STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **435124**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **02/20/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society Miller	**421 EAST 4TH ST , MILLER, South Dakota, 57362**

(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 2/17/26 through 2/20/26. Good Samaritan Society Miller was found not in compliance with the following requirements: F605, F637, F655, F657, F658, F686, F695, 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 2/17/26 through 2/20/26. The area surveyed was nursing services related to documentation of residents' vital signs, residents not receiving COVID-19 vaccinations, and appropriate action related to resident concerns. Good Samaritan Society Miller was found in compliance.	F0000		
F0605 SS = D	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: §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	F0605	1. Resident #4s medication regimen was immediately reviewed by the attending physician and consultant pharmacist. A gradual dose reduction (GDR) was reviewed and declined by primary physician. The physician documented the clinical rationale regarding continuation or modification of the medications and whether a GDR was clinically contraindicated. The residents are plan was updated to reflect the current medication management plan and monitoring parameters. An audit of all residents currently receiving psychotropic medications was completed by the Director of Nursing and consultant pharmacist to ensure: a. Documentation of GDR attempts when required b. Documentation when GDR is clinically contraindicated c. Any identified concerns were communicated to physician. 2. Education was provided to nursing leadership, licensed nurses, and interdisciplinary team members by Director of nursing/designee by 3/24/26 or prior to next working shift regarding: a. Psychotropic medication regulations b. Requirements for gradual dose reduction. c. Documentation requirements for physician rationale when GDR is contraindicated Continued on to next page	03/24/26

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
Petar Mirkovic	Administrator	03/27/26

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F0605 SS = D	Continued from page 1 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 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	F0605	A standardized process was implemented requiring the Director of Nursing to review the consultant pharmacists monthly medication review reports to ensure all GDR recommendations are communicated to providers and addressed. Once the providers have reviewed the recommendations and addressed them, the facility will ensure the consultant pharmacist completes a review. 3. The administrator or designee will conduct monthly audits for three months of four residents receiving psychotropic medications to verify: a. GDR attempts are documented as required b. Physician documentation exists when GDR is contraindicated c. Consultant pharmacist recommendations are addressed The administrator or designee assigned to the above audits will bring the results to the QAPI program and additional corrective action will be taken if concerns are identified. The facility is expecting to achieve 100% compliance for the 3 months of audits.	

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F0605 SS = D	Continued from page 2 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 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 provider failed to ensure one of two sampled resident (4) who received an antipsychotic medications (a drug that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions) and a psychotropic medication (drugs that affect brain activities associated with mental processes and behavior) had an attempted gradual dose reduction (systemic dose reduction over time to determine if the condition could be managed with a lower dose or discontinuation of the medication) (GDR) or a physician's documented rationale to support that a GDR was clinically contraindicated (not appropriate based on the resident's condition, potential risks, or	F0605		

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

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F0605 SS = D	Continued from page 3 adverse effects) for the use of those medications. Findings include: 1. Review of resident 4's electronic medical records (EMR) revealed: *He was admitted on 12/21/23. *His diagnoses included dementia (a group of symptoms affecting memory, thinking, and social abilities) with psychotic disturbance (a state of losing touch with reality) and residual schizophrenia (a chronic mental disorder that affects how a person thinks, feels, and behaves, causing a distorted sense of reality). *A 12/21/23 physician's order to be given two 50 milligram (mg) tablets of thioridazine hydrochloride (an antipsychotic) by mouth daily for schizophrenia and one 50 mg tablet of trazodone hydrochloride (an antidepressant) by mouth daily for insomnia (inability to sleep). *His 2/19/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) had a focus area that indicated "The resident uses psychopharmacological medications [the use of medications to treat mental health disorders by altering brain chemistry] R/T [related to] schizophrenia, and insomnia. Takes antipsychotic and anti-depressant medication" with an intervention to "Consult with pharmacy, health care provider, etc. to consider dosage reduction when clinically appropriate." *Resident 4's consultant pharmacist recommendations from 12/30/23 through 1/29/26 did not include a GDR for resident 4's trazodone or thioridazine or documentation that a GDR reduction was clinically contraindicated by resident 4's physician since his admission to the facility. 2. Interview on 2/20/26 at 8:52 a.m. with consultant pharmacist R revealed: *She reviewed all of the residents progress notes, labs, and medications monthly. *She spoke with staff to determine if there were any areas of concern related to medication use for that resident. *If she had any recommendations based on her record review and interviews with staff, she would document	F0605		

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F0605 SS = D	Continued from page 4 that in her consultant pharmacist progress note. *She stated the physicians were receptive to her recommendations and replied promptly to them. *She stated director of nursing (DON B) asked her about resident 4's GDR recommendation and she was unable to find that she had made that recommendation in his EMR. *The notes she made during her monthly medication review (MMR) stated in April 2025 that resident 4 needed to have a GDR recommended but she could not find where that recommendation was made and addressed by his physician. *If a resident was due for a GDR recommendation she would document that in her consultant pharmacist note for staff to address it with the resident's physician. 3. Interview on 2/20/26 at 12:53 p.m. with DON B revealed: *Each month, consultant pharmacist R completed an MMR, for each resident. *During those MMRs, consultant pharmacist R reviewed when each resident was due for a GDR recommendation and documented that recommendation in her progress note. *DON B would then print consultant pharmacist R's progress note and give it to that resident's physician to document why or why not a GDR was clinically contraindicated. *DON B stated GDRs were to be recommended by the consultant pharmacist and addressed by the resident's physician quarterly for the first year after the resident's admission to the facility or after the medication was started, and annually after that. *She stated she was unable to find documentation that a GDR had been recommended for resident 4 or documentation from resident 4's physician that indicated a GDR was clinically contraindicated. 4. Review of the provider's 12/9/25 Psychotropic Medications policy revealed: *Definition Graudal Dose Reduction "The stepwise tapering of a dose to determine whether symptoms, conditions or risks can be managed by a lower dose or whether the dose or medication can be discontinued." *"Based on a comprehensive assessment of a resident,	F0605		

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F0605 SS = D	Continued from page 5 the location must ensure that:" -"Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs." *"The reduction committee will review the need for psychotropic medications at least every three months and document the rationale for continuing the medication." *"The purpose of tapering medication is to find an optimal dose or to determine if continued use of the medication benefits the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolved and/or non-pharmacological interventions have been effective in reducing the symptoms." -"Within the first year a resident is admitted on an antipsychotic medication or after the location has initiated an antipsychotic medication, the location must attempt a gradual dose reduction (GDR) in two separate quarters with at least one month between attempts, unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated." -"The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the location and the physician has documented the clinical rationale for why any additional attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder."	F0605		
F0637 SS = D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan,	F0637	1.Resident #3s significant change MDS related to hospice admission was completed.The residents care plan was reviewed and updated to reflect current goals of care and hospice services. An audit of residents admitted to hospice within the last 60 days was conducted by the Director of Nursing and MDS coordinator to ensure that significant change MDS assessments were completed within required regulatory time frames. Any missing or delayed assessments were immediately addressed. 2. Education was provided by administrator/designee to nursing leadership and interdisciplinary team members regarding requirements for completing a significant change MDS within 14 days when a resident experiences a significant change, including hospice admission. Continued to next page	03/24/26

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F0637 SS = D	Continued from page 6 or both.) This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review the provider failed to ensure one of four sampled resident (3) who was recently admitted to hospice (specialized care for individuals with a terminal illness that focuses on comfort and quality of life rather than curative treatments) services had a significant change 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) completed within 14 days after the resident admitted to hospice. Findings include: 1. Review of resident 3's electronic medical record (EMR) revealed: *He was admitted to the facility on 5/23/22. *He had a 10/15/25 physician's order for "Hospice referral and admit if appropriate". *He was admitted to hospice services on 10/20/25. *His significant change MDS assessment was completed on 11/21/25, 32 days after he was admitted to hospice. 2. Interview on 2/20/26 at 12:53 p.m. with administrator A revealed: *He expected the MDS coordinator to initiate significant change assessments. *The clinical team would discuss a resident who may qualify for a significant change MDS assessment during their daily meetings. *He was aware that a significant change MDS assessment needed to be completed when a resident was admitted to hospice, but he did not know how soon it needed to be completed after the resident's admission to hospice services. *He acknowledged that resident 3's significant change MDS assessment was not completed within 14 days after he admitted to hospice. *The provider's MDS coordinator was from the provider's corporate office and was not at the facility.	F0637	A standard process was implemented requiring the MDS coordinator and Director of Nursing to review hospice admissions during daily clinical meetings to ensure timely initiation and completion of the significant change MDS. 3. The Director of Nursing or designee will audit all residents admitted to hospice monthly for 3 months to ensure the significant change MDS is completed within required time frames. The Director of Nursing or designee assigned to the audits above will bring the results to QAPI meetings to be reviewed and corrective action will be implemented as needed.	

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F0637 SS = D	Continued from page 7 *He felt resident 3's significant change MDS assessment had was missed during the transition from having an on-site MDS coordinator to an off-site corporate MDS coordinator. 3. Review of the provider's 11/12/25 Hospice Provided Services policy revealed "review of documentation for residents receiving Hospice Service…A significant change MDS was completed when the resident enrolled in a hospice program". m".	F0637		
F0655 SS = E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission.	F0655	1. Residents #2, #5, #19, and #24 had their baseline care plans reviewed with the resident and/or resident representative. Copies of the baseline care plans were provided and documentation was completed in the medical record. An audit of residents admitted within the last 30 days was completed to verify that baseline care plans were reviewed with residents or representatives and copies were offered within 48 hours of admission. Any missing documentation was corrected. 2. Education was provided to interdisciplinary team members by the administrator regarding baseline care plan requirements including: a.Completion within 48 hours of admission b.Review with resident and/or representative c.Offering a written copy If the facility were to receive an admit after hours or on a weekend, the admit will be reviewed at next scheduled daily stand up meeting. The Director of nursing/designee is responsible for ensuring the baseline care plan process is followed during regular and after business hours. 3. The administrator or designee will audit all new admissions weekly for 3 months to ensure baseline care plans are reviewed and copies offered within 48 hours. The administrator or designee assigned to the audits above will bring the findings to the QAPI program and corrective action will be implemented if needed.	03/24/26

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F0655 SS = E	Continued from page 8 (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure the resident's baseline care plan (personalized plan that addresses a resident's care needs, goals, and interventions) was reviewed with, and a copy was provided to the resident and the resident's representative according to the provider's policy within 48 hours of the resident's admission to the facility for four of five newly admitted sampled residents (2, 5, 19, and 24). Findings include: 1. Review of resident 19's electronic medical record (EMR) revealed: *She admitted to the facility on 1/9/25 and the development of her baseline care plan was initiated. *Her baseline care plan was reviewed with her on 1/13/25, four days after she admitted to the facility. *There was no documentation that a copy of resident 19's baseline care plan was provided to her and her representative. 2. Review of resident 2's EMR revealed: *He admitted to the facility on 10/16/25, and the development of his baseline care plan was initiated.	F0655		

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F0655 SS = E	Continued from page 9 *His baseline care plan was not reviewed and acknowledged by resident 2 or his representative until his 11/5/25 care conference meeting, 20 days after he was admitted to the facility. 3. Review of resident 5's EMR revealed: *He admitted to the facility on 12/16/25. *His baseline care plan was initiated on 12/17/25. *His baseline care plan was emailed to his representative on 12/31/25, 15 days after he admitted to the facility. *There was no documentation that resident 5 BCP was provided a copy of his baseline care plan. 4. Interview on 2/17/26 at 4:00 p.m. with resident 24 revealed: *She admitted to the facility about a month ago. *She did not remember anyone talking to her about her personal care needs or her individual goals when she admitted to the facility. *She did not remember being offered a copy of her baseline care plan when she admitted to the facility. 5. Review of resident 24's EMR revealed: *She admitted to the facility on 1/20/26. *Her 1/26/26 Brief Interview for Mental Status (BIMS) assessment score was 10, which indicated she had moderate cognitive impairment. *Her baseline care plan was initiated on 1/21/26. *Her baseline care plan was provided to her representatives on 1/27/26, seven days after she admitted to the facility. *There was no documentation that resident 24 was provided a copy of her baseline care plan. 6. Interview and review of the residents' baseline care plans on 2/20/26 at 12:53 p.m. with administrator A and director of nursing (DON) B revealed: *The nurse who admitted the resident would initiate the resident's baseline care plan.	F0655		

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F0655 SS = E	Continued from page 10 *The admitting nurse or the interdisciplinary team (nursing, activities, social services, and dietary staff) was responsible for editing the resident's baseline care plan to reflect that resident's individual care needs and goals. *DON B stated the baseline care plan was to be completed within 48 hours of the resident's admission to the facility. *Neither administrator A or DON B were aware that the resident's baseline care plan was required to be reviewed with, and a copy offered to the resident or the resident's representative within 48 hours of admission to the facility. *They acknowledged the baseline care plans for residents 2,5,19, and 24 were not reviewed with, and a copy offered to the resident or resident's representative within 48 hours of admission to the facility. 7. Review of the provider's 12/1/25 Care Plan policy revealed: *"Baseline care plan – Includes instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care." *"Person-centered care – A focus on the resident as the locus of control and supporting the resident in making his or her own choices and having control over their daily life." *"A baseline care plan will be developed upon admission according to federal and state regulations. The location must provide the resident and resident representative with a written summary of the baseline care plan."	F0655		
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	F0657	1.Residents #2 and #16 had their care plans reviewed and updated to reflect individualized needs, including weight monitoring and behavioral interventions related to bathing. The Director of nursing completed an audit of current resident care plans to ensure care plans reflect individualized needs and current interventions. This was completed by 3/2426. Continued to next page	03/24/26

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Good Samaritan Society Miller	**421 EAST 4TH ST , MILLER, South Dakota, 57362**

(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
F0657 SS = D	Continued from page 11 includes but is not limited to-- (A) The attending physician. (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, record review, interview, and policy review, the provider failed to ensure the care plan (personalized plan that addresses a resident's care needs, goals, and interventions) was reviewed and revised to reflect the current care needs for two of seventeen sampled residents (2 and 16). Findings include: 1. Interview on 2/20/26 at 9:25 a.m. with certified nursing assistant (CNA) H regarding residents' care needs revealed she would reference the residents' care plans or Kardex (a report of the resident's care needs and interventions) to know how to care for each resident. 2. Review of resident 2's electronic medical record (EMR) revealed: *His admission date was 10/16/25. *His 12/9/25 Brief Interview of Mental Status assessment score was a 7, which indicated his cognition was severely impaired.	F0657	Any care plans identified as incomplete or not individualized were updated by the interdisciplinary team. 2. Education by the administrator/designee was provided to the interdisciplinary team members regarding: a. Development of individualized care plans b. Updating care plans when resident conditions change During the daily stand up meetings or clinical meetings the team will review residents and update care plans at time of meetings. The IDT is responsible for updating applicable care plans after daily meeting. 3. The interdisciplinary team will conduct monthly audits of 5 resident care plans for 3 months to ensure they are individualized and reflect current care needs. All members of the IDT have access to edit care plans. The interdisciplinary team will bring the results of the audits above to the QAPI committee and additional corrective action will be taken if concerns are identified.	

