication was to be administered for or alternative treatment options. He had a 1/21/26 physician's order for mirtazapine 15 mg to be administered one time a day for insomnia (inability to sleep) related to senile degeneration of the brain and dementia with anxiety. There was no documentation to indicate that the resident or the resident's representative was informed of the risks versus benefits of that medication, what the medication was to be administered for, alternative treatment options, or consent obtained before that medication was to be administered to resident 23. He had a 2/20/26 physician's order for fluoxetine (an antidepressant medication) 10 mg to be administered one time daily. Resident 23's 11/21/25 consent for the fluoxetine did not indicate what the medication was to be administered for or alternative treatment options. 6. Interview on 8/6/26 at 8:48 a.m. with LPN J revealed that the nurse who admitted a resident or received a resident's new psychotropic medication order was responsible for completing the psychotropic medications consent form. When she completed the psychotropic medication form, she went over what was on the form with the resident or the resident's representative, including the side effects, and why that medication was ordered. The	F0552		

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F0552 SS = E	Continued from page 5 psychotropic medications form did not include what the alternatives to the medication may be. She did not review alternatives to the medications with the resident or the resident's representative. 7. Interview on 8/6/26 at 9:24 a.m. with DON B revealed the psychotropic medication consents were to be completed by the nurse who admitted the resident. If a new psychotropic medication was ordered by the physician after a resident admitted to the facility, the nurse who received the physician's order for the medication was responsible for completing the psychotropic medication consent with the resident or the resident's representative. DON B expected the psychotropic medication consents to be complete. She expected the nurse who completed the psychotropic medication consent sign the form to indicate which nurse provided the education to the resident or resident's representative and obtained the consent for the administration of the psychotropic medication before it was administered. DON B did not know that the resident or resident's representative was to receive education about alternative treatment options before the psychotropic medication was administered. She stated she was unable to find a psychotropic consent for resident 23's mirtazapine, which would indicate the resident or the resident's representative was educated about the risk versus benefits of the medication, what the medication was being administered to treat, the alternative treatment options, and consent was obtained before the mirtazapine was administered to resident 23. 8. Review of the provider's 12/9/25 Psychotropic Medications policy revealed, "If the reduction committee determines that initiating a medication is warranted, then the committee nurse will ensure the following is completed: …The reduction committee will ensure that the family/legal representative and [the] resident are notified of this change in treatment." "A consent must be signed for the use of psychotropic medications."	F0552		
F0605 SS = E	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:	F0605		

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F0605 SS = E	Continued from page 6 §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F0605	DNS or designee faxed resident 2 provider on 8/26/26 to obtain a usage order stop date and documented reasoning for the continuation of their as needed psychotropic medications beyond 14 days. DNS or designee faxed resident 23 provider on 8/6/26 to obtain a usage order stop date and documented reasoning for the continuation of their as needed psychotropic medications beyond 14 days. Facility received order back from provider stating reason for continuation of PRN psychotropic medication. On 8/26/26, DNS faxed resident 23 provider requesting discontinuation of PRN psychotropic medication due to non-use. DNS or designee faxed resident 46 provider on 8/10/26 to obtain a usage order stop date and documented reasoning for the continuation of their as needed psychotropic medications beyond 14 days. Resident 14 discharged from the facility on 8/14/26. All residents who have an ordered psychotropic medication have the potential to be affected by the same deficient practice. On 8/26/26, DNS or designee reviewed all residents who have an ordered psychotropic medication to ensure documentation of a usage order stop date is present and documented reasoning for continuation of their as needed psychotropic medications is present. If documentation was not present of a usage order stop date is present and documented reasoning for continuation of their as needed psychotropic medications, DNS or designee will fax the resident's provider immediately to obtain the required documentation. All LPNs, RNs and nurse leaders will be educated by clinical lead development specialist or designee on the psychotropic medications policy related to documentation of a usage order stop date and documented reasoning for continuation of their as needed psychotropic medications beyond 14 days.	

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F0605 SS = E	Continued from page 7 drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the	F0605	Education completed for all LPNs, RNs and nurse leaders will be completed by 9/4/2026. All LPNs, RNs, or nurse leaders who do not complete education by 9/4/2026 will be educated by clinical lead development specialist or designee prior to their next scheduled shift. DNS or designee will review psychotropic medication orders end dates daily and present information to IDT team during daily clinical meeting. A prompt will be added to the daily clinical meeting stand up sheet to ensure IDT team review and oversight. Documentation of a usage order stop date and documented reasoning for continuation of their as needed psychotropic medication beyond 14 days will be audited for 10 residents including resident 2, 23 and 46 weekly x4, every other week x2 and monthly x2 by DNS or designee to ensure compliance. DNS or designee will report audit findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring. Substantial compliance will be achieved on 9/11/2026.	9/11/2026

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F0605 SS = E	Continued from page 8 attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the facility failed to protect the residents' rights to be free of unnecessary medications, specifically psychotropic medications (drugs that affect brain activities associated with mental processes and behavior), for three of four sampled residents (2, 23, and 46) who were ordered psychotropic medications without a usage order stop date or documented reasoning for the continuation of their as needed psychotropic medications beyond fourteen days. Findings include: 1. Review of resident 46's electronic medical record (EMR) revealed he admitted to the facility on 7/17/26. His 7/17/26 Brief Interview of Mental Status (BIMS) assessment score was 13, which indicated his cognition was intact. His diagnoses included depression (a mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities), anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and insomnia (a sleep disorder characterized by persistent difficulty sleeping). He had a 7/17/26 physician's order for Zolpidem Tartrate (a hypnotic medication used to treat insomnia) 5 milligrams (mg) to be administered by mouth once every 24 hours as needed at bedtime for insomnia. That physician's order did not have an end date. 2. Interview on 8/6/26 at 8:12 a.m. with contracted travel Minimum Data Set (MDS) coordinator/licensed practical nurse (LPN) F revealed she confirmed that resident 46's Zolpidem Tartrate was ordered on 7/17/26 as a PRN (as needed dose) and there was no documented end date for that medication. She acknowledged Zolpidem Tartrate was a psychotropic medication that should not be ordered as a PRN medication for longer than 14 days without the physician providing documented reasoning why the medication was to be administered longer than 14 days and identified a specific end date for that medication.	F0605		

