STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435098	A. BUILDING B. WING	08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY TYNDALL	2304 LAUREL STREET , TYNDALL, South Dakota, 57066

(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 complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/26/26 through 8/27/26. The area surveyed was control and accountability of medications. Good Samaritan Society Tyndall was found to have past noncompliance at F755.	F0000		
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 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	F0755	"Past Noncompliance - no plan of correction required"	

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

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F0755 SS = D	Continued from page 1 maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), observation, interview, and record review, the provider failed to ensure the staff prepared and administered medications according to professional standards of practice for two of two residents (1 and 2) when licensed practical nurse (LPN) (C) prepared both residents' medications at the same time, mistakenly gave resident 1 the wrong medication, and tried to place resident 2's medication back into the wrong medication bubble pack using a piece of tape. LPN C did not inform the nursing home leadership team, the resident's representatives, or the resident's primary care providers about the medication error. This citation is considered past non-compliance based on review of the corrective actions the provider implemented immediately following the incident. Findings include: 1. Review of the provider's 7/30/26 submitted SD DOH FRI report revealed that on 7/30/26, certified nursing assistant (CNA)/certified medication aide (CMA) G was preparing to administer resident 2's PRN (as needed) hydrocodone medication, a controlled narcotic medication that controls pain and is potentially addicting. CNA/CMA G noticed that the pill in the #9 slot of the medication bubble pack looked different from the others and notified registered nurse (RN) B and LPN E at that time. The provider immediately secured the medication cart, counted all controlled medications, and found no other discrepancies. An investigation determined that on 7/26/26, LPN C mistakenly mixed-up medications while preparing medications for two residents at the same time. She accidentally gave resident 2's PRN hydrocodone to resident 1 instead of resident 1's scheduled tramadol (a synthetic opioid pain reliever), and then placed resident 1's tramadol into resident 2's hydrocodone bubble pack. Resident 1 experienced no adverse effects from receiving resident 2's hydrocodone. LPN C, along with all staff licensed to administer medications, was counseled and educated on safe medication practices, including preparing medications for one resident at a time, verifying medications with the resident's medication administration record (MAR), and never returning	F0755		

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F0755 SS = D	Continued from page 2 medications to bubble packs once they were removed. Additional training and competencies were completed on medication destruction procedures. A facility-wide audit showed no further issues. Follow-up monitoring included weekly medication pass observations for four weeks, then monthly for two months, plus ongoing controlled substance audits. The provider planned on reviewing the results of their audits through their Quality Assurance and Performance Improvement (QAPI) committee. 2. Observation on 8/26/26 from 9:03 a.m. to 11:04 a.m. of LPN E, RN F, and LPN H during medication administration revealed no concerns related to the control and accountability of controlled medications. There were no discrepancies noted. Interviews with those nurses at the time of the observations revealed that LPNs E and H were aware of the incident and confirmed they received retraining and competencies regarding medication administration. RN F was a new employee and that day was her third shift at the facility. She confirmed she received orientation and training on the provider's policies and procedures, including medication administration, and their process for tracking controlled medications. 3. Interview on 8/26/26 at 3:13 p.m. with administrator A revealed that education coordinator I provided the staff with the education and checked the staff's competencies related to medication administration, control and accountability of drugs, and medication destruction. At the beginning of their investigation, they did not know who taped the wrong medication back into resident 2's medication card. They interviewed all their nurses and medication aides, and LPN C confirmed what happened. Administrator A confirmed that resident 1's representative and their primary care provider were notified of the medication error. 4. Review of LPN C's employee file revealed she was hired at the facility on 3/17/25. She completed the annual medication administration retraining on 7/24/26. On 8/4/26, she received formal re-education and competency training on medication administration. 5. Review of the provider's investigation file from the above incident revealed that the issue was identified on 7/30/26. On 8/1/26 and 8/4/26, licensed nurses and medication aides were re-educated on "Managing Interruptions and	F0755		

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F0755 SS = D	Continued from page 3 Distractions During Medication Administration," "Medication Bubble Pack Reminders," and "Narcotic Reminder[s]." The provider initiated audits during medication administration starting on 8/6/26. Audits were completed on 8/6/26, 8/13/26, and 8/23/26. Areas reviewed included, "Did [the] nurse perform medication rights during medication administration? Yes/No;" "Was hand hygiene performed during medication administration? Yes/No;" and "Was narcotic count correct during audit? Yes/No." There were no discrepancies found during their audits. 6. The provider's implemented actions to mitigate the likelihood of the deficient practice from reoccurring were verified from 8/26/26 through 8/27/26 after record review, and interview with administrator A revealed that the facility had followed its QAPI process regarding medication administration. They monitored and documented the staff's performance during medication administration and verified that the narcotic count was correct. In addition, three of three licensed nurses (LPNs E and H, and RN F) were observed during medication administration on 8/26/26 and no issues were identified. LPN C was counseled and reeducated on the provider's medication administration policies and procedures on 8/4/26. All licensed nurses and medication aides were educated from 8/1/26 to 8/4/26. Audits to ensure sustained compliance were initiated on 8/6/26 and were ongoing at the time of the survey. Based on the above information, noncompliance at F755 occurred on 7/26/26, and based on the provider's corrective action plans that were initiated on 7/30/26 and implemented for the deficient practice confirmed on 8/27/26, the noncompliance is considered past noncompliance. Shalla Pete	F0755	9/2/2026	