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F0657 SS = D	Continued from page 12 *His diagnoses included: dementia (a group of symptoms affecting memory, thinking, and social abilities), fracture of the right hip, insomnia, and heart failure. *His weight record included the following weights: *On 10/16/25, his weight was 147.0 lbs. *On 11/6/25, his weight was 157.0 lbs. *On 12/11/25, his weight was 149.0 lbs. *On 1/8/26, his weight was 169.0 lbs. *On 1/26/26, his weight was 151.5 lbs. *On 2/6/26, his weight was 139.5 lbs. 3. Review of resident 2's care plan revealed: *A 1/26/25 focus area that indicated "The resident has unplanned/unexpected weight loss R/T [related to] (SPECIFY) E/B [evidenced by] (SPECIFY)." -The goal for that focus area was the "Resident will maintain weight between (SPECIFY: ____ and ____ lbs. [pounds]) by review date." -The intervention for that focus area was "Weigh (SPECIFY FREQ. [frequency])." 4. Interview on 2/20/26 at 2:00 p.m. with director of nursing (DON) B and interim DON C regarding residents' care plans revealed: *When a resident had weight loss, it was to be addressed on that resident's care plan. She expected care plan prompts such as "SPECIFY" to be replaced with the resident's individualized status and needs. She acknowledged that resident 2's care plan regarding his weight loss was not individualized. *DON B stated she did not feel resident 2's weight loss was a true weight loss. She indicated he had edema (excess fluid) and took a diuretic to reduce fluid build-up, which would cause fluctuations in his weight. 5. Review of resident 16's EMR revealed: *She was admitted on 10/3/23.	F0657		

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F0657 SS = D	Continued from page 13 *Her 12/22/25 BIMS score was a 2, which indicated her cognition was severely impaired. *Her diagnoses included: anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), and chronic pain. *She had a physician's order for Haldol (brain-calming medicine that improves thinking, mood, and behavior and calms severe agitation) to be given before her bath. 6. Interview on 2/20/26 at 9:33 a.m. with CNA H regarding resident 16 revealed: *Resident 16 does not like her baths, and she received "medicine" to help her stay calm. -Resident 16 required two staff members to assist her with bathing, one to wash her and the other to keep her calm. -She was to receive a bath on Mondays and Thursdays and the medicine "unless she is having a good day." 7. Review of resident 16's care plan revealed bathing interventions that included "BATHING: Resident requires assist [assistance] of 1-2 [one to two] staff with bathing. Prefers 1 w/p [whirlpool] bath a week. No preference to time of day." -There was no indication on the care plan that resident 16 had behaviors with her bathing activity. 8. Interview on 2/20/26 at 10:43 with registered nurse (RN) K, regarding developing and updating a residents' care plan, revealed that she thought DON B completed a residents' admission and then developed the residents' care plan. 9. Interview on 2/20/26 at 1:53 p.m. with DON B and interim DON C regarding residents' care plans revealed: *Each department was to develop and edit the residents' care plan based on their assigned areas. *The Minimum Data Set (MDS) nurse would make changes to	F0657		

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

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F0657 SS = D	Continued from page 14 the resident's care plan after completing the MDS assessments (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs), and as the residents' care needs changed, and quarterly. -The MDS nurse worked remotely. -All of the nurses had access to update the residents' care plans, as the residents' care needs changed, and quarterly. *DON B expected resident 16's care plan to include interventions for her behaviors that occurred with bathing. 10. Review of the provider's 12/1/25 Care Plan policy revealed: *"Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. Any problems, needs and concerns identified will be addressed through use of departmental assessments, the Resident Assessment Instrument (RAI) and review of the physician's orders." *"This plan of care will be modified to reflect the care currently required/provided for the resident." *"The care plan will emphasize the care and development of the whole person ensuring that the resident will receive appropriate care and services. It will address the relationship of items or services required and facility responsibility for providing these services." *"The interdisciplinary team will review care plans at least quarterly. Care plans also will be reviewed, evaluated and updated when there is a significant change in the resident's condition."	F0657		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F0658	1. Resident #4's supra pubic catheter documentation was reviewed and updated. A physician order for catheter care was clarified and entered correctly into the electronic medical record. Nursing staff were instructed on appropriate catheter care and documentation requirements. Resident #16's physician order for Haldol no longer needs to be corrected due to the physician order being discontinued. Continued to next page	03/2426

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F0658 SS = D	Continued from page 15 (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the staff members followed professional standards of care for: *The assessment, care, and accurate documentation regarding one of one sampled resident (4) with a newly placed suprapubic catheter (flexible tubing surgically placed in the bladder through the abdominal wall to drain urine). *Accurately entering physician's orders into the electronic medical record to ensure one of one sampled resident's (16) Haldol (medication for reducing symptoms of mental health conditions) was transcribed and administered as ordered. Findings include: 1. Observation and interview on 2/18/26 at 3:21 p.m. with resident 4 in his room revealed he: *Had a suprapubic catheter. *Did not know how long he had the suprapubic catheter but stated it had not been "too long". 2. Review of resident 4's EMR revealed: *He was admitted on 12/21/23. *His 12/22/25 Brief Interview for Mental Status (BIMS) assessment score was 12, which indicated his cognition was moderately impaired. *He had a 3/6/25 physician's order for an "indwelling foley catheter [flexible tubing placed in the bladder to drain urine] to straight drainage. 18 FR [French: a standardized sizing system for urinary catheters] Coude tip [a specialized catheter with a curved tip]". *There was a 12/12/25 physician's order to "Keep appointment with Urology on 12/16/25. They are to further discuss with Dr. [redacted name] possible placement of a suprapubic catheter." *His treatment administration record (TAR) had a 1/18/26 nursing order to, "Cleanse supra pubic [suprapubic] catheter site with soap and water. Apply slit sponge [a gauze dressing with a cut through half	F0658	An audit of residents with indwelling or supra pubic catheters was conducted to verify: a. Physician orders were present b. Treatments were documented appropriately c. Care was provided according to standards 2. The Director of Nursing/designee provided education to licensed nurses by compliance date or prior to next working shift regarding: •Accurate transcription of physician orders •Documentation of treatments in the TAR •Assessment and documentation when residents return from outside procedures. The Director of Nursing/designee will also complete ongoing competency validation for nurses to ensure the correct process is followed as listed above. This will be done quarterly and 2 nurses selected at random. 3. The Director of Nursing or designee will conduct weekly audits of 2 residents for 3 months to ensure physician order transcription and treatment documentation. The Director of Nursing, or designee assigned to the audits above, will bring the findings to QAPI meetings to be reviewed.	

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F0658 SS = D	Continued from page 16 of the gauze] and tape daily". The TAR indicated that was to be documented as completed daily at bedtime. -That treatment was not documented as completed on his TAR from 1/18/26 through 1/31/26 from 2/1/26 through 2/9/26, on 2/11/26, and on 2/12/26. *There was no documentation that resident 4 had a suprapubic catheter inserted and when that occurred. 3. Interview and record review regarding resident 4's suprapubic catheter on 2/20/26 at 8:02 a.m. with director of nursing (DON) B revealed: *On 2/18/26 she requested documentation related to resident 4's suprapubic catheter from the hospital where it was surgically placed. *On 2/20/26 administrator A received resident 4's history and physical examination documentation and a procedure note from the hospital regarding his suprapubic catheter placement. -That procedure note indicated resident 4 had his suprapubic catheter surgically placed on 1/15/26. -It did not include any instructions related to the care of the suprapubic catheter site or follow-up after the procedure. *DON B verified there were no discharge instructions provided by the hospital, as she requested on 2/18/26. 4. Interview and record review regarding resident 4's TAR on 2/20/26 at 10:28 a.m. with registered nurse (RN) K revealed: *Resident 4's suprapubic catheter site was scheduled on his TAR to be cleaned and a gauze sponge applied to that site daily at bedtime. *She looked at his suprapubic catheter site that morning (2/20/26), after resident 4's bath, and felt the site looked "normal" for a newly inserted suprapubic catheter. *She expected the nurse who completed a treatment on a resident would document that treatment as completed in the resident's TAR. -If there was no documentation that the treatment had been completed in the resident's TAR, she would assume that the treatment had not been completed.	F0658		

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F0658 SS = D	Continued from page 17 5. Interview and record review regarding resident 4 on 2/20/26 at 12:53 p.m. with DON B and administrator A revealed: *Administrator A and DON B did not know what was used as the provider's reference for professional standards. *DON B expected that when a resident left the facility for an appointment or procedure and returned to the facility, a progress note would be entered into that resident's EMR. *DON B acknowledged that there was no documentation in his EMR that indicated resident 4 left the facility to have a suprapubic catheter surgically placed or when he returned to the facility. *DON B acknowledged that there was no documentation that resident 4 and his newly placed suprapubic catheter were assessed when he returned from the surgical procedure. *DON B expected the staff would have assessed resident 4 and his suprapubic catheter insertion site upon his return to the facility and documented their findings. *DON B acknowledged that there were no discharge instructions provided to the facility on how to care for resident 4's newly placed suprapubic catheter when he returned to the facility. *DON B stated the nurse should have called the medical facility where resident 4's suprapubic catheter placed and requested discharge instructions. *DON B acknowledged the treatment order to clean and apply a gauze sponge to resident 4's suprapubic site was entered on 1/18/26, three days after his suprapubic catheter placement. *DON B acknowledged there was no documentation that the cleaning and gauze sponge treatment was completed until 2/10/26, 23 days after the suprapubic catheter placement. *DON B stated the treatment order was not entered into resident 4's EMR correctly so it did not show up on the TAR as a treatment to be completed by the nurse. *DON B stated the nurses told her they had been cleaning the site and applying the gauze sponge around resident 4's suprapubic catheter but there was no documentation to support that.	F0658		

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F0658 SS = D	Continued from page 18 *DON B expected the nurse who identified that the treatment order was not on resident 4's TAR to have corrected the entry error to ensure accurate documentation of completion. *DON B acknowledged that not cleaning and dressing a new suprapubic catheter insertion site could increase the resident's risk of infection. 6. Review of the provider's 4/6/25 Catheter: Care, Insertion and Removal policy revealed: *"It is important to keep the dressing dry and cleanse the suprapubic skin insertions site using clean technique every day and as necessary." 7. Review of the provider's 4/6/25 Physician/Practitioner Orders policy revealed: *"Order must be obtained for wound care including products to be used, when to change and when to reassess." *"Nursing orders are not crested as physician/practitioner orders. Nursing orders must be documented as care plan approaches." Based on record review, interview, and policy review, the provider failed to ensure: *One of one sampled resident's (16) physician order for scheduled Haldol was entered into the resident's electronic medical record (EMR) as ordered. 8. Review of resident 16's electronic medical record (EMR) revealed: *She was admitted on 10/3/23. *Her medication administration record (MAR) included a 10/7/25 physician order for "Haloperidol [an antipsychotic medication that alters neurotransmitter activity to reduce symptoms of mental health conditions] Oral Tablet 1 MG (Haloperidol) Give 1 tablet by mouth as needed for prn [as needed] 1 hour prior to bath". *The 10/7/25 original physician order stated "Give Haldol [haloperidol] 1 mg 1 hr [hour] prior to shower scheduled".	F0658		

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F0658 SS = D	Continued from page 19 9. Interview on 2/20/26 at 1:49 p.m. with DON B and interim DON C regarding resident 16's physician order for Haldol revealed: *DON B acknowledged the 10/7/25 written physician's order for Haldol was to be "scheduled" to be administered one hour before resident 16 received a bath. -She acknowledged the 10/7/25 written physician's order for Haldol was entered into resident 16's EMR as a PRN (as needed) order and that resident 16 had not received the medication as ordered, as she had not received it before each bath, as the order had been entered as a PRN order. *DON B expected the physician's orders entered into a resident's MAR to be verified by two nurses, to ensure they are accurate and followed as ordered, and this order had been. -She was unable to determine how that transcription error had occurred. 10. Review of the provider's 4/6/25 Physician/Practitioner Orders policy revealed: *"Physician/Practitioner orders are a critical component to providing quality care to residents. Accurate processing of physician/practitioner orders is important. The nursing services and health information management (HIM) departments each have responsibilities for processing physician/practitioner orders in a timely and accurate manner." *"Orders are processed and transcribed into [electronic medical records system] – Clinical – Orders immediately upon receipt of an order. All orders must be noted by the licensed nurse who has processed the order." -"Prescriber Entered Orders must be confirmed by a licensed nurse."	F0658		
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F0686	1. Resident #5's pressure ulcer was healed prior to annual survey conducted, facility unable to retro-actively correct noncompliance. The residents care plan was updated to reflect prevention of future pressure ulcer injuries. An audit of residents at risk for pressure ulcers was conducted to ensure: •Braden assessments were completed •Prevention interventions were implemented •Care plans reflect individualized pressure injury prevention measures Any deficiencies identified were corrected. Continued to next page..	03/24/26