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F0605 SS = E	Continued from page 9 3. Review of resident 2's EMR revealed she admitted to the facility on 10/23/24. Her diagnoses included dementia (a group of symptoms affecting memory, thinking, and social abilities) and depression. She had a 12/9/25 physician's order for lorazepam (an antianxiety medication) 0.5 mg to be administered every four hours as needed for agitation related to dementia. The physician's order did not have an end date. Resident 2's 7/15/26 consultant pharmacist monthly medication review indicated, "Still has [an] order for PRN [as needed] lorazepam with no end date in [EMR]- resent note." 4. Review of resident 23's EMR revealed he admitted to the facility on 11/21/25. His diagnoses included depression, senile degeneration of the brain (severe age-related mental decline), and dementia with anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability). He had a 11/25/25 physician's order for lorazepam 0.5 mg to be administered every four hours as needed for agitation, restlessness, depression, senile degeneration of the brain, and dementia with anxiety. The physician's order did not have an end date. Resident 23's 6/9/26 consultant pharmacist monthly medication review indicated, "[The resident's] PRN lorazepam order was okay'd for 6 months back in November." Resident 23's 7/15/26 consultant pharmacist monthly medication review indicated, "No notation on lorazepam PRN duration- resent." 5. Interview and EMR review on 8/6/26 at 9:24 a.m. with director of nursing (DON) B revealed she was responsible for reviewing the pharmacist's recommendations to the physician. She tried to review the physician's responses to the pharmacist's recommendations to be sure all the pharmacist's recommendations were addressed by the physician. She was aware as needed psychotropic medications needed to have an end date of 14 days after the medication was prescribed. The physician could provide a rationale of why the medication end date was to be longer than 14 days after that medication was prescribed, and the end date would need to be indicated.	F0605		

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(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
F0605 SS = E	Continued from page 10 She thought that when the as needed medications were reordered, the nurse who entered the physician's order into the resident's EMR did not enter the end date. She was not aware that residents 2 and 23 had a pharmacist recommendation that indicated there was no end date on the physician's order for lorazepam and the physician did not address the recommendation. 6. Review of the provider's 12/9/25 Psychotropic Medications policy revealed, "PRN orders for psychotropic drugs are limited to 14 days. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order."	F0605	On 8/25/26, DNS or designee reviewed resident 4, 6, and 27 care plans and updated them to reflect restorative needs including PROM. On 8/25/26 fax was sent to resident 37's provider for a PT and OT evaluation to treat. PT and OT were consulted for resident 37 and order received for therapy services due to desire for increased physical activity due to weight gain and a fear of losing his mobility. On 8/24/26, DNS reviewed resident 37's care plan and updated it for restorative needs including encouragement for resident to participate in daily movement activities in the main lounge. All residents with an identified need for a restorative therapy program have potential to be affected by the same deficient practice. On 8/24/26-8/26/26, DNS or designee reviewed all current residents for restorative needs, including ROM, PROM, mobility, ambulation, and transfer ability. On 8/24/26-8/26/26, DNS or designee reviewed all resident care plans to ensure that a restorative nursing program has been implemented as appropriate for each resident. If resident care plan does not accurately reflect resident specific restorative program and it is determined that additional therapy services are recommended, physical therapy or occupational therapy will be consulted for therapy recommendations and formal therapy will be added to the residents care plan.	
F0688 SS = E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure an ongoing restorative nursing program was implemented for three of three sampled residents (4, 6, and 27) identified as at risk for declining in their range of motion (ROM) and one of one sampled resident (37) who expressed a desire for increased physical activity due to weight gain and a fear of losing his mobility.	F0688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435074	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2026

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F0688 SS = E	Continued from page 11 Findings include: 1. Observation and interview on 8/4/26 at 8:50 a.m. with resident 4 in his room revealed he was seated in a power tilt-in-space wheelchair (a specialty wheelchair that tilts the entire seat and backrest backwards as a single unit), had difficulty holding his head up, and had limited use of both hands. He felt he was not receiving the exercises he needed to maintain his strength or ROM, and was getting weaker. He stated he used to complete exercises at the facility where he previously lived, but no staff members at this facility came to assist him with exercises or ROM. 2. Review of resident 4's electronic medical record (EMR) revealed he admitted to the facility on 12/26/25. He had a diagnosis of spastic quadriplegic cerebral palsy (a severe form of cerebral palsy, a permanent neuromuscular condition caused by damage to the developing brain before, during, or shortly after birth, characterized by extreme muscle stiffness, impact on all four limbs, and involvement of the torso and face). His 7/24/26 Brief Interview for Mental Status (BIMS) assessment score was 13, which indicated his cognition was intact. His care plan (personalized plan that addresses a resident's care needs, goals, and interventions) included a 12/26/25 focus area that he had an activity of daily living self-care performance deficit related to "limited mobility E/B [evidenced by] contractures [a permanent or severe tightening and shortening of muscles] and weakness", and that he had a "Cerebral Palsy diagnosis upon admission." His goal was to "maintain [his] current level of functioning in eating, assisting with dressing, [and] assisting with [his] hygiene cares..." His care plan also included a focus area that "The resident expressed need for customized dining services R/T [related to his] diet, [and] adaptive dining equipment..." The goal was "Resident [4] will express his/her dining services needs are met, and he/she feels supported in dining decisions..." His most recent quarterly 7/1/26 Minimum Data Set (MDS) assessment (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) indicated he had a functional limitation in ROM in both lower extremities (hips, knees, ankles, and feet) and both upper extremities (shoulders, elbows, wrists, and hands), and he received no restorative nursing exercise programs.	F0688	By 9/11/2026, MDS coordinator and DNS will complete success center courses for restorative training to oversee the restorative program. MDS coordinator or designee will review all resident restorative programs quarterly to ensure resident restorative programs are effective and resident specific. Clinical Lead Development Specialist will educate CNAs on restorative interventions to ensure they are competent on resident specific restorative programs. Education for all CNAs will be completed by 9/4/2026. All CNAs who do not complete education by 9/4/2026 will be educated by clinical lead development specialist or designee prior to their next scheduled shift. On 8/27/26, DNS or Designee will enter restorative program as a daily task on PCC to ensure CNA completion. All CNAs will be educated by 9/4/2026 to ensure that restorative programs are being completed per the resident's plan of care. MDS Coordinator or designee, who screens for GG and sit, stand, walk UDA, will assist with identifying restorative needs and will review resident restorative programs at least quarterly. Clinical Lead Development Specialist will educate DNS and nurse leaders on policies and procedures related to restorative programs to ensure nurse leadership oversight on resident restorative programs. Education for DNS and nurse leaders will be completed by 9/4/2026. DNS or designee will review clinical dashboard daily and any documented change in resident condition will be reviewed at the daily clinical stand up with IDT team. A prompt will be added to the daily clinical stand up sheet to address any new residents who are determined to be appropriate for a restorative program. The facility's Restorative Nursing Program policy was reviewed and implemented to guide resident assessment, program development, documentation, oversight, and monitoring.	

