STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435098	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/16/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/14/26 through 7/16/26. Good Samaritan Society Tyndall was found not in compliance with the following requirements: F584, F684, F686, and F695. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/14/26 through 7/16/26. The areas surveyed were the quality of care and a safe, clean homelike environment related to cluttered hallways. Good Samaritan Society Tyndall was found in compliance.	F0000	**F0686 - Treatment/Services to Prevent Pressure Ulcers** Resident #11's care plan, physician orders, treatment documentation, and interventions related to pressure ulcer prevention and skin integrity will be reviewed by the Director of Nursing (DON) or designee and corrected as indicated. The care plan will be revised to ensure interventions related to pressure ulcer prevention, wound management, positioning, brace use, skin monitoring, nutrition and hydration, moisture management, and other identified risk factors are individualized, current, and clearly communicated to the interdisciplinary team. Resident #11 currently does not have any existing pressure ulcers. If resident #11 develops or is identified with any pressure ulcer, it will be staged, measured, treated according to physician orders, assessed for signs of infection, and documented in the wound record and care plan so healing progression is tracked consistently. A root cause analysis, including an avoidable versus unavoidable determination, will be completed for any pressure ulcer identified for resident #11. Findings will be used to guide care plan revisions.	
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- (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, interview, record review, and policy review, the provider failed to implement pressure ulcer (skin and/or underlying tissue injury from prolonged pressure) prevention interventions for one of one sampled resident (11) who was	F0686		**August 14th, 2026**

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the ins
safeguards provide sufficient protection to the patients. (See reverse for further instruc
90 days following the date of survey whether or not a plan of correction is provided. Fo
14 days following the date these documents are made available to the facility. If deficie
program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shalee Pitman	Administrator	08/09/2026

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F0686 SS = G	Continued from page 1 identified as having a mild risk for developing a pressure ulcer and developed a stage IV (4; open wound with full-thickness skin and tissue loss. Bone, tendon, or muscle may be visible) pressure ulcer to her right antecubital space (the shallow triangular depression directly in front of the elbow joint). Findings include: 1. Observation on 7/15/26 at 2:19 p.m. revealed resident 11 was sitting in her recliner in her room. She wore an arm brace that started just above her right wrist and stopped at her elbow, and there were no visible wounds on her right arm. 2. Interview on 7/15/26 at 3:25 p.m. with resident 11 revealed that she did not have any current wounds, but had an open wound on her right arm a month ago; that wound had healed. She was unable to move her right arm and had worn an arm brace that had caused the wound on her right arm a month ago. She now wore a different arm brace on her right arm that provided more padding. 3. Review of resident 11's electronic medical record (EMR) revealed that she admitted to the facility on 7/1/24. Her Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. Her diagnoses included spastic hemiplegia (a neuromuscular condition causing muscle stiffness on one side of the body) affecting her right dominant side, peripheral vascular disease, contracture (the permanent tightening or shortening of muscles, tendons, ligaments, or skin that prevents normal joint movement) on her right side, and a non-pressure chronic ulcer on the right upper arm with the fat layer exposed. Her 3/3/26 Braden scale (a tool used to assess the risk of developing pressure ulcers) assessment score was 15, which indicated she had a mild risk of developing a pressure ulcer. Resident 11's 4/28/26 weekly skin assessment revealed that she had developed a moisture-associated skin damage (MASD) open area in the right antecubital space of her right arm. The wound measurements were 1.2 centimeters (cm) in length x 0.8 cm in width x 0.2 cm in depth. A non-stick Telfa dressing (a sterile, non-adherent wound dressing designed to protect wounds without sticking to the healing tissue) was placed over the area for protection. The CCL E requested a	F0686	Resident #11's nutritional and hydration needs related to pressure ulcer prevention and healing will be verified and incorporated into the care plan. Moisture management and incontinence care needs, including barrier cream use and scheduled toileting when indicated, will be assessed and ensured. Device-related risks, including pressure, friction, and shear associated with braces, splints, positioning devices, or other medical equipment, will be specifically assessed and monitored. Resident #11's brace management plan will be reviewed with nursing and therapy staff to ensure the brace is applied and removed according to physician/therapy orders, skin is assessed for pressure or breakdown associated with the device, and required monitoring and interventions are documented.	**August 14th, 2026**