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F0686 SS = G	Continued from page 20 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to monitor and implement pressure ulcer (skin and/or underlying tissue injury due to prolonged pressure) healing and prevention interventions for one of one sampled resident (5) identified at risk for developing pressure ulcers and developed a stage II (2; open wound or blister with partial-thickness skin loss) pressure ulcer to his coccyx (tailbone). Findings include: 1. Observation and interview on 2/17/26 at 3:53 p.m. with resident 5 in his room revealed: *He had a cushion in his wheelchair and an air mattress (a specialized mattress filled with air used for pressure reduction) on his bed. *He did not know why he had the air mattress or cushion in his wheelchair. *He did not know if he had a skin wound. 2. Review of resident 5's electronic medical record (EMR) revealed: *He was admitted to the facility on 12/16/25. *His 12/22/25 Brief Interview for Mental Status (BIMS) assessment score was 8, which indicated he had moderate cognitive impairment. *His diagnoses included stage II pressure ulcer of sacral region (bone directly above the tailbone), diabetes (a condition involving disruptions in how the body regulates blood sugar), weakness, and dementia (a group of symptoms affecting memory, thinking, and social abilities).	F0686	2. The Director of Nursing/designee provided education to licensed nurses by 3/24/26 or prior to next working shift regarding: •Pressure ulcer prevention •Implementation of pressure reduction interventions •Documentation of skin assessments In the education above the following topics were covered: •Appropriate pressure-reducing interventions are available, implemented as directed, and appropriately maintained. -The DON is notified of changes in a resident's wound (ie: it has become larger). -The MDS nurse is triggering daily skin assmts and also triggering appropriate POC tasks such as barrier cream application. -The physician is notified r/t changes in wound size and the need for changes in the PU tx plan and that nurse documentation reflects this information. -Accurate and consistent wound care measurements are occurring. Staff were reminded to update care plans when pressure injuries are identified. 3. The Director of Nursing or designee will conduct weekly skin and pressure prevention audits for two residents at risk for or with a current skin or pressure injury for three months The individual topics referred to in the previous two paragraphs will compose the framework of the audit tool. The Director of Nursing or designee assigned to the audits above will bring the Results to be reviewed during QAPI meetings to ensure ongoing compliance.	

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F0686 SS = G	Continued from page 21 *Resident 5's 12/16/25 Braden Scale for Predicting Pressure Sore Risk (a tool used to assess the risk of developing pressure ulcers) assessment score was 16, which indicated he had a mild risk for the development of a pressure ulcer. -The interventions recommended for mild risk were, "Frequent Turning (e.g., q [every] 2 hours), Maximal Remobilization, Pressure-Reduction Support Surfaces if Bed- or Chair-Bound, Protect Heels, Manage Moisture, Manage Nutrition, Manage Friction and Shear*If other major risk factors are present (advanced age, poor dietary intake of protein, diastolic pressure below 60, hemodynamic instability), advance to next level of risk." *His 2/18/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) had a focus area that indicated "The resident has potential impairment to skin integrity" initiated on 12/17/26 with interventions of "High risk for skin injury – use caution during transfers and bed mobility" and "Keep skin clean and dry. Apply protective barrier cream to peri/rectal [skin between the anus and genitals] area following incontinent [involuntary urine or bowel leakage] episodes and prn [as needed]". *His 2/18/26 care plan had a focus area that indicated "The resident has hx [history] of Stage 2 pressure ulcer" that was initiated on 12/23/26 and revised on 2/18/26 with interventions that indicated "Educate resident/family as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning", "Inform resident/family of any new are of skin breakdown", and "Notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care." -It did not include his wheelchair cushion or an air mattress. *His 12/22/25 wound assessment documentation indicated that resident 5 had a stage II pressure ulcer to his coccyx that measured 1 cm (centimeter) in length by 0.5 cm in width by 0 cm in depth. The evaluation of the ulcer was documented as a "Pink open area. First layer of skin gone." -Resident 5's physician was notified.	F0686		

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F0686 SS = G	Continued from page 22 --There was no documentation on the wound assessment that indicated when resident 5's physician was notified. -The wound was cleansed and a Duoderm dressing was applied. *His 12/23/25 wound assessment documentation indicated resident 5's pressure ulcer on his coccyx measured 1 cm by 0.5 cm by 0.1 cm. *Resident 5's 12/24/25 Braden Scale for Predicting Pressure Sore Risk (a tool used to assess the risk of developing pressure ulcers) assessment score was 17, which indicated he had a mild risk for the development of a pressure ulcer. -12/24/25 was after the stage II pressure ulcer had been identified on resident 5's coccyx on 12/22/25. *Hia 12/26/25 wound assessment documentation indicated resident 5's pressure ulcer on his coccyx measured 2.2 cm by 2 cm by 0 cm. -There was no documentation that resident 5's physician was notified of the increased wound size or if the treatments or interventions changed. *His 12/27/25 wound assessment documentation indicated resident 5's pressure ulcer on his coccyx measured 2 cm by 1.5 cm by 0.1 cm. *His 12/30/25 wound assessment documentation indicated resident 5's pressure ulcer on his coccyx measured 0.5 cm by 0.5 cm by 0.1 cm. *His 1/05/26 wound assessment documentation indicated resident 5's pressure ulcer on his coccyx measured 2.5 cm by 1.5 cm by 0.1 cm. -There was no documentation that resident 5's physician was notified of the increased wound size or if the treatments or interventions changed. *His 1/12/26 wound assessment documentation indicated resident 5's pressure ulcer on his coccyx measured 0.5 cm by 0.5 cm by 0.1 cm. *His 1/15/26 wound assessment documentation indicated resident 5's pressure ulcer on his coccyx measured 0.7 cm by 0.4 cm. -There was no documentation of the depth of the pressure ulcer.	F0686		

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F0686 SS = G	Continued from page 23 *His 1/16/26 wound assessment documentation indicated resident 5's pressure ulcer on his coccyx measured 0.5 cm by 0.2 cm by 0.2 cm and was documented has having improved as evidence by the wound measurements were "smaller". *His 1/17/26 wound assessment documentation indicated resident 5's pressure ulcer on his coccyx measured 0.5 cm by 0.5 cm by 0.1 cm. *The 1/24/26 wound assessment documented resident 5's pressure ulcer on his coccyx measured 0.5 cm by 0.5 cm by 0.7 cm. -There was no documentation that resident 5's physician was notified of the increased wound depth or that the treatments or interventions had changed. *On 1/30/26 resident 5's pressure ulcer on his coccyx was documented as healed. 3. Interview on 2/19/26 at 10:32 a.m. with certified nursing assistant (CNA) H revealed: *She did not know when the cushion was placed in resident 5's wheelchair. *She stated that his wheelchair cushion was missing, but it was replaced about two weeks ago. -CNA H did not know how long it was missing. 4. Interview on 2/19/26 at 12:28 with administrator A revealed: *He stated the Minimum Data Set (MDS) nurse had entered barrier cream to be applied following incontinent episodes in resident 4's care plan on 12/17/25 but did not trigger the task in the point of care (POC), a portion of a resident's EMR that includes the types and frequency of care needed, there was no documentation to support that the CNAs had applied barrier cream to resident 5 after his incontinent episodes. *The MDS nurse had not triggered the daily skin inspection task in resident 5's POC so there was no documentation that the CNAs completed daily skin inspections. *There was no documentation to support that resident 5's physician was notified that his pressure ulcer had increased in size.	F0686		

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F0686 SS = G	Continued from page 24 *There was no documentation when the cushion was placed in resident 5's wheelchair. 5. Interview on 2/20/26 at 9:20 a.m. with CNA/unlicensed assistive personnel (UAP) I revealed: *She was aware resident 5 previously had a pressure ulcer on his coccyx. *She stated that prior to him developing the pressure ulcer, the staff helped him transfer between his bed and wheelchair to offload the pressure on his buttocks. *She stated he was able to reposition himself in his wheelchair. *She stated if barrier cream was being applied on resident 5 it would have been documented in his POC tasks in his EMR. *She did not know when the cushion was placed in his wheelchair. 6. Interview on 2/20/26 at 10:28 a.m. with registered nurse (RN) K revealed she would expect a resident's physician to be notified if the size of the resident's pressure ulcer increased from the previous assessment. 7. Interview on 2/20/26 at 12:53 with director of nursing (DON) B revealed: *The provider did not have a designated wound nurse. *All licensed nursing staff were responsible for completing the resdients' wound documentation and treatments. *She expected every resident to have a skin assessment completed upon admission to the facility by a licensed nurse. *If a resident was incontinent barrier cream was to be added to the CNA POC tasks in the resident's EMR. *DON B stated the barrier cream task and the daily skin check task were not added into resident 5's POC tasks when he was admitted. She stated she added it to the CNAs POC tasks on 2/20/26. *She acknowledged there was no documentation to support when resident 5's cushion was placed in his wheelchair. *She stated the air mattress was put on resident 5's bed after he had developed the pressure ulcer on his	F0686		

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F0686 SS = G	Continued from page 25 coccyx. *She acknowledged resident 1's air mattress, wheelchair cushion, and repositioning that were indicated as interventions for his pressure ulcer on the wound assessments were not on his care plan. *She expected the physician to be notified when a pressure ulcer was identified, if there was no improvement in the pressure ulcer from week to week, and if the pressure ulcer worsened in size or characteristics to determine if there needed to be a change in the treatment of the resident's pressure ulcer. *DON B acknowledged that resident 5's physician had not been notified when his pressure ulcer increased in size and there was no change in treatment to the pressure ulcer. *She was not aware that the size of resident 5's pressure ulcer had increased in size between his weekly skin assessments. *She acknowledged that ensuring the barrier cream was applied after his incontinent episodes, the CNAs were made aware through his care plan to assist resident 5 with repositioning, and the cushion was placed in his wheelchair upon his admission to the facility could have potentially prevented resident 5 from developing the pressure ulcer. 8. Review of the provider's 2/17/25 Pressure Ulcers policy revealed "Based on the resident's comprehensive assessment, the location will use prevention and assessment interventions to assure that a resident entering the location without pressure ulcers does not develop a pressure ulcer unless the individual's clinical condition demonstrates that this was unavoidable." 9. Review of the provider's 12/8/25 Skin Assessment Pressure Ulcer Prevention and Documentation policy revealed: *"Any resident at risk [for developing a pressure ulcer] will be placed on a pressure redistribution surface as determined appropriate." *"When a pressure ulcer is present, complete the Wound Data Collection UDA [user defined assessment] daily, documentation should include the following: -An evaluation of the ulcer, if no dressing is	F0686		

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F0686 SS = G	Continued from page 26 present... -The presence of possible complications, such as signs of increasing area of ulceration or soft tissue infection". *"If the pressure ulcer is not determined to be clinically unavoidable, the ulcer should show signs of improvement within two to four weeks. Signs of improvement might include decrease in size of the wound (length times width), decrease in the amount of exudate [drainage] and improvement in the tissue type". *"Observations of the ulcer's characteristics may be documented by a licensed nurse and should include at least the following: -Measurements - length, width, depth -Characteristics of the ulcer – including wound bed, undermining, and tunneling, exudate, surrounding skin, etc. -Presence of pain -Current treatments".	F0686		
F0695 SS = E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to ensure the staff followed professional standards of practice related to respiratory care for: *Cleaning and storing nebulizer equipment (a device used when using a nebulizer machine that converts liquid medication into an inhalable mist) for three of three sampled residents (13, 19, and 28) who used nebulizer machines.	F0695	1. The residents identified during the survey had their respiratory care reviewed by the Director of Nursing. The resident's treatment orders were reviewed and updated to ensure respiratory interventions, monitoring, and documentation accurately reflect the resident's current clinical needs. An audit was conducted of all residents receiving respiratory services including oxygen therapy, and respiratory treatments to ensure: •Physician orders were present and current •Care plans reflected respiratory care needs •Documentation accurately reflected treatments and monitoring Any identified concerns were addressed immediately. 2. Education was provided to licensed nursing staff by 3/24/26 or prior to next working shift regarding: •Professional standards for respiratory care •Documentation of respiratory treatments and monitoring •Ensuring physician orders are followed and accurately documented The professional standards of care cover the topics of cleaning, storage and maintenance of respiratory equipment. The Director of Nursing/designee will complete ongoing competency validation to ensure professional standards of care are followed for respiratory care. Continue to next page.	03/24/26

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F0695 SS = E	Continued from page 27 *Cleaning the Continuous Positive Airway Pressure (CPAP) machine (a device that uses air pressure to keep breathing airways open) for one of one sampled resident (13) who used a CPAP machine. *Cleaning and storing oxygen equipment for four of four sampled residents (13, 19, 28, and 29) who used oxygen. Findings included: 1. Observation on 2/17/26 at 12:38 p.m. of resident 29's room revealed: *She had an oxygen concentrator (a device that filters room air into purified oxygen) beside her bed. *Her nasal cannula (flexible tubing with prongs that delivers oxygen through the nose) was draped over that concentrator. *That nasal cannula was not dated with the date it had been replaced. *The oxygen concentrator filters and the covers that hold the filters in place were missing on both sides of the concentrator. Observation on 2/18/26 at 3:17 p.m. of resident 29's room revealed: *Resident 29 was lying in her bed. *She was wearing an undated nasal cannula that was attached to the concentrator beside her bed. *There was an undated nasal cannula hanging on the handle of her wheelchair that was attached to a portable oxygen tank. Review of resident 29's electronic medical record (EMR) revealed: *She admitted to the facility on 9/7/23. *Her 1/22/26 Brief Interview for Mental Status (BIMS) assessment score was 7, which indicated she had severe cognitive impairment. *She had a 12/29/25 physician's order for "Oxygen at 3 LPM [liters per minute] continuously per nasal cannula". *There was no order for her nasal cannula to be replaced and dated, which would indicate to the nursing	F0695	3. The Director of Nursing or designee will conduct weekly audits for 3x residents receiving respiratory treatments for 3 months to verify: •Physician orders are followed •Treatments are documented •Care plans reflect respiratory needs •Proper cleaning, storage and maintenance conducted of each respiratory device. Audit results will be reviewed through the facility QAPI program to ensure substantial compliance.	