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F0688 SS = E	Continued from page 12 3. Interview on 8/5/26 at 9:16 a.m. with physical therapist (PT) S revealed that physical therapy did not assess resident 4's need for a restorative exercise or ROM program when he admitted to the facility because the facility did not offer a restorative program. She stated that the facility offered a walking program for residents who could walk to their meals and that physical therapy prescribed home exercise programs (HEP) for residents in the facility who could complete exercises independently or had family members who could assist them. Those exercise programs were taught to the residents and their family members, and the certified nursing assistants (CNAs) were not trained to or expected to assist the residents with them. Resident 4 did not have an HEP because he was unable to complete exercises independently. She did not know if resident 4 would benefit from a restorative program or HEP because she had not assessed resident 4. 4. Interview on 8/5/26 at 9:26 a.m. with resident 4 revealed he felt he dropped more food when he ate his breakfast and that his "eating muscles" were stiffer and weaker than when he admitted to the facility. He stated that he remembered doing hand exercises with the staff members at the facility where he used to live, and that those staff members moved his arms and legs to prevent them from being stiff. He was frustrated that the staff members at this facility did not help him with exercises or ROM activities. 5. Interview on 8/5/26 at 9:35 a.m. with certified occupational therapy assistant (COTA) R revealed that resident 4 was seen for occupational therapy (OT) services related to the safe driving of his wheelchair. OT did not assess resident 4's ability to use adaptive dining equipment or his need for a restorative exercise or ROM program because the facility did not offer a restorative program. She thought resident 4 brought his own adaptive equipment with him to the facility and that he was at his baseline when he admitted to the facility. 6. Observation and interview on 8/5/26 at 10:07 a.m. with resident 6 in her room revealed that she gestured thumbs up and thumbs down, or nodded her head to answer most questions, and at other times used one-word answers to respond. She was lying in bed and could only move one arm. She indicated that no one came to assist her with ROM exercises and she felt stiff, and that she was losing her strength.	F0688	DNS or designee will audit 10 residents, including resident 4, 6, 27, and 37, to ensure their care plans reflect a resident specific restorative program and documentation is recorded to ensure completion of restorative interventions. Audits will be completed weekly x4, every other week x2 and monthly x2 by DNS or designee to ensure compliance. DNS or designee will report audit findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring. Substantial compliance will be achieved by 9/11/2026.	9/11/2026

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F0688 SS = E	Continued from page 13 7. Review of resident 6's EMR revealed she admitted to the facility on 3/12/26. Her diagnoses included hemiplegia (the total or partial paralysis on one side of the body, affecting the arm, leg, and often the face) following a cerebral infarction (stroke) affecting her left non-dominant side. Her 6/5/26 BIMS assessment score was 7, which indicated her cognition was severely impaired. Her care plan included a 4/11/25 focus area that stated "The resident has potential alteration in musculoskeletal status R/T [related to] immobility, risk for developing contracture of legs/feet." Her goal was to "remain free of complications related to immobility, such as contracture formation, embolism..." Interventions included "Encourage resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility such as: PT/OT." Her 10/27/25 Physical Therapy Discharge Summary recommendations stated, "Husband provided with cervical, UE [upper extremity] and LE [lower extremity] HEP to continue completing independently..." "Restorative Program Established/Trained = Restorative ROM Program." Her most recent modification of the quarterly 6/4/26 MDS assessment indicated she had a functional limitation in ROM in one lower extremity and one upper extremity, and she received no restorative nursing exercise programs. 8. Observation on 8/5/24 at 10:12 a.m. with resident 27 in her room revealed she sat in a Broda chair (a specialized positioning wheelchair), her hands were closed in fists, and she was unable to answer the surveyors' questions. 9. Review of resident 27's EMR revealed she admitted to the facility on 11/27/19. Her diagnoses included Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions). Her 6/2/26 BIMS assessment score was 1, which indicated her cognition was severely impaired. Her most recent modification of the quarterly 6/2/26 MDS assessment indicated she had a functional limitation in ROM in both upper and lower extremities, and she received no restorative nursing exercise programs. Her care plan included a 9/8/20 focus area "resident [27] has arthritis. Resident will be/remain free of complications related to arthritis (contractures, joint stiffness, swelling, or decline in mobility)." Interventions included "Observe/document/report...complications of	F0688		

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F0688 SS = E	Continued from page 14 arthritis: Joint pain; joint stiffness, usually worse on wakening; swelling; decline in mobility; decline in self-care ability; contracture formation/joint shape changes; crepitus [cracking and popping sound in the joint]; pain after exercise or weight bearing." 10. Interview on 8/5/26 at 10:45 a.m. with CNA O revealed that she did not assist residents with ROM or exercise programs. Some residents were provided with exercise programs by the therapy department and completed those exercises independently. She did not think residents 4, 6, or 27 had any exercise programs since they were unable to complete them themselves. 11. Interview on 8/5/26 at 11:36 a.m. with administrator A revealed that there was no restorative program offered at the facility. There was no documentation related to recommendations for restorative programs or documentation that exercise programs or ROM exercises were completed for residents 4, 6, or 27. 12. Observation and interview on 8/5/26 at 1:40 p.m. with resident 37 in his room revealed that he sat in a recliner and used a four-wheeled walker (a mobility device to help maintain balance with a built-in seat). He stated he used his four-wheeled walker independently to walk to his meals. He had gained weight since he moved to this facility because he was unable to ride an exercise bike and was afraid that he was getting weaker. The dietitian recommended that he exercise to lose weight about a month ago. There was no plan for that, but he thought more exercise would be good for him. He stated that he used to complete exercises and ride an exercise bike at the facility where he previously lived, but he was told there was no exercise bike at this facility that he could ride. 13. Review of resident 37's EMR revealed he admitted to the facility on 6/13/25. His diagnoses included dementia (a group of symptoms affecting memory, thinking, and social abilities). His 5/28/26 BIMS assessment score was 15, which indicated his cognition was intact. His care plan included a 6/13/25 focus area that he was at risk for falling related to the use of a walker for ambulation (walking), with a goal that he would be free of injury. A 6/13/26 focus area indicated that resident 37 had an "unplanned weight gain R/T potentially overeating." The goal was that resident 37 would "maintain weight WNL [within normal limits] for	F0688		