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F0686 SS = G	Continued from page 2 physician's order to continue with the Telfa dressing at that time. Resident 11's medication administration record (MAR) included a 4/29/26 physician's order for a "Brace to be ordered for extension and contracture", and a 5/5/26 physician's order for "Resident brace to right elbow to be placed on in the AM and removed at HS". There was no documentation on resident 11's treatment MAR to support when her old brace was placed or when it was removed. On 5/12/26, resident 11 was referred to and seen in the wound clinic, and her initial wound measurements on her right arm were 0.5 cm in length x 0.7 cm in width x 0.2 cm in depth. The fat connective tissue was exposed, and there was a moderate amount of serosanguineous (a thin, watery wound drainage that is light pink or pale red in color) drainage. The wound clinic staff indicated the wound was a stage III (3; open wound with full-thickness skin loss. Fatty tissue may be visible) pressure injury. The wound clinic physician's orders were to change the dressing on resident 11's right arm every other and to have her arm brace on during the day and off at night. A 5/19/26 wound clinic note indicated that her right arm wound measured 0.4 cm in length x 0.5 cm in width x 0.2 cm in depth. A 5/26/26 wound clinic note indicated that her right arm wound measured 0.4 cm in length x 0.4 cm in width x 0.1 cm in depth. Wound clinic staff indicated the wound was a stage IV pressure injury. A 6/9/26 wound clinic note indicated that resident 11's right arm wound was completely healed and resident 11 would be discharged from wound clinic care. Review of resident 11's 7/15/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) indicated she had "an actual and potential risk for pressure ulcer development due to increased need for assistance and a right arm contracture." The goal was to maintain her intact skin without redness or discoloration. The interventions included providing a right arm brace, which was initiated on 6/8/26, and a goal for the staff to immediately notify the nursing department of any new skin issues such as redness, blisters, bruising, or discoloration during bathing or daily care that was initiated 7/1/24. The care plan	F0686	The DON or designee will conduct a facility-wide review of residents who have current or previous pressure ulcers/wounds, are at risk for impaired skin integrity, or utilize braces, splints, positioning devices, or other medical equipment that may contribute to skin breakdown. The review will include care plans, physician orders, treatment records, skin and risk assessments, positioning interventions, nutrition and hydration needs, moisture management and incontinence care, and device-related skin monitoring. Moisture management and incontinence care, including barrier cream use and scheduled toileting when indicated, will be assessed and ensured for all at-ri ted immediately.	August 14th, 2026

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F0686 SS = G	Continued from page 3 contained no evidence of implemented interventions to prevent resident 11's antecubital stage III pressure injury at the right arm brace site before was identified on 4/28/26. 4. Interview on 7/15/26 at 4:11 p.m. with licensed practical nurse (LPN) F revealed that the resident's dressing changes were completed based on the physician's order in the resident's medication administration record (MAR). The nurses tried to change the residents' dressings in the morning when the staff members were helping the residents get up and dressed for the day. 5. Phone interview on 7/16/26 at 2:34 p.m. with clinical care leader (CCL) E regarding the process to prevent and monitor the resident's skin for breakdown revealed that the weekly skin assessments were completed on the residents to monitor for skin breakdown. Resident 11's pressure ulcer to her antecubital space on her right arm was found during a weekly skin assessment. CCL E stated she had called resident 11's primary care provider (PCP) to provide an update and request an order for wound care. Initially, resident 11's wound was identified as a moisture-associated skin damage (MASD) wound. Resident 11 received a physician's order on for a foam dressing to be placed on the antecubital space of her right arm daily and for continued monitoring of the pressure ulcer. CCL E discussed with the care team the possibility of a different arm brace for resident 11 to help manage her contracture and to prevent further skin breakdown in that area. CCL E had contacted the physical therapy department, who suggested obtaining an order from resident 11's physician for what brace to use, and a new brace was purchased for resident 11's right arm. When resident 11's right arm wound did not improve, she was referred to the wound clinic for further treatment. 6. Interview on 7/16/26 at 6:00 p.m. with certified nursing assistant (CNA) G regarding resident 11's right arm wound revealed that she did not notice a wound on resident 11 while providing her care. CNA G stated that if she were to notice a skin issue, she would report it to the nurse on duty. 7. Interview on 7/16/26 at 6:07 p.m., with the director of nursing (DON) B and administrator A revealed the facility utilized the Braden Scale as its standardized skin risk assessment tool. DON B explained that the Braden Scale assessments were documented in the resident's EMR and that the nursing staff members were expected to complete an	F0686	The facility will implement a standardized Skin Integrity and Medical Device Review Process and checklist. The review will verify current orders; individualized pressure injury prevention interventions; device instructions and application/removal schedules; skin monitoring; nutrition and hydration support; moisture management; device-related friction and shear risks; completion of preventive interventions; and timely reassessment and care plan revision when condition changes. Licensed nurses and certified nursing assistants will be re-educated on pressure ulcer prevention, early identification of skin concerns, individualized care plan interventions, skin integrity monitoring related to braces/splints/devices, nutrition and hydration support, moisture management including incontinence care, recognition of signs of infection and wound deterioration, timely provider notification, and required documentation.	August 14th, 2026