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F0695 SS = E	Continued from page 28 staff when to change the nasal cannula. *There was no documentation that supported when her nasal cannula was replaced in her EMR. 2. Observation and interview on 2/17/26 at 1:52 p.m. with resident 13 in his room revealed: *Resident 13 was sitting in his wheelchair and independently wheeling himself to his door. *Resident 13 had an oxygen concentrator beside his bed. *Resident 13's CPAP and nebulizer machines were stored on top of his three-drawer wood dresser beside his bed. *A black mesh bag was taped to the top drawer of the wood dresser, dated "1/26". *His oxygen tubing, CPAP hose, and mask attached to the concentrator machine were dated 12/1/25. -The CPAP mask was stored in the black mesh bag. *His nebulizer mask was dated 2/9/26. *The nebulizer mask and tubing were stored in the black mesh bag. Observation on 2/18/2026 at 4:57 p.m. in resident 13's room revealed: *His CPAP mask, dated 12/1/25, was hanging over the top drawer of the wood dresser next to his bed. *Resident 13's CPAP mask and connection hose were secured with clear medical tape at their connection point and the tape was wrapped down the hose approximately six inches. -The tape was coming loose in areas and was visibly soiled with small fibers, debris, and dust that adhered to its "sticky" side. -The non-sticky side of the tape was discolored and light brown in color. *The filter on his concentrator machine contained dust fibers and lint. *Resident 13's assembled nebulizer mask was lying on his bed with clear liquid in the medicine chamber of the nebulizer mask.	F0695		

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

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F0695 SS = E	Continued from page 29 Review of resident 13's EMR revealed: *He admitted to the facility on 7/2/25. *His 12/23/25 BIMS assessment score was 11, which indicated he had moderate cognitive impairment. *Resident 13 had a 7/2/25 physician's order to "Change O2 [oxygen] and neb mask weekly on Monday one time a day." *Resident 13 had a 7/2/25 physician's order to "Clean CPAP every morning one time a day." *There was no order for his nebulizer mask to be cleaned daily. *There was no order for his concentrator filter to be cleaned or replaced. *There was no documentation of the nebulizer mask being cleaned in his EMR. *There was no documentation of the concentrator filter being cleaned or replaced in his EMR. Observation and interview on 2/18/26 at 5:21 p.m. with director of nursing (DON) B in resident 13's room revealed: *She stated, "It does not appear that his c-pap mask is getting removed and cleaned daily." *She acknowledged that clear medical tape had been used to secure the hose and mask together and that the tape was visibly soiled. *She acknowledged that resident 13's oxygen tubing and CPAP mask had a date of 12/1/25, had no staff initials written on it, and was not stored in the black mesh bag. *She acknowledged that resident 13's concentrator filter was visibly soiled with dust fibers and lint. *She acknowledged that resident 13's CPAP mask was hanging over the top drawer of the wood dresser and contained a clear liquid in the cup of the nebulizer mask. *She acknowledged that the staff had not cleaned the nebulizer mask after his scheduled nebulizer treatment at 4:00 p.m. and that the nebulizer mask was not stored in the black mesh bag.	F0695		

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F0695 SS = E	Continued from page 30 3. Observation on 2/17/26 at 1:53 p.m. of resident 19's room revealed: *Resident 19 was lying in her bed. *She was wearing a nasal cannula attached to an oxygen concentrator beside her bed. *There was a nebulizer machine on her bedside table with an assembled nebulizer mask lying on top of the machine. *There were drops of clear liquid in the cup of the nebulizer mask. Observation on 2/17/26 at 2:37 p.m. of resident 19's room revealed an undated nasal cannula lying on the floor beside resident 19's bed. Observation on 2/18/26 at 3:22 p.m. of resident 19's room revealed an undated nasal cannula hanging on the side rail of her bed. Observation and interview on 2/20/26 at 9:15 a.m. with resident 19 in her room revealed: *Her nasal cannula and nebulizer mask were stored in a black bag attached to her bedside table. *Resident 19 stated she did not have a bag to store her nasal cannula in until yesterday (2/19/26). Review of resident 19's EMR revealed: *She admitted to the facility on 1/9/25. *Her 12/29/25 BIMS assessment score was 13, which indicated her cognition was intact. *She had a 1/9/25 physician's order to "Change label date oxygen tubing and neb tubing weekly every evening shift every Mon [Monday]". 4. Observation on 2/17/26 at 1:58 p.m. of resident 28's room revealed: *Resident 28 had a nebulizer machine with an assembled nebulizer mouthpiece and tubing lying on his bedside table. *His nebulizer tubing was not dated, and the mouthpiece was dated 1/3/26.	F0695		

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F0695 SS = E	Continued from page 31 *The nebulizer machine was visibly dusty. Observation and interview on 2/18/26 at 10:32 a.m. in resident 28's room revealed: *Resident 28 was sitting on the edge of his bed. *The nebulizer machine with the same assembled nebulizer tubing and mouthpiece remained on his bedside table. *Resident 28 did not know how often the nebulizer tubing and mouthpiece should be replaced. *Resident 28 said he did not use the nebulizer with the mouthpiece for a few weeks and only used it when needed. *Resident 28 said he did not have a storage bag for the nebulizer tubing and mouthpiece to store it in when it was not in use. Review of resident 28's EMR revealed: *He admitted to the facility on 11/6/25. *His 12/20/25 BIMS assessment score was 15, which indicated his cognition was intact. *Resident 28 had a 12/30/25 physician's order to administer "Albuterol Sulfate Inhalation Nebulization Solution - one inhalation orally every four hours as needed for cough/congestion." *There was no order for his nebulizer tubing and mouthpiece to be cleaned or replaced. *There was no documentation of the replacement of his nebulizer tubing and mouthpiece in his EMR. Interview on 2/18/26 at 5:13 p.m. with DON B in resident 28's room revealed: *She stated that resident 28's nebulizer tubing and mouthpiece were packaged together as one unit. *She said that the nebulizer tubing and mouthpiece unit was supposed to have one date and staff initials written on it when it was replaced. *She acknowledged that resident 28's nebulizer tubing and mouthpiece unit was dated 1/3/26 and had no staff initials written on it.	F0695		

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F0695 SS = E	Continued from page 32 *She acknowledged that resident 28's nebulizer machine was visibly dusty, and his nebulizer tubing and mouthpiece unit were not stored in a storage bag. 5. Interview on 2/19/26 at 10:29 a.m. with certified nursing assistant (CNA) H revealed: *Resident 29 required staff assistance to put on, remove, and store her nasal cannulas. *Nasal cannulas that were not being used were to be stored in a bag in the resident's room. *Resident 19 was able to apply, remove, and store her nasal cannula and nebulizer equipment independently. *CNA H acknowledged that resident 19 would not be able to store her nasal cannula or nebulizer equipment in a bag if there was not a bag provided for her in her room. 6. Interview on 2/19/26 at 2:17 p.m. with CNA/UAP I revealed: *She said UAP's were responsible for cleaning the resident's nebulizer mask after each use. *She stated that the mask or mouthpiece was to be rinsed with water and then placed on a clean paper towel to air dry after each use. *She said nebulizer tubing and masks were to be replaced every week on Mondays and dated. 7. Interview on 2/20/26 at 9:20 a.m. with CNA/unlicensed assistive personnel (UAP) I revealed: *The UAPs were responsible for replacing the residents' nasal cannulas and nebulizer masks weekly on Mondays. *After replacing the nasal cannulas and nebulizer masks she would document those replacements on the resident's TAR. *If the replacement of the resident's nasal cannulas and nebulizer masks were not on the TAR she would replace them but the replacement would not be documented. *She stated the staff know who received oxygen and nebulizer treatments, so they knew who had nasal cannulas and nebulizer masks that needed to be replaced weekly even if it was not on a resident's TAR.	F0695		

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F0695 SS = E	Continued from page 33 8. Interview on 2/20/26 at 12:53 p.m. with DON B revealed: *The CPAP masks and tubing were to be washed out daily and replaced according to the manufacturer's instructions. *Nasal cannulas and nebulizer masks were to be replaced weekly. *The replacement of the nasal cannulas and nebulizer masks was to be documented in that resident's MAR or TAR. *When the residents' nasal cannulas and nebulizer masks were not in use they were to be stored in the black bags in the resident's room. *DON B acknowledged that nasal cannulas were at risk of being contaminated when they were hung on wheelchairs, oxygen concentrators, or bed rails. *Oxygen concentrator filters were to be cleaned at least monthly and placed back on the concentrator. 9. Review of the provider's 7/30/25 Oxygen Administration policy revealed: *"All oxygen therapy equipment will be clean, safe and functional." *"When oxygen is not in use, store cannula, face mask or face tent and tubing in zip-lock bag/plastic bag secured to the oxygen cylinder or concentrator." *"Disposable equipment should be changed weekly or according to manufacturer's instructions and marked with date and initials." *"Change filters between resident uses". *"Clean filters according to manufacturer's instructions". 10. Review of the 2022 DeVilbiss 5-Liter Oxygen Concentrator Instruction Guide revealed: *"A mask or any nasal cannula can be used with continuous flow delivery and may be sized according to our prescription as recommended by your homecare provider who should also give you advice on the proper usage, maintenance and cleaning." *"Individual maintenance requirements may vary based	F0695		

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F0695 SS = E	Continued from page 34 upon local operating conditions, regulations, or other circumstances." *"Clean and replace the cannula/mask, tubing, and humidifier bottle according to the manufacturer's instructions." *"Check to be sure the cabinet air filter (if applicable) and the intake filter are in place." *"Inspect the vents periodically, and wipe with a dry cloth as needed to remove dust." *"Cleaning:" -"Outer Cabinet – 7 days -Water, use only a damp cloth." -"Filter Door Vents – 7 days – Wipe with dry cloth, or a cloth dampened with water to remove dust." 11. Review of the provider's 12/10/25 Nebulizer policy revealed: *"Following medication administration clean nebulizer after each use: … 4. Separate the nebulizer parts (mask/mouthpiece, cup) and wash in warm soapy water and rinse thoroughly… 6. Place mask or mouthpiece and cup on a paper towel and air-dry until the next use. Cover with clean cloth or towel." 12. Review of the undated Power Neb Ultra Compressor Nebulizer Instruction Guide revealed: *"Clean After Every Use:" -"Disassemble mouthpiece or mask from cap." -"Wash all items, except tubing, in a hot water/dishwashing detergent solution. Rinse under hot tap water for 30 seconds to remove detergent residue. Allow to air dry." *"Disinfect Daily:" -"Using a clean container or bowl, soak items in three parts hot water to one part white vinegar for 30 minutes OR use a medical bacterial-germicidal disinfectant available through your provider. Be sure to follow manufacturer's instructions carefully."	F0695		

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F0695 SS = E	Continued from page 35 -"With clean hands, remove items from disinfectant solution, rinse under hot tap water, and air dry on a clean paper towel. Store in a zip-lock bag." *"Do not towel dry nebulizer parts; this could cause contamination." 13. Review of the undated ResMed AirCurve 10 CPAP User Guide revealed: *"You should clean the device weekly as described." *"Wash the water tub and air tubing in warm water using only mild detergent." *"Rinse the water tub and air tubing thoroughly and allow to dry out of direct sunlight and/or heat." *"Wipe the exterior of the device with a dry cloth." *"Check the air tubing and replace it if there are any holes, tears or cracks." *"Check the air filter and replace it at least every six months. Replace it more often if there are any holes or blockages by dirt or dust." -"The air filter is not washable or reusable." *"Clean the mask daily by soaking the cushion and frame in warm, soapy water (mild detergent) for 5-10 minutes, then rinse thoroughly and air dry out of direct sunlight." *Hand wash the headgear and any soft sleeves in warm, soapy water, then air dry weekly." *"Clean the air tubing in warm soapy water, rinse thoroughly, and hang to dry weekly." *"Check the air tubing and mask for cracks, tears, or hardening components weekly and replace as needed."	F0695		
F0755 SS = E	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	F0755	1. The controlled medication records for residents identified during the survey were reviewed immediately by the Director of Nursing. Missing narcotic count signatures and documentation discrepancies were investigated and corrected as appropriate. The director of nursing/designee completed an audit of 1x resident each wing controlled medication records to ensure: •Narcotic counts are completed at each shift change •Signatures are present for both staff completing the count Any discrepancies were investigated and corrected. Continued to next page.	03/24/26

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F0755 SS = E	Continued from page 36 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 observation, interview, record review, and policy review, the provider failed to maintain a system to account for all controlled (medications with risk for abuse, addiction, and potential theft) medications for one of two observed medication carts and for one of one treatment cart in the East hall, and to document medications related to their receipt, counts, administration details, and destruction process. Findings include: 1. Review of the February 2026 Controlled Drugs Count Record on the treatment cart revealed: *There were three headings labeled 7-3 Shift, 3-11 Shift, and 11-7 Shift. *Below heading were columns labeled Nurse Off, Nurse On, and Card or prescription count. *The controlled drug count was signed off by one nurse as the on-coming nurse under the 7-3 heading and the	F0755	2. The Director of Nursing/Designee provided education to licensed nurses/medication aides by 3/24/26 or prior to next working shift regarding: •Controlled medication storage and security •Completion of narcotic counts at each shift change including signatures •The reporting process for a missing narcotic If a discrepancy is found the following investigation process will be conducted: Recount of narcotics, cross check MAR/TARS, review waste documentation. The Director of Nursing will interview nurses on duty and any staff that have had contact with the narcotic medication. 3. The Director of Nursing or designee will conduct audit of narcotic count sheets weekly x3 months to verify: -Narcotic counts are completed each shift -Documentation is accurate -Discrepancies are investigated immediately The Director of Nursing or designee will conduct audit of 3x random resident MARS weekly x3 months to verify: -The medication was given -The documentation is correct -Any missing documentation is investigated by the DNS and reported as a med error if needed. Audit results will be reviewed through the facility QAPI program to ensure substantial compliance.	