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F0688 SS = E	Continued from page 15 resident..." Interventions included "Review overall meal plan with resident/family and adjust goals and interventions to meet resident's preferences and weight goals." His most recent 6/30/26 dietitian assessment indicated he had gained 30 pounds since he admitted to the facility. Her recommendations included "Encourage physical activity." 14. Interview on 8/5/26 at 3:32 p.m. with administrator A revealed the facility did not have a restorative program since the COVID-19 outbreak due to a lack of staffing. Some residents walked with the staff to meals, and other residents were assessed by the therapy department as independent with their exercise programs. She expected the therapists to educate the resident on a HEP and provide the resident with a handout to complete those exercises independently. The nursing staff did not oversee those programs. Those exercise programs were only for residents who could complete them independently. Residents with cognitive issues did not participate in OT or PT because they could not understand the directions needed to participate. Residents with limited ROM or contractures, who required assistance, did not receive restorative therapy because there was no program or the staff to complete them. She did not expect the CNAs to complete ROM exercises with residents because there was no program established for them. She thought a restorative program would be beneficial, but they did not have the staff members needed to complete it. 15. Interview on 8/6/26 at 10:31 a.m. with administrator A and director of nursing (DON) B revealed administrator A thought that OT and PT departments reviewed resident 4's admitting documents and determined that they did not think that he needed OT or PT because he was at his baseline and no restorative nursing program was available. She expected the CNAs to notify the nurse if any residents, including 4, 6, and 27, had any decline in their ability to get dressed or increased mobility issues so orders for a therapy evaluation could be requested. There were no preventative interventions in place for the residents who required assistance with ROM or exercises to ensure they maintained their highest level of function. She thought that resident 37's weight gain was because he ate too many snacks, and she did not think there was a decline in his ability to walk	F0688		

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F0688 SS = E	Continued from page 16 because he walked to his meals independently. There were group exercises provided by the activities department in the living room that he chose not to attend. She was unaware that resident 37 wanted to ride an exercise bike. There was an exercise bike in the therapy room, but he would have to be able to ride it independently. She did not think resident 37 was assessed to do that. Resident 37 was unable to ride that exercise bike if he required any assistance or supervision because the facility did not have a restorative program. Administrator A did not think the CNAs were trained to assist residents with ROM or exercise programs and that the residents who were able to complete exercises independently were given HEP's. She did not think that there needed to be services provided to the residents to maintain, improve, or prevent avoidable decline in ROM and mobility. 16. Review of the provider's undated Certified Nursing Assistant job description revealed that the CNAs provide "assistance with basic healthcare needs, including daily living activities that may include but are not limited to.... range of motion and passive exercises." 17. Review of the provider's reviewed 12/8/25 Restorative- Nursing Care Policy Implementation and Screening revealed "Each resident will receive restorative nursing care to the extent possible, based on individual strengths, needs and problems as defined in nursing assessments. This restorative care will be outlined in the resident's nursing care plan. Care includes safe measures to prevent complications and contractures, maintain strength and self-care abilities including eating and dressing, promote mobility and a feeling of well-being." "The goal of restorative nursing care is to attain and maintain the maximum possible and/or prevent rapid declines through their interventions for each resident." "Implementation of Resident's Restorative Program... 2. The information is shared with interdisciplinary team members during the initial care planning process. The interdisciplinary team, including therapy, should communicate upon a resident's facility admission, regarding the initiation of the Restorative Nursing Assessment, exclusive of the resident's status with skilled therapy. It is the goal to include the resident in the development of the care plan goals and interventions to ensure a	F0688		

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F0688 SS = E	Continued from page 17 person-centered approach to care." Examples of conditions for implementation of a restorative nursing program included medical conditions that affect joint mobility, pressure ulcers, limited range of motion; disease processes, and prognosis; spasticity, contractures, or decreased sensation, resident's willingness to participate, motivation, fall reduction programs promoting strength, flexibility, endurance and balance. 18. Review of the provider's 6/3/26 Facility Assessment revealed resources available to deliver care needed by the residents included "restorative therapy."	F0688		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure expired medications and supplies were discarded for one of one resident medication refrigerator, two of two medication carts, one of one medication storage	F0761	On 8/6/26, DNS removed all expired medications and supplies from resident medication refrigerator, medication carts, medication storage room, supply room and shower room. On 8/6/26, DNS or designee recorded temperature for resident medication refrigerator that was identified as not having temperatures appropriately recorded. All residents have the potential to be impacted by the same deficient practice. On 8/10/26, DNS or designee reviewed all medication refrigerators, medication carts, medication storage rooms, supply rooms and shower rooms to ensure no expired medications or supplies were present. If medications or supplies were identified as being expired upon review, they were immediately removed and discarded at time of review. On 8/28/26, DNS or designee reviewed all resident medication refrigerators to ensure temperatures were appropriately recorded and documentation was present. If any temperatures were missing, DNS or designee immediately recorded the temperature to ensure the refrigerator temperature was within compliance.	