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F0755 SS = E	Continued from page 37 off-going nurse under the 11-7 heading on 2/1/26, 2/2/26, 2/4/26, 2/6/26, 2/10/26, 2/11/26, and 2/14/26. *The controlled drug count was not completed the entire day on 2/3/26, 2/12/26, 2/13/26, 2/18/26, and 2/19/26. *The controlled drug count was signed off by one nurse as the 7-3 on-coming nurse and the 3-11 off-going nurse on 2/5/26 with no documentation under the 11-7 heading. *On 2/7/26 the controlled drug count was signed off by one nurse as the on-coming nurse under the 7-3 heading and no other signatures were documented that day. 2. Review of resident 3's Individual Resident Narcotic Record forms from 12/21/25 through 2/19/26 revealed: *From 12/21/25 to 1/18/26 there were three pages labeled as resident 3's alprazolam (a medication used to treat anxiety) Individual Resident's Narcotic Records, one labeled a.m., one labeled noon, and one labeled 8:00 p.m. These forms did not have documented on them the medication form, the method of administration, the medication dosage, the prescription number, or the pharmacy name. -There were no times documented when the alprazolam was removed from locked storage to be administered to resident 3 for any of the dates on the a.m. or noon record. -There was no time documented when the alprazolam was removed from locked storage to be administered to resident 3 on 12/22/25 on the 8:00 p.m. record. -On 12/28/26 there was no documentation of an alprazolam having been removed from locked storage to be administered at 8:00 p.m. *From 1/19/25-2/15/26 there were three pages labeled as resident 3's alprazolam Individual Resident's Narcotic Records, one labeled a.m., one labeled noon, and one labeled p.m. These forms did not have documented on them the medication form, the method of administration, the medication dosage, or the pharmacy name. -There were no times documented when the alprazolam was removed from locked storage to be administered to resident 3 for any of the dates on the a.m. or noon record from 1/19/26 to 2/11/26. - On 1/25/26 and 2/6/26 there was no documentation of an alprazolam having been removed from locked storage	F0755		

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F0755 SS = E	Continued from page 38 to be administered at 8:00 p.m. -On 1/28/26 an alprazolam was documented as having been removed at 7:45 a.m. The a.m. and noon alprazolam Individual Resident's Narcotic Records did not have times documented when the medication was removed from the locked storage for administration to determine if the 8:00 p.m. alprazolam had been removed from the a.m. or noon medication card. -On 1/31/26 on the p.m. alprazolam Individual Resident's Narcotic Record, it was documented that there were 17 remaining. --The next entry was dated 2/2/26 and it was documented that there were 18 on hand, one was administered, and the remaining was documented as 16. --The next entry is dated 2/1/26, there was no number in the amount on hand column, one was administered, and it was documented there were 15 remaining. -On the bottom of Resident 3's p.m. alprazolam Individual Resident's Narcotic Records it was documented that on 2/17/26 three tablets were returned to the retail pharmacy for repackaging. * From 1/19/25-2/15/26 there were three pages labeled as resident 3's alprazolam Individual Resident's Narcotic Records, one labeled a.m., one labeled noon, and one labeled H.S (bedtime). These forms did not have documented on them the medication form, the method of administration, the medication dosage, or the pharmacy name, or resident 3's name or sticker. -There was no time documented when the controlled medication was removed from locked storage to be administered to resident 3 on 2/19/26 on the noon record. 3. Observation and interview on 2/17/26 at 1:09 p.m. with resident 3 in his room revealed: *He had a feeding tube (a tube surgically placed through the abdomen into the stomach to administer liquid nutrition, fluids and medications). *He waved when surveyor entered the room. *He gave a thumbs up when asked how he was doing. *His verbalizations were grunting noises.	F0755		

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F0755 SS = E	Continued from page 39 4. Review of resident 3's electronic medical record (EMR) revealed: *He was admitted on 5/23/22. *His diagnoses included depression, anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), diabetes (a condition involving disruptions in how the body regulates blood sugar), traumatic brain injury without return to pre-existing conscious level (damage to the brain resulting from an external force resulting in permanent impairment in cognitive, physical, and emotional function), and post traumatic seizures. *Review of resident 3's January 2026 and February 2026 medication administration record (MAR) revealed: -DuoNeb Solution (a medication used to open the airways and reduce mucous) four times daily by nebulizer (a device that converts liquid medication into an inhalable mist) for aspiration and was not documented as having been administered on 2/4/26, 2/7/26, and 2/18/26 at 4:00 a.m., 2/4/26, and 2/15/26 at 12:00 p.m., 2/8/26 at 4:0 p.m., and 1/14/26, 1/22/26, 2/7/26, 2/9/26, and 2/12/26 at 8:00 p.m. -Reglan (a medication used to treat heartburn) 10 mg (milligrams) before meals and at bedtime was not documented as having been administered on 2/15/26 at 11:00 a.m., 2/8/26 at 4:00 p.m., and 1/22/26 and 2/9/26 at 9:00 p.m. -Tylenol 1000 mg three times daily for pain was not documented as having been administered on 2/15/26 at 12:00 p.m. and 1/22/26 and 2/9/26 at 8:00 p.m. -Alprazolam 0.25 mg three times daily was not documented as having been administered on 2/15/26 at 12:00 p.m., and 1/22/26, 1/26/26, 2/6/26, and 2/9/26 at 8:00 p.m. --On 1/22/26, 1/26/26, and 2/9/26 resident 3's 8:00 p.m. dose of alprazolam and on 2/15/26 resident 3's 12:00 p.m. dose of alprazolam was documented as having been removed from the locked storage for controlled medication but not documented as having been administered on resident 3's MAR. --On 1/25/26 at 8:00 p.m. resident 3's alprazolam was documented as having been administered on his MAR but was not documented as having been removed from the	F0755		

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F0755 SS = E	Continued from page 40 locked storage for controlled medications. --On 2/6/26 at 8:00 p.m. resident 3's alprazolam was not documented as having been removed from the locked storage for controlled medications to be administered and was not documented as having been administered to him in his MAR. -Simethicone (a medication used to treat gas and bloating) 80 mg three times daily was not documented as having been administered on 2/15/26 at 12:00 p.m. and 1/22/29 and 2/9/26 at 8:00 p.m. -Topamax (a medication to treat seizures and headaches) 50 mg two times daily was not documented as having been administered on 1/22/26 and 2/9/26 at 8:00 p.m. -Valproic acid (a medication for seizure prevention) 250 mg/ml (milligrams per milliliter) give 25 ml two times per day was not documented as having been administer on 1/22/26 and 2/9/26 at 8:00 p.m. -Lispro insulin (a fast-acting insulin used to lower blood sugars) sliding scale (the dose depends on the person's blood sugar level) two times daily was not documented as having been administered on 2/4/26, 2/7/26, 2/10/26, and 2/18/26 at 4:00 a.m. and on 1/27/26, 2/8/26, and 2/12/26 at 4:00 p.m. --Resident 1's blood sugar was not documented as having been taken on 1/27/26 at 4:00 p.m., 2/4/26 at 4:00 a.m. or 4:00 p.m., 2/7/26 at 4:00 a.m., 2/8/26 at 4:00 a.m. or 4:00 p.m., 2/10/26 at 4:00 a.m., 2/12/26 at 4:00 p.m., and on 2/18/26 at 4:00 a.m. -Levetiracetam (a medication for seizure prevention) 100 mg/ml give 15 ml two times daily was not documented as having been administered on 1/22/26 and 2/9/26 at 8:00 p.m. -Guaifenesin (a medication for cough and congestion) 200 mg/5ml give 10 ml two times daily was not documented as having been administered on 1/22/26 and 2/9/26 at 8:00 p.m. -Augmentin (an antibiotic) 400-57 mg/ml give 10 ml two times daily for 10 days was not documented as having been administered on 1/28/26 during the "PM" medication pass. -Melatonin (a medication used to aid sleep) 6mg one time daily was not documented as having been administered on 1/22/26 and 2/9/26 at 8:00 p.m.	F0755		

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F0755 SS = E	Continued from page 41 -Mirtazapine (a medication used to treat depression) 20 mg one time daily was not documented as having been administered on 1/22/26 and 2/9/26 at 8:00 p.m. -Basaglar insulin (a long-acting insulin used to lower blood sugars) 20 units one time daily was not documented as having been administered on 1/22/26, 1/26/26, 2/6/26, and 2/9/26 during the "HS [bedtime]" medication pass. -On 1/8/26 at 11:56 a.m. Morphine sulfate (a narcotic used to treat severe pain) 20 mg/ml give 0.25 ml was documented as having been removed from the locked storage for controlled medications but it was not documented as having been administered in resident 3's MAR. 5. Observation and interview on 2/19/26 at 2:33 p.m. with certified nurse aide(CNA)/unlicensed assistive personnel (UAP) I of a binder labeled "Narcotic Binder" on the east medication cart revealed: *CNA/UAP I stated that the residents' controlled medications were sent from the pharmacy in bubble pack medication cards and stored in a locked box in a locked drawer in each medication cart. *She said the nurse and UAPs were to count the residents' controlled medications at each shift change, and both were to sign as complete with no discrepancies on the narcotic inventory records. *The controlled medication count for each medication cart was to be completed at every shift change by the on-coming and off-going nurses and UAPs. *When the nurses and UAPs signed the residents' narcotic inventory records, it would indicate that the controlled medications were counted, and the medication counts were accurate. *The residents' controlled medications were stored in the east medication cart within the locked drawer and in a locked compartment. *She said that if a controlled medication count was off, she was to notify the nurse and the director of nursing (DON) B, and they would investigate what could have happened. *Review of the East medication carts Controlled Drug - Count Record inventory sheet for February 2026 revealed 48 out of 116 missing signatures.	F0755		

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F0755 SS = E	Continued from page 42 *She acknowledged that there were missing signatures on the February 2026 inventory sheet for the East medication cart. 6. Review of the East medication carts Controlled Drug – Count Record inventory sheets for November 2025, December 2025, and January 2026 for the East medication cart revealed: -November 2025 had 17 missing signatures out of 180 opportunities. -December 2025 had 28 missing signatures out of 186 opportunities. -January 2026 had 62 missing signatures out of 186 opportunities. 7. Observation on 2/19/26 at 2:37 p.m. with CNA/UAP I with the count of the controlled medications locked in the East medication cart revealed that resident 1 had: *A bubble pack medication card dated 2/3/26 that had a pharmacy label reading "Pregabalin 150 mg (milligram) capsules, and to take 1 capsule by mouth two times a day. [a.m. and p.m.]." *The Controlled Drug – Count Record inventory sheet identified that the facility received 12 Pregabalin 150 mg capsules from the pharmacy on 2/3/26 that were to be given to him in the mornings. *It was documented on 2/10/26 at 8:32 a.m. that resident 1 received 1 Pregabalin 150 mg capsule, leaving 5 Pregabalin 150 mg capsules remaining. *Resident 1 was transferred to a local hospital on 2/10/26 at 12:54 p.m. and did not receive another dose of that controlled medication as he had not returned to the facility. *It was observed during the controlled medication count that resident 1's a.m. bubble pack medication card, which contained his Pregabalin 150 mg capsules, recorded a remaining count of 4 capsules. *CNA/UAP I acknowledged that resident 1's a.m. bubble pack medication card count for his Pregabalin 150 mg capsules was short by 1 capsule. *CNA/UAP I said she did not know anything about the	F0755		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society Miller	**421 EAST 4TH ST , MILLER, South Dakota, 57362**

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F0755 SS = E	Continued from page 43 discrepancy and would need to report the information to DON B immediately. *CNA/UAP I acknowledged that she and the nurse going off shift counted all the residents' controlled medications in the East cart and said all the counts were accurate that morning. 8. Observation and interview on 2/19/26 at 2:42 p.m. with DON B and CNA/UAP I revealed: *The residents' controlled medications were stored in the east medication cart within the locked drawer and in a locked compartment. *DON B acknowledged that resident 1's a.m. bubble pack medication card count for his Pregabalin 150 mg capsules was short by 1 capsule *DON B and CNA/UAP I searched the East medication cart and surrounding areas for resident 1's missing capsule of Pregabalin and were unable to locate it. *She said the nurse and UAPs were to count the residents' controlled medications at each shift change, and both were to sign off on the narcotic inventory records. *The controlled medication count for each medication cart was completed at every change of shift by the nurses and UAPs. *When the nurses and UAPs signed the residents' narcotic inventory records, it would indicate that the controlled medications had been counted, and the medication count was accurate. *DON B stated that if there was an incorrect count, the nurse or UAP would notify her immediately, and she would investigate. *DON B stated that usually the counts were off due to a nurse or UAP adding and/or subtracting incorrectly after administering a dose. *DON B said she was going to review the camera footage and notify the pharmacist. 9. Interview on 2/19/26 at 3:00 p.m. with DON B revealed: *DON B expected that each nurse and UAP would check	F0755		

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F0755 SS = E	Continued from page 44 their own charting for completion before they left their shifts. *She acknowledged that there were multiple missing signatures on the Controlled Drug – Count Record inventory sheet from November 2025 through February 2026 for the East medication cart, which could indicate that the counts had not been completed. *She acknowledged that with the staff not counting the controlled medications at every change of shift by the on-coming and out-going nurse or UAP could increase the risk of drug diversion, and it would make it difficult to determine when the controlled medication went missing. 10. Interview on 2/19/26 at 3:20 p.m. with administrator A revealed: *He was notified by DON B that they were unable to locate resident 1's missing medication capsule and that he was reporting the incident to the SD DOH as it was a reportable incident per their facility policy. 11. Interview on 2/19/26 at 4:07 p.m. with RN K revealed: *She stated resident 3 had a few medications that were in pill form, that were to be crushed and administer through his feeding tube, but most of his medications were liquid. *The pills were sent out through a scheduled monthly refill and the pills are administered from the bubble pack number that corresponds with the date, so those would be more obvious if a medication was not punched out of the medication card. *RN K stated the liquid medications and insulin would be more difficult to determine if a scheduled medication administration had been missed. *If she identified a medication was not administered, she would fill out a medication error form and notify that resident's provider. Review of the provider's medication error reports from September 2025 through 2/19/26 revealed there were no medication error reports completed for resident 3.	F0755		

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F0755 SS = E	Continued from page 45 12. Phone interview on 2/20/26 at 8:15 a.m. with retail pharmacist S revealed: *He said that he was at the facility monthly and that the pharmacy delivered resident medications on a daily basis with provider orders and provided the scheduled monthly medication bubble pack cards for all the residents. *He said that he contracted a pharmacist to provide the facility with a consultant pharmacist to review resident charts every month and said that they shared responsibilities. *He said they checked the emergency medication kit, medication carts, and medication storage room for expired medications when they were at the facility. *He said that he had not reviewed medication error or incident reports involving missing medications for the provider, but that DON B would notify him of incidents and discrepancies. *He would not be able to determine if resident 3's liquid medications and insulin were being used at an expected rate because those medications are on a routine refill schedule to avoid resident 3 running out of those medications. 13. Interview on 2/20/26 at 9:20 a.m. with CNA/UAP I revealed: *All of resident 3's medications were administered by nurses because they were administered through his feeding tube. *If a resident's medication was not documented as having been administered in that resident's MAR, she would assume that medication had not been administered because the medications should be signed off as administered in the resident's MAR immediately after they were administered to that resident. 14. Interview on 2/20/26 at 9:30 a.m. with DON B revealed: *DON B said that the camera footage confirmed that licensed practical nurse (LPN) T and CNA/UAP I completed the controlled medications count of the East cart the morning of 2/19/26 at 6:30 a.m. *The camera footage confirmed that CNA/UAP I counted	F0755		

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F0755 SS = E	Continued from page 46	F0755		

the medications and LPN T acknowledged the count from the Controlled Drug – Count Record inventory sheets.

*DON B said that she called LPN T during her investigation, and she stated that LPN T did not recall the exact remaining amount of resident 1's Pregabalin medication on the morning of 2/19/26.

*DON B said she educated LPN T and CNA/UAP I on 2/19/26 and that during the count, they both were to look at the medication cards and narcotic inventory sheets together for accuracy and confirmation of correct counts.

*DON B said she did not know when resident 1's medication went missing or what had happened with it.

15. Interview on 2/20/26 at 10:28 a.m. with RN K revealed:

*This was her fifth shift at that facility.

*She had not checked in medications from the pharmacy.

*The controlled medication count was to be completed at every change of shift by the nurses and UAPs.

*The nurse worked 12-hour shifts so the controlled medication count on the treatment cart would be twice daily.

*When the nurses and UAPs signed the Controlled Drugs Count Record it would indicate the controlled medications had been counted and the medication count was accurate.

*If the controlled medication count was not accurate, she would not let any staff member leave and would search for the missing medication.

*She acknowledged that resident 3's alprazolam Individual Resident's Narcotic Record did not have his name on them, and she would not be able to identify whose forms those forms were if they were not on the treatment cart, because he was the only resident whose medications were stored in that cart.

*If a resident's medication was not administered at its designated time the medication would display red on the MAR to alert the nurse or UAP that the medication was not administered or if it was it was not documented.

*If she noticed that there were medications that had

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F0755 SS = E	Continued from page 47 not been documented as administered, she would notify her supervisor. 16. Interview on 2/20/26 at 11:02 a.m. with CNA/UAP L revealed: *She had received medications from the pharmacy delivery person and compared the medication list against the medications that were received from the pharmacy with the pharmacy delivery person. *When a controlled medication was received she would put the resident's name or a resident sticker on a Individual Resident's Narcotic Record and complete the documentation related to the medication such as the name of the medication, dose of the medication, the administration instructions, the prescription number, the amount of the medication that was received, and the date the medication was received. 17. Interview on 2/20/26 at 12:53 p.m. with director of nursing (DON) B revealed: *The pharmacy brings the medications to the facility. *The pharmacy delivery person and the nurse or UAP review the list of medications sent to the facility and compare it to the medications that were received. *If the list and the medications received match the pharmacy delivery person and the nurse or UAP sign that the medications sent were received and each keep a copy of the receipt. *The nurse or the UAP filled out the information related to the medication and the resident on the Individual Resident's Narcotic Record for each controlled medication that was received. *DON B expected the nurse or UAP to complete the medication name, medications strength, medication form, method of administration, medication dosage, the prescription number, the pharmacy name, the date the medication was received, and the amount received, as well as the resident's name or a resident sticker on the Individual Resident's Narcotic Record. *DON B acknowledged there was missing information related to the medication information and resident's name on the Individual Resident's Narcotic Records. *The controlled medications were to be counted by the	F0755		

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F0755 SS = E	Continued from page 48 on-coming and off-going nurse or UAP at every shift change. *After the controlled medications were counted both nurses or UAPs were to sign the Controlled Drugs Count Record, which indicated the controlled medication count had been completed and the count was accurate. *If the count was not accurate the nurse was to notify DON B immediately and search for the missing controlled medication. *She acknowledged there were multiple shifts where the controlled medication count was not documented as having been completed and accurate. *She acknowledged that staff not counting the controlled medications at every change of shift by the on-coming and out-going nurse or UAP could increase the risk of drug diversion, and it would make it difficult to determine when the controlled medication went missing. *She acknowledged there were controlled substances removed from the medication cart, checked out on the Individual Resident's Narcotic Record and not documented as having been administered to the resident. *She acknowledged there were multiple doses of medications that were not documented as having been administered to resident 3. *She had not been aware of the undocumented medications. *She expected the nurses and UAP staff to review each resident's MAR to be sure all the medications for that shift had been administered and documented that they were administered. *She acknowledged that resident 3's sliding scale insulin dose would not be able to determine if his blood sugar had not been checked. *She acknowledged resident 3's medications that had not been documented as having been administered to him, such as his insulin and seizure medications, could significantly affect his physical wellbeing. 18. Review of the provider's revised 7/30/25 Pharmaceutical Services – R/S, LTC policy revealed: *"A licensed pharmacist will be employed to provide	F0755		

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F0755 SS = E	Continued from page 49 consultation on all aspects of pharmacy services." Establish a system of records of receipt and disposition of all controlled medications in sufficient detail to enable accurate reconciliation." *"Determine that medication records are in order and that an account of all controlled medications is maintained and periodically reconciled. Report any irregularities to the attending physician or the director of nursing services or both. (These reports must be acted upon, and follow-up documentation maintained)." 19. Review of the provider's revised 10/20/25 Medication: Missing/Diversion of Medication – R/S, LTC, AL policy revealed: *"Upon discovery of a medication that may be missing or diverted, notify the Director of Nursing/AL Nurse. Document the incident in SAFE Event Reporting application." *"If controlled medication is discovered missing during perpetual count, consider: Recount, Checking addition and subtraction from previous activity, check the outdated medications." *"Nursing employees with access to the medication cart are asked to search the cart, their pockets and surrounding areas for the missing medications." *"An investigation of the situation is performed by the investigation team." *"Notify the administrator, the state survey and certification agency, law enforcement, and other designated agencies in accordance with state law of a medication diversion." 20. Review of the provider's revised 3/4/25 Medications: Acquisition, Receiving, Dispensing, and Storage – R/S, LTC policy revealed: *"It Is preferred that a licensed nurse receive and verify the medications. Once the medications are received, they will be secured in the appropriate storage area (i.e., medication cart or medication room). Licensed nurses and medication aides (when allowed by state law) are responsible for reconciling medications received." *"Disposal will be done in accordance with	F0755		

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

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F0755 SS = E	Continued from page 50 state/pharmacy regulations." *"Controlled drugs (Schedule II) and other drugs subject to possible abuse will be stored in separate, locked, permanently fixed compartments, except when a single unit package drug distribution is used. These drugs will be reconciled daily through an appropriate system of records of receipt and disposition established by the licensed pharmacist."	F0755		
F0761 SS = D	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, and policy review, the provider failed to ensure the medication labels and the resident's medication administration record (MAR) matched during two of two observed medication administrations for two of eleven sampled residents (7 and 29) by certified nurse aides (CNAs)/unlicensed assistive personnel (UAPs) L and I. Findings include:	F0761	1. The identified residents receiving eye drops without appropriate current orders were immediately reviewed. Eye drop orders were either discontinued, modified or clarified based on the clinical order. Documentation was updated to reflect appropriate amount of drops to be given. An audit of residents receiving eye drops was conducted by the DNS/designee. The audit included verification of orders and labels ensuring that they are correct and current. 2. The facility has implemented the following system changes. Nurses and med aides have been instructed to cross check the Mar, label, and order ensuring all three match before administration. Any discrepancies must be brought to nurses' attention to be addressed by the physician. Applicable staff verbalized understanding that any discrepancy must be reported and reconciled before administering a medication. 3. The Director of Nursing or designee will conduct audit on 4x residents on eye drops weekly x 4 weeks, then monthly x2 months to ensure the following: Ensuring labels are current and accurate. The director of nursing or designee will bring the audit results to QAPI meetings to ensure ongoing compliance.	03/24/26

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F0761 SS = D	Continued from page 51 1. Observation and interview on 2/19/26 at 11:00 a.m. with certified nurse aide (CNA)/unlicensed assistive personnel (UAP) L during medication administration revealed: *The medication cart contained resident 7's medications. *The resident's “Blink Tears Solution 0.25%” (polyethylene glycol 400) (a medication to treat dry eye symptoms) eye drop pharmacy label on the medication container read: “Instill 1 drop in both eyes every morning and at bedtime.” *Her February 2026 medication administration record (MAR) read: "Instill 1 drop in both eyes four times a day for macular degeneration.” *CNA/UAP L agreed that resident 7's medication label for that medication did not match the 4/7/22 physician order on her MAR. *She did not know why they did not match and stated that the medication container came from the pharmacy with the label. *She said she was to report the discrepancy to the floor nurse or the director of nursing (DON) B for clarification and notified the floor nurse. *She waited to administer resident 7's eye drops until she had clarification from the nurse. 2. Interview on 2/19/26 at 11:10 a.m. with registered nurse (RN) K revealed: *She acknowledged that the medication label for resident 7's Blink tears solution eye drops did not match the 4/7/22 physician's order on her MAR. *She said she was calling the pharmacy to clarify the physician's order they had recorded for resident 7's Blink tears solution eye drops from the physician. *RN K said that the pharmacy received an order from the physician in February 2025 to change resident 7's Blink tears solution eye drops from four times daily to twice daily. -RN K could not recall the date the physician's order was received by the pharmacy.	F0761		

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F0761 SS = D	Continued from page 52 *She acknowledged that the facility had not received the February 2025 physician order for resident 7. 3. Observation and interview on 2/19/26 at 2:20 p.m. with CNA/UAP I during medication administration revealed: *The medication cart contained resident 29's medications. *The resident's “Genteal Tears Solution Moderate”(a medication to treat dry eye symptoms) eye drop pharmacy label on the medication container read: “Instill 1-2 drops 2-3 times a day into affected eye as directed.” *Her February 2026 MAR read: "Artificial Tears Solution 1.4% (Polyvinyl Alcohol) Instill 1 drop in both eyes three times a day for dry eyes, irritation.” *CNA/UAP I agreed that resident 29's medication label for that medication did not match the 10/23/24 physician order on her MAR. *She did not know why they did not match and stated that the medication container came from the pharmacy with the label. *She said she was to report the discrepancy to DON B for clarification and notified her. *She waited to administer resident 29's eye drops until she had clarification from DON B. 4. Interview on 2/19/26 2:30 p.m. with DON B revealed: *She acknowledged that the medication label for resident 7's Blink tears solution eye drops did not match the 4/7/22 physician's order on her MAR. *DON B said she was calling the pharmacy to clarify the physician's order they had on file for resident 29's Genteal tears solution eye drops from the physician. *DON B stated that resident medication containers or cards requiring a new medication label were to be removed from the medication carts and sent to the pharmacy for new packaging and labeling. *She said the nurse or UAP's working on the floor were responsible for removing any medication containers or cards that needed new labels and notifying the pharmacy promptly to avoid missed medication doses for	F0761		

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F0761 SS = D	Continued from page 53 residents. *She expected the nurses and UAPs to promptly identify discrepancies between the medication label and the physician's order in the MAR when they completed their safety checks with medication administration. *She acknowledged that a discrepancy between pharmacy labels and resident MARs increases the risk of medication errors with UAPs, who may not recognize medications and cannot calculate dosages. *She acknowledged that the pharmacy had received a physician's order on 4/9/25 to substitute resident 29's previous eye drop medication with Genteal Tears eye drop medication. *She acknowledged that the pharmacy had not received a physician's order for resident 29's dose change. 5. Phone interview on 2/20/26 at 8:15 a.m. with retail pharmacist S revealed: *The pharmacy provides daily and monthly medications for the residents. *He said that he or consultant pharmacist R would review and check resident medications in the medication storage room and carts for expiration dates, correct labels, narcotic logs, and perform chart audits monthly. *He said if there was a physician's order change, the resident's medications would be sent back to the pharmacy to be re-packaged with a new pharmacy label. *He stated that he had specialty physicians send new orders to the pharmacy, and those specialty physicians did not forward that new order information on to the resident's primary physician at the facility, which created discrepancies between the pharmacy labels and the resident's MARS. *He stated that the nurses usually caught the discrepancies in a timely manner and called to notify the pharmacy of the updated information. 6. Review of the provider's revised 3/4/25 Medications: Acquisition, Receiving, Dispensing, and Storage-R/S, LTC policy revealed: *"The medication orders/changes are communicated to the	F0761		