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F0761 SS = E	Continued from page 18 room, one of one supply room, and one of one shower room, and temperatures were monitored for one of one resident medication refrigerator. Findings include: 1. Observation on 8/4/26 at 3:45 p.m. of the shower room in the 100-hallway revealed there was a brown wooden cabinet. In the cabinet, there were ointments and dressing supplies. There was a silicone bordered dressing that expired on 2/12/25. There were 20 alcohol prep wipes that expired on 11/30/25. There was a package of iodine swabs that expired on 6/5/25. There was an oil emulsion dressing that expired on 3/7/26. There was an open, partially used tube of silicone cream that expired in October 2018. There was an opened, partially used tube of Dermaceptin with Menthol barrier cream that expired in July 2021. There were two packages of collagen powder that expired in January 2023. Beside the shower there was a white and clear plastic three drawer storage container that contained an open partially used protective ointment that expired in August 2025, and an opened partially used Calzinc Oxide cream that expired in March 2024. 2. Observation and interview on 8/5/26 at 3:52 p.m. with certified nursing assistant (CNA) N in the shower room revealed she was the full-time bath aide. She checked for expired supplies in the whirlpool and shower rooms every couple of months. She verified there were expired supplies in the shower room. She stated she must have missed them when she last checked for expired supplies. She verified she was using the creams in the white and clear plastic container for residents after they showered. 3. Observation, medication refrigerator temperature log review, and interview on 8/5/26 at 1:04 p.m. of the medication storage room with registered nurse (RN) I revealed the resident's medication refrigerator contained a vial of opened partially used tuberculin (used for tuberculosis skin testing) solution that was dated as opened on 6/30/26. There were six syringes of influenza vaccine with an expiration date of 6/26/26. There was one high dose influenza vaccine syringe with an expiration date of 6/26/26. The August 2026 medication refrigerator temperature log indicated the temperatures were to be checked	F0761	All LPNs, RNs and nurse leaders will be educated by clinical lead development specialist or designee on policies and procedures related to removal and disposal of expired supplies and recording temperatures of refrigerators. Education completed for all LPNs, RNs and nurse leaders will be completed by 9/4/2026. All LPNs, RNs, or nurse leaders who do not complete education by 9/4/2026 will be educated by clinical lead development specialist or designee prior to their next scheduled shift. All treatment supplies were removed from the shower rooms on 8/27/26 and nurses educated by DNS to ensure treatment carts brought to the shower room if treatments are needed. Inventory clerk or designee will monitor all medication and supply storage rooms weekly to ensure no medications or supplies are expired and facility remains in compliance. DNS or designee will monitor medication carts and resident rooms weekly to ensure no medications or supplies are expired and facility remains in compliance. DNS or designee will audit resident medication refrigerator, medication carts, medication storage room, resident rooms, supply room and shower room to ensure all medications and supplies are in compliance and are not expired. Audits will be completed weekly x4, every other week x2 and monthly x2 by DNS or designee to ensure compliance. DNS or designee will report audit findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring. Substantial compliance will be achieved on 9/11/2026.	9/11/2026

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F0761 SS = E	Continued from page 19 two times daily. There were no temperatures documented on the evening of 8/1/26 and 8/2/26, and in the morning on 8/2/26 and 8/3/26. RN I verified that the medication refrigerator temperatures were not documented as having been monitored for the above dates in August. She verified the tuberculin solution should have been disposed of 30 days after it was opened, and the influenza vaccine syringes were expired. 4. Observation and interview on 8/5/26 at 1:25 p.m. of the medication carts with RN I revealed that in the 300 hallway medication cart there was a petroleum gauze dressing that expired on 5/16/26. In the 100 and 200 hallways medication cart was resident 37's Debrox ear drops (used to remove ear wax) that expired in January 2026. RN I stated that the night nurse was responsible for checking for expired medications and supplies stored in the medication room, the supplies storage room, and the medication carts every Sunday. The night nurse was to sign the calendar on the medication storage room door that they checked the medications and supplies' expiration date. RN I verified the dressings and supplies in the shower room were for the residents. They were there in case a nurse was changing a resident's dressing and needed to apply a new dressing. 5. Observation on 8/5/26 at 1:35 p.m. of the supply room revealed four boxes that contained rolls of InterDry moisture-wicking fabric that expired on 3/17/24. There were eight, four inch by five inch Telfa dressings (a nonadherent dressing) that expired on 3/1/25, and ten 6 inch by six inch Telfa dressing that expired on 3/1/25. 6. Review of the provider's May 2026 through July 2026 medication refrigerator temperature log revealed the temperatures were to be monitored and documented in the morning and evening. There was no documentation that the temperatures were monitored in the mornings of 5/7/26, 5/9/26, 5/14/26, 5/27/26, 5/28/26, 5/29/26, and in the evenings on 5/26/26, 5/27/26, 5/28/26, and 5/29/26 in the month of May. In June 2026 there was no documentation that the temperatures were monitored in the mornings of 6/2/26, 6/3/26, 6/4/26, 6/7/26, 6/8/26, 6/11/26,	F0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435074	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2026

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F0761 SS = E	Continued from page 20 6/12/26, 6/16/26, 6/17/26, 6/18/26, 6/21/26, 6/22/26, 6/25/26, 6/26/26, 6/27/26, 6/30/26 and in the evenings on 6/1/26, 6/2/26, 6/3/26, 6/6/26, 6/7/26, 6/9/26, 6/10/26, 6/11/26, 6/15/26, 6/16/26, 6/17/26, 6/20/26, 6/21/26, 6/24/26, 6/25/26, 6/26/26, and 6/29/26. In July 2026 there was no documentation that the temperatures were monitored in the mornings of 7/3/26, 7/5/26, 7/6/26, 7/17/26 through 7/25/26, 7/28/26, 7/29/26, 7/30/26 and in the evenings on 7/1/26, 7/2/26, 7/4/26, 7/5/26, 7/8/26, 7/9/26, 7/10/26, 7/15/26, 7/16/25, 7/17/26, 7/18/26, 7/20/26 through 7/24/26, 7/27/26, 7/28/26, and 7/29/26. 7. Review of the provider's March 2026 through July 2026 medication storage room expiration dates checklist calendar revealed the medication storage room was to be checked for expired medications and supplies every Sunday night and signed that the checks were completed. The March 2026 calendar did not have a signature to indicate the medication storage room was checked for expired medications and supplies on 3/1/26, 3/8/26, 3/15/26, and 3/22/26. The April 2026 calendar did not have any signatures to indicate the medication room had been checked for expired medications and supplies. The May 2026 calendar did not have signatures to indicate the medication storage room was checked for expired medications and supplies on 5/3/26, 5/17/26, 5/24/26, and 5/31/26. The June and July 2026 calendars did not have any signatures on it to indicate the medication storage room was checked for expired medications and supplies. 8. Interview on 8/6/26 at 9:24 a.m. with director of nursing (DON) B revealed she expected the temperature of the medication refrigerator to be monitored and documented two times daily in the morning and in the evening. The nurses were responsible for monitoring and documenting the medication refrigerator temperatures. She was aware there was missing documentation to indicate the medication refrigerator temperatures were monitored. She acknowledged that without the refrigerator temperature documentation she could ensure the medications in that refrigerator were stored within the manufacturers' recommendations for safe storage.	F0761		