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F0761 SS = D	Continued from page 54 pharmacy." *"The order will include the date of the change, the location name, resident's name, medication name, dosage, route, quantity or duration and strength, diagnosis or indication for use and the physician's name." *"All medications (including medication samples or other medications dispensed by the physician) are packaged in accordance with the location dispensing system and state pharmacy rules. These medications must be labeled according to state pharmacy regulations. Cautionary and accessory instructions, as well as the expiration date, will be included. New labels will be applied by the pharmacist or the pharmacist's agent as needed." 7. Review of the provider's revised 4/8/25 Medication: Administration Including Scheduling and Medication Aides- R/S, LTC revealed: *"Because medication aides may only dispense medications, they are not allowed to make a determination if one or two tabs [tablets] are needed; therefore, orders with ranges are not accepted from prescribers. For example: 1-2 tablets every 3-4 hours should not be accepted."*"Perform three checks: Read the label on the medication container and compare with the MAR when removing the container from the supply drawer, when placing the medication in an administration cup/syringe and just before administering the medication."	F0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435124	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society Miller	421 EAST 4TH ST , MILLER, South Dakota, 57362

(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
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 2/18/26. Good Samaritan Society Miller was found not in compliance with the following requirement: E030.	E0000		
E0030 SS = C	Names and Contact Information CFR(s): 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following:	E0030	1. The Emergency Preparedness binder located in the vestibule outside the Administrator's office was immediately updated to include a current staff contact list to ensure required communication information is readily accessible during an emergency. The Administrator verified that the communication plan now contains names and contact information for staff as required by regulation. Because the communication plan applies to the entire facility, this deficiency had the potential to affect all residents in the building. The Administrator reviewed the entire Emergency Preparedness communication plan to ensure all required contact information is present, including staff, physicians, contracted service providers, other facilities, and volunteers as applicable. 2. The facility reviewed its Emergency Preparedness policy to verify that the staff contact list be maintained within the Emergency Preparedness binder and reviewed for accuracy. The Administrator or designee will update the staff contact list whenever staffing changes occur and ensure the most current list remains in the Emergency Preparedness binder. 3. The Administrator or designee will audit the Emergency Preparedness binder quarterly for 2 quarters to ensure the staff contact list remains present and current. The Administrator or designee will bring the results of the audits to the QAPI meeting to ensure continued compliance. .	03/24/26

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
Petar Mirkovic	Administrator	03-19-26

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **435124**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **02/18/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society Miller	**421 EAST 4TH ST , MILLER, South Dakota, 57362**

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E0030 SS = C	Continued from page 1 (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices.	E0030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435124	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/18/2026

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E0030 SS = C	Continued from page 2 *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is NOT MET as evidenced by: 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 2/18/26. Good Samaritan Society Miller was found not in compliance with the following requirement: E030. Record review on 2/18/26 at 11:45 a.m. revealed the following: The Emergency Preparedness binder located in the vestibule outside the administrator's office did not contain a contact list for staff in the event of an emergency. A contact list was located posted on the wall in the administrator's office. Interview with the administrator at the time of the record review confirmed that finding. The deficiency could affect 100% of the building	E0030		

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

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E0030 SS = C	Continued from page 3 occupants.	E0030		

South Dakota Department of Health

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	10651	A. BUILDING: ____ B. WING ____	02/20/2026

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GOOD SAMARITAN SOCIETY MILLER	421 E 4TH STREET MILLER, SD 57362

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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 2/17/26 through 2/20/26. Good Samaritan Society Miller was found not in compliance with the following requirements: S199, S206, S236, S290, and S323.	S 000		
S 199	44:73:04:04 Personnel The facility shall have a sufficient number of qualified personnel to provide effective and safe care. Healthcare personnel on duty must be awake at all times. Any supervisor must be eighteen years of age or older. The facility shall make available written job descriptions and personnel policies and procedures to personnel of all departments and services. The facility may not knowingly employ any person with a conviction for abusing another person. The facility shall establish and follow policies regarding healthcare personnel on contract. This Administrative Rule of South Dakota is not met as evidenced by: " Based on observation, record review, and interview, the provider failed to ensure one of one sampled nurse assistant trainee (Q) was certified as a medication aide before administering medications to residents. Findings include: 1. Review of the provider's validation of certification revealed that NAT Q's certification as a medication aide had lapsed on 11/3/25. Her hire date was 11/18/25, and she was hired as a nurse	S 199	1. The facility immediately removed NAT Q from medication administration duties upon identification of the deficient practice. The Administrator and Director of Nursing completed an audit of all employees who administer medications to verify current certification/licensure and competency status. Any employee found without current required certification/licensure was immediately removed from medication administration duties until compliance was verified. 2. The facility reviewed its process for verification of medication aide and nurse aide certification at hire, transfer, and prior to assignment of medication administration duties. a. Certification/licensure will be verified through the appropriate state board/registry before an employee is permitted to pass medications. b. The Administrator/Director of Nursing/ designee will receive and review expiration reports at least monthly. c. The Administrator/Director of Nursing reviewed the requirement that only properly certified staff may administer medications and signed the education acknowledging they understand the regulation. 3. The Administrator/designee will audit all staff assigned to medication administration weekly for 4 weeks, then monthly until 2 consecutive months of 100% compliance is achieved. Audit results will be reported through the facility's QAPI process, and corrective action will be taken for any identified concerns.	03/24/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Petar Mirkovic
TITLE: Administrator
(X6) DATE: 03/25/26

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S 199	Continued From page 1 assistant trainee. 2. Interview on 2/18/26 at 5:26 p.m. with administrator A and director of nursing (DON) B related to NAT Q's medication aide lapsed certification revealed: *DON B acknowledge NAT Q had been passing medications to residents and was not aware that her medication aide certification had lapsed. *Administrator A stated NAT Q passed medications "only 2 days", because she just passed her certified nurse aide (CNA) course and he thought she was already certified as a medication aide, that it was current (not lapsed), and that she could pass medications once she was also certified as a nurse aide. -Administrator A provided a 1/29/26 email from the provider's corporate training coordinator that indicated NAT Q had passed her CNA course. NAT Q's certification as a CNA was unable to be verified on the South Dakota Board of Nursing website. 3. Interview on 2/18/26 at 5:45 p.m. with administrator A regarding NAT Q's medication aide certification revealed: *Medication aide certifications for employees were monitored by the "corporate office", they would notify him when a staff member's certification was going to expire. -He had not received notification that NAT Q's medication aide certification had expired. -He stated he had hired NAT Q "about two months ago" as a NAT. -He acknowledged NAT Q's medication aide certification had expired and that she should not have passed residents' medication. 4. Review of the provider's 9/17/25 Medication Assistant job description revealed:	S 199		

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S 206	Continued From page 4 required orientation for mandatory reporting of incidents and diseases within 30 days of hire. 4. Review of environmental services technician employee (EST) M's employee file revealed she was hired on 9/15/25. She did not complete the required orientation training for: proper restraint use, advance directives, and mandatory reporting of incidents and diseases within 30 days of hire. 5. Review of licensed practical nurse (LPN) J's employee file revealed she was hired on 11/16/25. She did not complete the required orientation training for: confidentiality of resident information and mandatory reporting of incidents and diseases within 30 days of hire. 6. Interview on 2/20/26 at 11:25 a.m. with administrator A regarding staff education and training revealed the facility's process that the required training was assigned by the corporate office to employees using an online platform. A report was sent to administrator A periodically to monitor and follow up with the staff to ensure they completed the training. He acknowledged the deficient practice of the annual and orientation trainings not being completed within the required time frames for the above employees.	S 206		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare personnel or residents are as follows: (1) Each new healthcare personnel or resident shall receive an initial individual TB risk assessment and the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within twenty-one days of	S 236	1. Resident 1's TB screening documentation was reviewed. The facility addressed the incomplete documentation and verified current TB screening status in the medical record. The Director of Nursing/designee reviewed the resident for any follow-up needs and ensured the record reflected complete TB screening information to the extent possible. Continue to next page.	03/24/26

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S 236	Continued From page 5 employment or admission to a facility. The qualified personnel must record the assessment and the test in the employee's record or the resident's medical record. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of admission or employment is considered a two-step test. A TB blood assay test completed within a twelve-month period prior to the date of admission or employment is an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare personnel or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin testing having been completed within the prior twelve months. Skin testing or a TB blood assay test is not necessary if documentation is provided by the transferring healthcare facility, healthcare personnel, or resident, of a previous positive reaction to either test. Any new healthcare personnel or resident who has a newly recognized positive reaction to the skin test or TB blood assay test must have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure one of five sampled residents (1) received his two-step tuberculin (TB) skin test within 21 days of his admission to the facility. Findings include: 1. Review of resident 1's electronic medical	S 236	An audit of current residents admitted within the past 12 months was completed to verify TB Mantoux test completion unless contraindicated, baseline screening, timing, and documentation of results in the medical record. Any missing or incomplete documentation was corrected, and any needed follow-up was initiated. 2. The facility reviewed its admission process for TB Mantoux test and documentation. a. Admission checklist was reviewed to include TB Mantoux test unless contraindicated, placement date, read date, result, and second-step due date when applicable. b. The director of nursing/designee provided education to licensed nurses on the requirement that TB test results must be documented clearly in the medical record/ immunization module and that "N/A" is not an acceptable result.This education was completed by 3/24/26 or prior to next working shift. 3. The Director of Nursing/designee will audit all new admissions weekly for 4 weeks, then monthly until 2 consecutive months of 100% compliance has been achieved to verify TB screening was completed and documented according to policy and regulation. Findings will be brought to QAPI for review and further action as needed.	

South Dakota Department of Health

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S 236	Continued From page 6	S 236		

record (EMR) revealed:
*He was admitted on 1/6/26.
*His first TB skin test was administered on 1/6/26. The results were to be read on 1/9/26.
-The 1/9/26 results were documented as "N/A" in his EMR. There was a notation of "Nurse reading [the TB skin test] must record results in the immunization module."
-There was no documentation of his1/6/26 TB skin test results in the immunization module.
*His second step TB skin test was administered on 1/13/26 and was read on 1/15/26 with 0 mm (meaning there was no raised, hard, or swollen skin at the injection site), indicating a negative result.

2. Interview on 2/20/26 at 12:56 p.m. with administrator A and director of nursing (DON) B regarding documentation of resident 1's TB skin test revealed they acknowledged that the documented "NA" had not provided the information required to determine a negative or positive result. They acknowledged that not having the results of his first TB skin test did not meet the requirement.

3. Review of the provider's 9/30/25 Tuberculosis Control Plan for Residents policy revealed:
*"Baseline Screening for TB".
*"A two-step Mantoux method should be used for TST when testing. This involves administering the initial test upon admission, which is read within 48 to 72 hours by a nursing professional or physician/practitioner. If the first TST is negative, the second test should be placed one to three weeks after the placement of the first test or per state regulations. The second test is read 48 to 72 hours after administration."
*"Document TB screening and results in the medical record."

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S 290	44:73:07:05 Food Supply The facility shall maintain an on-site supply of perishable and nonperishable foods to meet planned menus for three days. A facility shall maintain an additional supply of nonperishable foods as part of the facility's emergency preparedness plan. A facility may use military meals ready to eat and dried milk in an emergency event according to the facility's emergency response plan. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to follow their process for ensuring an emergency supply of non-perishable food was available to implement their designated disaster menu according to their emergency preparedness plan. Findings include: 1. Observation and interview on 2/18/26 at 7:40 a.m. with supervisor nutrition and food services (SNFS) N in a storage closet in the assisted living hallway revealed: *The closet was designated for the facility's emergency supply of non-perishable food. *The storage closet had no food inventory on the shelves. *SNFS N acknowledged that the facility was not maintaining an emergency food supply that enabled them to implement their disaster menu. *She said that she had to discard the three-day emergency food a few months ago because it expired. *She said there was no budget to reorder the three-day emergency food supply, but she was aware that it was a state regulation requirement.	S 290	1. The facility immediately reviewed its emergency food supply process and placed orders to obtain the required non-perishable food and beverage supply consistent with the disaster menu and emergency preparedness plan. Existing stock and menu quantities were reviewed for adequacy based on facility census, staff, and anticipated needs in an emergency. The Administrator, Supervisor of Nutrition and Food Services, and/or designee reviewed the disaster menu, menu guide, and inventory requirements to verify sufficient stock is maintained for emergency use. Quantities were reconciled to ensure menu items, including protein sources and other required items, are available in amounts necessary to serve the identified population. 2. The emergency supply will be stored in the designated area and inventoried routinely. The dietary manager is responsible for the storage of emergency food. a. Expiration dates will be tracked and stock rotated per inventory tracking log. The dietary manager is responsible for following the tracking log and will review this quarterly to ensure emergency food is stocked appropriately. b. The dietitian/designee will review the emergency menu and corresponding inventory at least every 6 months, and more often as needed with census changes. c. Dietary leadership and administration reviewed the state requirements for maintaining emergency food supply and for ensuring purchases match the disaster menu quantities. Dietary leadership and administration signed the education acknowledging they understand. Continue to next page	03/24/26

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S 290	Continued From page 8 2. Interview and observation on 2/18/26 at 12:10 p.m. with administrator A regarding the three-day emergency food supply and a 2/18/26 purchase order revealed: *He acknowledged that he was aware that the facility had not been maintaining a three-day emergency non-perishable food supply and said that they could improve in that area. *He provided a 7-day disaster menu and menu order guide that the facility followed for their emergency food supply and menus. *It was last reviewed and signed by dietitian D on 5/22/25. *The purchase order had an insufficient amount of proteins ordered, such as beef stew, tuna, and chicken. *He acknowledged that the purchase order did not include a sufficient amount of proteins as listed on the menus provided. 3. Interview on 2/20/26 at 2:00 p.m. with dietitian D revealed: *She said she last reviewed and signed the 7-day emergency menus on 11/5/25 and completed a review every six months. *She said administrator A had not provided the most current signed menus for review. *She did not know if the facility was maintaining a sufficient amount of non-perishable food and beverages to implement their disaster menu in an emergency, as she had never checked the emergency food supply closet to verify if it was stocked. *She acknowledged that the 7-day menu was based on resident census, total staff, and an average number of visitors. The menu also included recipes that specified the amount of food needed to serve 50 to 100 people.	S 290	3. The Administrator and Supervisor of Nutrition and Food Services/designee will complete a weekly inventory audit for 4 weeks, then monthly until 2 consecutive months of 100% compliance is achieved, to verify the required emergency food supply is present, not expired, and sufficient to implement the facility's disaster menu. Findings will be reviewed in QAPI.	