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F0761 SS = E	Continued from page 21 The night nurses were responsible for checking the medication storage room, medication refrigerator, and the medication carts for expired medications and supplies every Sunday night. She was aware there was no documentation to support that the nurses had checked for expiration dates and disposed of the expired medications and supplies every Sunday night. The calendars that the nurses used to document when they had checked for expired medications and supplies and disposed of any expired medications and supplies were given to DON B at the end of each month. She did not review the calendars to be sure the nurses had documented that they checked for, and disposed of the medications and supplies that were expired. She did not know who was responsible for checking for expired creams and supplies in the shower room. 9. Review of the provider's 3/30/26 Medications: Acquisition, Receiving, Dispensing, and Storage policy revealed, "The location will routinely check for expired medications and necessary disposal will be done in accordance with state/pharmacy regulations. All medications will be stored in accordance with manufacturers' recommendations." "Refrigerators holding medications (such as insulin, etc) will be kept between 36 [degrees] F [Fahrenheit] and 46 [degrees] F." "Check refrigerator temperatures once in the morning and once in the evening." 10. Review of the provider's undated CMS [Center for Medicare and Medicaid Services] Requirements for Expiration Dates of Ophthalmic [eye] Products for Long Term Care Facilities resource revealed, "TB [tuberculin] Solutions- Expires 30 days after opening."	F0761		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F0657	On 8/24/26, DNS reviewed resident 23's care plan and updated it to reflect current care needs, goals and interventions related to the psychotropic medication that they are on along with the nonpharmacological interventions that staff could utilize.	

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F0657 SS = D	Continued from page 22 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the residents' care plans (a personalized plan that addresses a resident's care needs, goals, and interventions) were reviewed and revised to reflect the current care needs for one of four sampled residents (23) who were on psychotropic medications (drugs that affect brain activities associated with mental processes and behavior). Findings include: 1. Review of resident 23's electronic medical record (EMR) revealed he admitted to the facility on 11/21/25. His diagnoses included depression, senile degeneration of the brain (severe age-related mental decline), and dementia (a group of symptoms affecting memory, thinking, and social abilities) with anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability). He had a 11/25/25 physician's order for lorazepam (an antianxiety medication) 0.5 milligrams (mg) to be administered every four hours as needed for agitation, restlessness, depression, senile degeneration of the brain, and dementia with anxiety. His 8/5/26 care plan did not indicate he was on an antianxiety medication or have nonpharmacological interventions that were to be attempted before the as needed lorazepam was administered.	F0657	All residents on a psychotropic medication have the potential to be impacted by the same deficient practice. On 8/24/26, all care plans for residents with an ordered psychotropic medication were reviewed by DNS or designee to ensure that current care needs, goals and interventions related to the psychotropic medication that they are on along with the nonpharmacological interventions that staff could utilize were documented and resident specific. If appropriate documentation related to ordered psychotropic medications and nonpharmacological interventions were not present at time of review, care plans were updated immediately by the DNS or designee. Clinical Lead Development Specialist or designee will educate social worker, DNS, and nurse leaders on policies and procedures related to psychotropic care plan requirements along with nonpharmacological interventions. Clinical Lead Development Specialist will educate all CNAs, CMAs, LPNs and RNs on how to access resident care plans to identify interventions put in place. Education will be completed by 9/4/2026. All required employees who do not complete education by 9/4/2026 will be educated by clinical lead development specialist or designee prior to their next scheduled shift. DNS or designee will review all care plans with changes in psychotropic medication orders and will present during daily clinical meeting. On 8/24/26, a prompt was added to the daily clinical stand up to discuss any residents who have a new order for a psychotropic medication to ensure IDT team reviews resident plan of care during clinical stand up and add resident specific nonpharmacological interventions.	

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F0657 SS = D	Continued from page 23 He had a 12/24/25 physician's order for risperidone (an antipsychotic medication; (a drug that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions) 0.25 mg to be administered two times a day for dementia with anxiety. His 8/5/26 care plan did not indicate he was on an antipsychotic medication or the nonpharmacological interventions that could be used by the staff for resident 23's symptoms or behaviors related to dementia with anxiety. He had a 1/21/26 physician's order for mirtazapine (an antidepressant medication) 15 mg to be administered one time a day for insomnia (inability to sleep) related to senile degeneration of the brain and dementia with anxiety. His 8/5/26 care plan did not indicate nonpharmacological interventions that the staff could use to help resident 23 with his insomnia. He had a 2/20/26 physician's order for fluoxetine (an antidepressant medication) 10 mg to be administered one time daily. His 8/5/26 care plan did not indicate nonpharmacological interventions that the staff could use to help resident 23 with his depression symptoms. 2. Interview on 8/5/26 at 3:36 p.m. with administrator A revealed that not all resident care plans reflected nonpharmacological interventions. "It just depends on the resident and the intervention," she said. "There is a list of interventions listed at the nurse's station that are not resident-centered, they're just general interventions for [the] staff to try." 3. Review of the list of interventions at the nurse's station revealed 29 nonpharmacological interventions for the staff to try when residents experienced behaviors, including redirecting the resident, reducing noise and overstimulation, and providing pet therapy or "fake" companion pets. The list did not include any resident names and did not indicate whether the interventions were successfully attempted with any residents. 4. Interview on 8/6/26 at 9:03 a.m. with contracted travel Minimum Data Set (MDS) coordinator/licensed practical nurse (LPN) F revealed that she began working at the facility on 6/15/26. She expected the resident's care plan or Kardex to list any psychotropic medications the resident took,	F0657	Daily stand up information will be posted at the CNA and nurses stations and any changes to resident care plans related to nonpharmacological interventions will be communicated to the direct care staff by DNS or designee. DNS and IDT team will complete weekly risk meetings to review all residents on psychotropic medications and ensure that nonpharmacologic interventions are appropriate and resident specific on their care plan. DNS or designee will update resident's care plan when changes occur or interventions are added. DNS or Designee will audit 5 resident care plans, including resident 23, to ensure psychotropic medications are documented along with resident specific nonpharmacological interventions. Audits will be completed weekly x4, every other week x2 and monthly x2 by DNS or designee to ensure compliance. DNS or designee will report audit findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring. Substantial compliance will be achieved by 9/11/2026.	9/11/2026

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F0657 SS = D	Continued from page 24 including adverse behaviors to monitor and successful interventions for the staff to use to reduce the resident's anxiety or agitation. She said nonpharmacological interventions were usually documented in the nursing progress notes, but she did not know if CNAs were able to view the progress notes. "If an intervention works, we put it in the task list for the CNAs to see," she said. 5. Interview on 8/6/26 at 9:20 a.m. with social services designee D indicated that the residents' care plans "are geared more towards resident safety, like falls and wheelchairs to use, more so than [their] behaviors." 6. Interview on 8/6/26 at 9:32 a.m. with contracted travel CNA Q revealed that she started working at the facility three days ago. She did not yet know the residents very well but expected to be able to reference their care plan or Kardex (a report of the resident's care needs and interventions) to learn whether they should be monitored for adverse behaviors and interventions to be used. If she witnessed a behavior by a resident that was not referenced in their care plan, she would ask one of the nurses or another CNA to determine whether the behavior was unusual for that resident. 7. Review of the provider's 12/9/25 Psychotropic Medications policy revealed, "Ensure that the order has clear parameters, i.e., severe agitation that does not respond to other care plan interventions. It is important to initiate other care plan interventions prior to the use of PRN psychotropic medications."	F0657		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by:	F0689	"Past Noncompliance - no plan of correction required"	

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F0689 SS = D	Continued from page 25 Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, and policy review, the provider failed to provide adequate supervision and assistance to ensure the safety of one of one sampled resident (26) who fell while being transferred by former contracted travel certified nursing assistant (CNA) (P), who did not transfer the resident as directed in the resident's care plan (a personalized plan that addresses a resident's care needs, goals, and interventions). This citation is considered past non-compliance based on a review of the provider's corrective actions immediately following the incident. Findings include: 1. Review of the provider's 6/13/26 SD DOH FRI regarding resident 26 revealed that on 6/13/26 at 4:34 p.m., former contracted travel CNA P transferred resident 26 from her wheelchair to her bed using a hygiene sling (a specialized support accessory used with a patient lift). The report specified that although resident 26 required assistance from two staff members to transfer her with a total body lift (a mechanical lift and sling used to lift a person's full body), former contracted travel CNA P transferred the resident alone, using the wrong sling. When the resident was suspended in the sling, she lifted her arms, causing her body to shift position within the sling and fall, hitting her head on the floor. Resident 26 was evaluated at the emergency room and returned to the facility the same day with no concerns other than a small bump on her head. Former contracted travel CNA P and all nursing staff were immediately reeducated on the provider's Safe Resident Handling Program. Following resident 26's fall, administrator A and director of nursing (DON) B reviewed the care plans for all other residents using a mechanical lift and found that they all accurately listed the appropriate sling and lift to be used during transfers. Administrator A and DON B audited resident transfers for four weeks to ensure the care plan was followed. Former contracted travel CNA P was terminated from employment on 6/14/26. 2. Review of resident 26's electronic medical record (EMR) revealed that she admitted to the facility on 9/13/24. She had diagnoses of progressive multiple sclerosis (a long-lasting disease of the brain and spinal cord where the body's immune system harms the protective cover of the nerve cells, slowing or	F0689		

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F0689 SS = D	Continued from page 26 blocking messages between the brain and body), muscle weakness, Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), and unspecified dementia (a group of symptoms affecting memory, thinking, and social abilities), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. She had a 6/11/26 Brief Interview for Mental Status (BIMS) assessment score of 4, which indicated her cognition was severely impaired. Her 3/13/26 fall assessment score was 12, indicating she had a medium risk of falling. Her 1/21/26 care plan indicated she required assistance from two staff members to transfer with a total body lift and a medium mesh or high-back yellow sling. Her 6/10/26 sit-stand-walk assessment indicated she required a total body lift, a medium full-body sling, and two employees to assist her with transfers. 3. Interview on 8/5/26 at 10:28 a.m. with CNA M revealed she referenced the resident's Kardex (a report of the resident's care needs and interventions) to determine how many staff members should assist the resident with transfers, and what type of lift and sling to use for the transfer. She said the resident's Kardex specified if they used a hygiene sling, which was reserved for transfers to the toilet or the shower chair. She said hygiene slings were never used to transfer a resident from their wheelchair to their bed. 4. Observation and interview of a total lift transfer on 8/5/26 at 3:45 p.m. of a supply closet with CNA L revealed that the staff were informed at the beginning of each shift if a resident's care plan was updated for a different lift or sling. The supply closet contained slings of various sizes and colors, stored next to the manufacturer's poster depicting how a sling was to be attached to the total body lift. CNA L confirmed that a hygiene sling was only used for transfers during toileting or bathing. He said resident 26 had always required the assistance of two staff members using a total body lift. 5. Interview on 8/6/26 at 9:32 a.m. with contracted travel CNA Q revealed she started working at the facility three days ago. During her first shift she received training on the types of lifts and slings used in the facility and was instructed to reference	F0689		

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F0689 SS = D	Continued from page 27 the residents' care plan or Kardex to determine the equipment and level of assistance the residents required during a transfer. She was also trained to perform a "time out" prior to transferring a resident, to ensure the sling was buckled and the color-coordinated straps were in the right place on the total body lifts. 6. Interview on 8/6/26 at 10:14 a.m. with administrator A and DON B revealed that all nursing staff received Safe Resident Handling Program (SRHP) training when they were hired and completed safe transfer competency skills testing annually. The SRHP training was also provided to contracted travel CNAs on their first shift, in addition to any training they received from their contracted travel agency. All nursing staff received safe transfer competency skills testing in June as part of the provider's mock survey preparations. Former contracted travel CNA P's competencies were completed on 4/7/26 and 6/5/26. The competency testing included a step to check the resident's care plan or Kardex before transferring a resident to determine the type of equipment to be used and the amount of staff assistance required. The nurses assessed each resident to determine the level of assistance required during transfers, and slings were assigned based on the resident's weight. Administrator A and DON B expected the nursing staff to follow the residents' care plans to safely transfer them using the specified sling and lift. DON B acknowledged it was her responsibility to ensure the staff followed the care plans. Administrator A said the charge nurses were also responsible for supervising the CNAs, who should "keep their peers in check and come to us with questions." They acknowledged that resident 26's care plan accurately reflected the assistance she required at the time of her fall and stated it was unacceptable for former contracted travel CNA P to have transferred resident 26 without the assistance of another staff member, and to use the wrong type of sling. Administrator A and DON B continued auditing resident transfers through the end of July and were pleased to see the staff adhering to transfer instructions specified in the residents' care plans. All 40 nursing staff members completed SRHP training and competency testing, except seven staff members scheduled as-needed (PRN), who would receive the training when they returned to work. "We	F0689		