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GOOD SAMARITAN SOCIETY MILLER	421 E 4TH STREET MILLER, SD 57362

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S 290	Continued From page 9 Review of the provider's 2022 Dining Service Menu Guide for Emergency Menu and Food Supply revealed: *"In the event of a disaster, emergency, or unplanned interruption to foodservice - all customers have availability to a 7-day emergency menu specially designed for loss of electricity and potable water." *"Emergency Menu food items need to be stored in a cool, dry storage area and the items are to be rotated out into service at least every 6 months." *"In the event of a planned kitchen shut down, in the event of an emergency, the dining service manager and registered dietitian should plan a menu to meet the needs of the residents."	S 290		
S 323	44:73:08:06(1-4) Documentation of Medication Disposal A facility shall ensure that a legend medication not controlled under SDCL chapter 34-20B is destroyed or disposed of by a nurse and another witness. Destruction or disposal of medication controlled under SDCL chapter 34-20B must be witnessed by two persons, both of whom must be a nurse or pharmacist, as designated by facility policy. The following are authorized methods of destruction or disposal: (1) Using a professional waste hauler to take the medications to a permitted medical waste facility or by facility disposal at a permitted municipal solid waste landfill. Prior to disposal all medications must be removed from original containers and made unpalatable by the addition of adulterants and alteration of solid dosage forms by dissolving or combination into a solid mass; (2) Return to the dispensing pharmacy for destruction according to federal and state	S 323	1. The facility immediately stopped the practice of allowing CMAs to witness destruction of controlled medications. Licensed nursing staff and leadership were notified of the requirement that controlled medication destruction must be completed only by two nurses in accordance with regulation. All residents have the potential to be affected. 2. The facility reviewed and reinforced its medication destruction procedure to require destruction of controlled medications by two nurses. a. CMAs were immediately removed from the controlled medication destruction process. b. The director of nursing/designee educated Licensed nurses and applicable staff received education on controlled substance destruction requirements by 3/24/26 or prior to next working shift.. c. The Director of Nursing or designee will review destruction documentation for completeness and compliance. Continued to next page.	03/24/26

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
	10651	A. BUILDING: ____ B. WING ____	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY MILLER	**421 E 4TH STREET MILLER, SD 57362**

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S 323	Continued From page 10 regulations; (3) Return to an authorized reverse distributor company licensed by the South Dakota Board of Pharmacy; or (4) Release to resident upon discharge after authorization by the resident's prescribing practitioner. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure that controlled (medications with risk for abuse, addiction, and potential theft) medications were destroyed by two authorized persons, both of whom were a nurse or pharmacist. Findings include: 1. Interview on 2/19/26 at 2:15 p.m. with certified nursing assistant (CNA)/certified medication aide (CMA) I revealed: *She said that the residents' controlled medications were counted at each shift change between nurses and CMAs. *She said that controlled medications were received and destroyed by nurses and CMAs per the provider's policy and that the pharmacist did not complete medication destruction at the facility. *The residents' controlled and regular medications were logged on a medication destruction form and signed by the nurse and CMA. *Resident medications were placed in the RX Destroyer (a chemical drug destruction product that deactivates medications upon contact) container after they were counted and logged on the medication destruction form.	S 323	3. The Director of Nursing/designee will audit 4 random residents-controlled medication destruction records weekly for 4 weeks, then monthly until 2 consecutive months of 100% compliance is achieved. Results will be reported through QAPI and corrective action taken for any noncompliance.	

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S 323	Continued From page 11 2. Review of the medication destruction logs for controlled medications for January and February 2026 revealed: *On 1/30/26, resident 12 had 18 tablets of Hydrocodone/APAP (a controlled pain medication) destroyed by a registered nurse (RN) and a CNA/CMA identified as a witness to the destruction. *On 1/30/26, resident 27 had 34 tablets of Pregabalin (a controlled medication to treat nerve pain) destroyed by an RN and a CNA/CMA identified as a witness to the destruction. *On 2/17/26, resident 1 had 26 tablets of Pregabalin and 9 tablets of Hydrocodone/APAP destroyed by an RN and a CNA/CMA identified as a witness to the destruction. *On 2/17/26, resident 6 had 11 tablets of Lorazepam (a controlled medication to treat anxiety) destroyed by an RN and a CNA/CMA identified as a witness to the destruction. *On 2/17/26, resident 23 had 29.25 ml (milliliters) of liquid Morphine (a controlled pain medication) destroyed by an RN and a CNA/CMA identified as a witness to the destruction. *On 2/17/26, resident 27 had 12 tablets of Tramadol (a controlled pain medication) destroyed by an RN and a CNA/CMA identified as a witness to the destruction. *On 2/20/26, resident 8 had 1 Fentanyl patch destroyed by an RN and a CNA/CMA identified as a witness to the destruction. 3. Interview on 2/19/26 at 3:00 p.m.with director of nursing (DON) B revealed: *The DON stated nurses and CMAs were to count the controlled medications together, sign the controlled medication records, and ensure that the narcotic count was accurate at the beginning and ending of each shift. *She acknowledged that controlled medications	S 323		

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S 323	Continued From page 12	S 323		

were received and destroyed by nurses and CMAs per the provider's policy and that the pharmacist did not complete medication destruction at the facility.
*She acknowledged that the above residents' controlled medications were logged and signed by CNAs/CMAs as witnesses to the medication destruction process.

4. Phone interview on 2/20/26 at 8:15 a.m. with retail pharmacist S revealed:
*He said that he was at the facility monthly, delivered resident medications daily as ordered by the physician's, and provided the resident's scheduled monthly medication bubble pack cards.
*He said that he contracted a pharmacist to provide the facility with a consultant pharmacist to review resident charts every month and said that they share responsibilities.
*He said they checked the emergency medication kit, medication carts, and medication storage room for expired medications when they were there.
*He said that he completed audits of nursing staff during medication administration and would provide a corrective action plan if needed.
*He had not attended a quality assurance process improvement (QAPI) meeting since the facility's COVID outbreak in January 2026.
*He acknowledged that he used to be involved in destroying the residents' controlled medications. He did not remember the last time he did that, and believed that two nurses were now responsible for it.

5. Phone interview on 2/20/26 at 8:52 a.m. with consultant pharmacist R revealed:
*She stated she was at the facility monthly and would review all resident progress notes, labs,

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S 323	Continued From page 13	S 323		

and medications during those facility visits.
*She acknowledged that she was not involved in destroying the residents' controlled medications.

6. Interview on 2/20/26 at 10:28 a.m. with RN K revealed:
*She had not checked in medications from the pharmacy but acknowledged that CMAs were allowed to check in resident medications, including controlled medications, received from the pharmacy.
*She acknowledged that CMAs were allowed to destroy controlled medications with a nurse.

7. Interview on 2/20/26 at 1:00 p.m. with administrator A, DON B, and interim director of nursing (IDON) C revealed:
*They acknowledged that controlled medications were received and destroyed by nurses and CMAs per their policy and that the pharmacist did not complete medication destruction at the facility.
*Administrator A and DON B stated that they were not aware of the state regulation that only authorized persons, such as a nurse and a pharmacist or two nurses, were permitted to complete controlled medication destruction.
*They acknowledged that residents' 1, 6, 8, 12, 23, and 27 controlled medications were logged and signed by CNAs/CMAs as witnesses to the medication destruction process.

8. Review of the provider's revised 3/4/25 Medications: Acquisition, Receiving, Dispensing, and Storage - R/S, LTC policy revealed:
*"Controlled drugs (Schedule II) and other drugs subject to possible abuse will be stored in separate, locked, permanently fixed compartments, except when a single unit package drug distribution is used. These drugs

South Dakota Department of Health

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S 323	Continued From page 14 will be reconciled at least daily through an appropriate system of records of receipt and disposition established by the licensed pharmacist."	S 323		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **435124**	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING 0...** B. WING	(X3) DATE SURVEY COMPLETED **02/18/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society Miller	**421 EAST 4TH ST , MILLER, South Dakota, 57362**

(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
K0000	INITIAL COMMENTS A recertification survey was conducted on 2/18/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Good Samaritan Society Miller was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0712 SS = F Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to maintain fire drill training for staff (a minimum required number of fire drills were documented, a lack of variance in the timing of the quarterly fire drills was noted for the second and third shifts, and a lack of adequate response to the survey in-house fire drill). Findings include: 1. Record review on 2/18/26 at 10:15 a.m. and observation on 2/18/26 at 11:22 a.m. revealed the following:A total of 12 documented fire drills were	K0712	1. Immediately following the survey, staff present during the fire drill observation were re-educated on the facility fire response procedures including RACE (Rescue, Alarm, Contain, Extinguish/ Evacuate), proper fire announcement procedures, checking a door for heat using the back of the hand prior to opening, and ensuring doors remain closed when smoke or fire conditions are present. A facility-wide education was initiated to ensure all staff demonstrate competence in fire safety procedures and emergency response. All residents have the potential to be affected by staff knowledge of fire safety procedures. 2. To ensure continued compliance with fire drill requirements, the facility has implemented the following measures: •The Maintenance Director and Administrator will review the Fire Drill Policy to ensure fire drills are conducted quarterly on each shift and at varied times and under varying conditions as required by NFPA 101. •All staff will receive education on fire safety procedures, including: o RACE procedures o Proper fire alarm/announcement procedures o Checking doors for heat prior to opening o Closing doors when smoke or fire conditions are present o Proper response when responding with fire extinguishers Fire drills will include evaluation of staff response and follow-up education when needed. Continued on next page	03/24/26

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
Petar Mirkovic	Administrator	03/19/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **435124**	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING 0...** B. WING	(X3) DATE SURVEY COMPLETED **02/18/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society Miller	**421 EAST 4TH ST , MILLER, South Dakota, 57362**

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K0712 SS = F Bldg. 01	Continued from page 1 found for 2025 held on a quarterly basis for a three-shift staffing arrangement (the minimum required to be held).Second shift (3:00 p.m. to 11:00 p.m.) drills were held on January 29, 2025 at 3:02 p.m., on April 23, 2025 (no time recorded), on July 28, 2025 at 3:04 p.m., and on October 29, 2025 at 3:10 p.m. The times of the drills were not varied.Third shift (11:00 p.m. to 7:00 a.m.) drills were held on March 25, 2025 at 5:50 a.m., on June 25, 2025 at 1:15 p.m., on September 30, 2025 (no time recorded), and on December 31, 2025 at 6:00 a.m.A single staff person responded to the fire drill location (initiated by a resident call light for room 13) and announced the fire over the walkie-talkie system one time (announcing three times is standard). Staff responding to the drill location with fire extinguishers did not know how to check the corridor door for heat (using the back of a hand to check the door first, then the door handle). Those staff did not know what to do if the room was engulfed with smoke when opening the corridor door (the door must be closed to protect the egress corridor and other residents).Interview with the maintenance director at the time of the observation confirmed those findings. The deficiency could affect 100% of the building occupants.	K0712	3. The Administrator or designee will monitor fire drill compliance by: •Audit drill documentation weekly x4, monthly x2 to ensure fire drills occur at varied times and on all shifts per schedule below. •Conducting random staff fire safety competency checks quarterly. The administrator or designee will report the audit findings to the QAPI program to ensure ongoing compliance.	

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S 199	Continued From page 2 *"License/Certification Details" "South Dakota: Must successfully complete the state approved Certified Medication Aide (CMA) course. CMA certification must be maintained with the State Board of Nursing."	S 199		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. All healthcare personnel must complete the orientation program within thirty days of hire and the ongoing education program annually thereafter. The orientation program and ongoing education program must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; (11) Abuse and neglect; and (12) Advanced directives. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section. The facility shall provide additional personnel education based on the facility's identified needs.	S 206	1. The identified employees' education records were reviewed. Missing orientation and/or annual training topics were assigned and completed or scheduled for immediate completion. Staff were not permitted to remain out of compliance with required education requirements without follow-up by administration. The Administrator/designee conducted a review of current employee files to verify completion of required orientation within 30 days of hire and annual required education topics thereafter. Any missing education was assigned for completion and tracked to completion. 2. The facility reviewed its on boarding and annual education compliance process. a. Required orientation topics will be reviewed at hire and monitored for completion within 30 days, this review will be completed by the administrator/designee. . b. Annual required education topics will be tracked by due date and reviewed quarterly. c. The Administrator/Director of Nursing/ designee will review education compliance reports at least monthly. 3. The Administrator/designee will audit 5 employee files weekly for 4 weeks, then 5 employee files monthly until 2 consecutive months of 100% compliance is achieved. Results will be reviewed in QAPI and additional corrective action taken as needed.	03/24/26

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S 206	Continued From page 3 This Administrative Rule of South Dakota is not met as evidenced by: Based on employee record review, interview, and policy review, the provider failed to ensure: *Two of five employees (F and H) reviewed completed the required annual training topics. *Three of five employees (G, J, and M) reviewed completed the required orientation training topics within 30 days of hire. Findings include: 1. Review of certified nurse aide (CAN) H's employee file revealed she was hired at a sister facility in December 2024, and completed her orientation training topics on 12/23/24 at that facility. She then transferred her employment to the provider's facility on 8/17/25. She did not complete the required orientation topics within 30 days of hire at the provider's facility, which included: fire prevention and response; emergency preparedness; infection prevention and control; accident prevention safety procedures; proper restraint use; resident rights; confidentiality of resident information; advanced directives; care of residents with unique needs; dining assistance, nutrition, and hydration; abuse and neglect; and mandatory reporting of incidents and diseases. There was no documentation that she completed any of the required trainings since 12/23/24. 2. Review of certified medication aide (CMA) F's employee file revealed she was hired on 1/30/24. She did not complete the required annual training topic of mandatory reporting of incidents and diseases. 3. Review of CNA G's employee file revealed she was hired on 2/17/25. She did not complete the	S 206		