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F0689 SS = D	Continued from page 28 didn't implement any system changes as a result of the audits, because all the transfers were done correctly according to the resident's care plan," administrator A stated. 7. Review of the provider's 7/7/25 Safe Resident Handling Program (SRHP) policy indicated that a total body lift required two staff members and should be used for residents who cannot sit upright on the side of the bed, do not have weight-bearing ability on at least one leg, and cannot pull themselves to a standing position requiring full weight-bearing support. The policy indicated that the nursing staff should follow the resident's care plan or Kardex to determine the type of mobility device, type and size of sling, and number of staff to safely transfer or position the resident. 8. The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 8/6/26 after record review revealed the facility had followed their quality assurance process, education was provided to all nursing staff regarding mechanical lift policy and fall policy, mechanical lift competencies were completed for all caregiver staff, and audits were being completed and would be ongoing. Interviews with the nursing staff indicated they understood the education provided regarding those topics. Observations of mechanical lift transfers in the residents' rooms were conducted and confirmed the staff understood how to use mechanical lifts and transfer residents safely. The provider's audits would be reviewed at their August 2026 Quality Assurance and Performance Improvement (QAPI) meeting and would continue to be a part of their QAPI process for further review to advise the staff as needed. 9. Based on the above information, non-compliance at F689 occurred on 6/13/26, and based on the provider's 6/14/26 implemented corrective actions for the deficient practice confirmed on 8/6/26, the non-compliance is considered past non-compliance.	F0689		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The	F0755	On 7/7/26, narcotic count for resident 14 was reviewed by DNS and RN I to ensure count was accurate and correlated with the administration record. On 7/7/26, DNS provided education on policies and procedures related to the documentation of controlled medication supply counts to RN I.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435074	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0755 SS = D	Continued from page 29 facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure the staff completed and documented controlled (medications with risk for abuse and addiction) medication supply counts by one of one registered nurse (RN) (I) who signed the controlled medication count book as completed before she completed the medication count with another nurse, and that a resident's narcotic (a broad term for habit-forming or illegal drugs that are strictly controlled) pregabalin (a narcotic medication that specifically treats nerve pain) medication was signed out of the controlled drug count book when it was administered to one of one sampled resident (14). Findings include: 1. Interview and controlled count book review on 8/5/26 at 1:26 p.m. with RN I revealed that she had signed for the 6:30 p.m. controlled medication counts in the controlled drug count book on 8/5/26 before counting the controlled medications. She confirmed that by signing the controlled drug count	F0755	All residents with an ordered narcotic medication have the potential to be impacted by the same deficient practice. On 8/10/26, DNS or designee reviewed all resident narcotic medication records to ensure count is recorded, accurate and signed off on. If any narcotic count is not accurate, a full facility investigation will be conducted. Clinical Lead Development Specialist or designee will educate all LPNs, RNs, Nurse leaders and the DNS on policies and procedures for distributing and documenting controlled medications. Education completed for all LPNs, RNs and nurse leaders will be completed by 9/4/2026. All LPNs, RNs, or nurse leaders who do not complete education by 9/4/2026 will be educated by clinical lead development specialist or designee prior to their next scheduled shift. DNS or Designee will audit 10 resident narcotic counts, including resident 14, to confirm the physical card count matches the narcotic book along with verifying that the nurses sign the narcotic book during every shift change or staff change. Audits will be completed weekly x4, every other week x2 and monthly x2 by DNS or designee to ensure compliance. DNS or designee will report audit findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring. Substantial compliance will be achieved on 9/11/2026.	9/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435074	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0755 SS = D	Continued from page 30 book, her signature indicated she had completed the count, and it was accurate. RN I stated that she was not aware of any missing medications. 2. Review of resident 14's electronic medical record (EMR) revealed that on 7/6/26 there was a nurse's progress note that indicated that at evening shift change, two nurses counted the resident's controlled medications, and found that resident 14 was missing a pregabalin from her a.m. medication bubble pack card. The nurse had signed the medication as administered in resident 14's medication administration record (MAR) but did not verify that the number of medication capsules in the bubble pack card matched the number of pregabalin capsules in the medication count book. The nurse indicated in the progress note that she was unable to verify the count of pregabalin, before administration, or if she had given resident 14 two capsules of the medication in error. Resident 14's vital signs were not taken as the error was "caught several hours later." 3. Interview on 8/6/26 at 9:15 a.m. with director of nursing (DON) B regarding resident 14's missing pregabalin revealed DON B stated she was aware of the incident but did not that the medication was missing. She confirmed the nurse should have verified the medication count on the resident's medication bubble pack card when she signed the medication as administered in the resident's MAR and on the controlled drug count sheet. 4. Interview on 8/6/26 at 9:24 a.m. with DON B regarding controlled medication counts revealed she expected the count to be done at every change of shift, by the oncoming nurse and the off-going nurse. After the count was completed and found to be accurate, she expected the staff members to sign the form in the controlled medication count book. She stated it was not acceptable for the controlled medication count book to be signed before the count was completed. 5. Review of the provider's 6/30/26 Medications: Controlled policy revealed, "The location will along with their consultant pharmacist will establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation that determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled and meets all state and federal requirements for controlled medications." "Each time the keys that secure controlled	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435074	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2026

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

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F0755 SS = D	Continued from page 31 medications change from one nurse/medication aide to another, the oncoming and off-going nurse/medication aide will work together to reconcile all controlled medications, including all discontinued controlled medications and document the same." "If the physical count is NOT in agreement with the [Corporately used form] or Controlled Substance Bound Book the error must be found or an incident report must be completed prior to the end of the shift and reported to the director of nursing services before any staff administering medications for the shift leave the building."	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435074	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/04/2026

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

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E0000	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 on 8/4/26. Good Samaritan Society De Smet was found in compliance.	E0000		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	9/4/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435074	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 08/04/2026

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

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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 8/4/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Good Samaritan Society De Smet was found in compliance.	K0000		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	9/4/2026

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10614	A. BUILDING: _____ B. WING _____	08/06/2026

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

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/4/26 through 8/6/26. Good Samaritan Society De Smet was found in compliance.	S 000		

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

TITLE: Administrator

(X6) DATE: 9/4/2026