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F0686 SS = G	Continued from page 4 additional nursing note. DON B stated that CNAs were trained to report any skin concerns such as redness or bruising to a nurse on duty at that time. The staff members were educated on care-plan interventions for residents identified as having a high risk of developing pressure ulcers, including specialized mattresses, heel floating, repositioning, and other preventive strategies. DON B expected the nursing staff to notify the resident's primary care provider of any skin changes and follow the provider's recommendations and orders. Regarding resident 11's right arm wound and brace, DON B reported that the new arm brace was ordered after consulting with resident 11's physician, and the physical therapy (PT) department educated the nursing staff on how to apply the brace. The nurses were responsible for applying the brace and were to document its removal. DON B was unaware of any documentation that resident 11's old right arm brace was put on and removed during April or May 2026 and was unsure who was responsible for putting on and removing the brace. Resident 11 received restorative services, as listed in her care-plan. DON B did not recall any differences between the two arm braces that resident 11 used. DON B was unsure whether the nurses had received any education regarding brace management. DON B stated there was no documented education provided by the PT department specific to resident 11's old arm brace, and they were not involved in establishing a schedule for when to put on and remove resident 11's brace. There was no documented education that any staff members were trained in putting on and removing resident 11's old arm brace. DON B stated CCL E initially identified resident 11's pressure ulcer during a weekly skin assessment on 4/28/26. Resident 11 was referred promptly to the wound care clinic, and the clinic routinely sent their visit notes back to the facility. The resident's antecubital area on her right arm was initially treated at the facility for MASD. DON B stated there was no documentation indicating resident 11's old arm brace caused her right arm wound. DON B was unsure what interventions were in place for resident 11's old right arm brace to prevent her from acquiring a pressure ulcer. DON B believed the old brace was intended to prevent further contracture of the resident's right arm.	F0686	Education will be completed during the mandatory all-staff meeting on August 11, 2026, by the clinical care lead, Nicole DeFries, and the clinical learning and development specialist, Rosemary Bender. Staff unable to attend on August 11, 2026 will complete make-up education prior to their next worked shift. Newly hired staff will receive education during orientation. The DON or designee will complete weekly audits of five residents identified as being at risk for impaired skin integrity, including resident #11 when applicable, for four weeks; every other week for four weeks; and monthly for two additional months until substantial compliance is achieved and sustained. Concerns will be corrected immediately. Audit results and trends will be reported monthly to QAPI. Results of any root cause analysis will also be reviewed by QAPI to identify facility-wide trends and guide system-level improvements. **Compliance Date: August 14th, 2026**	August 14th, 2026

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F0686 SS = G	Continued from page 5 8. Review of the provider's 3/2/26 Pressure Ulcer policy revealed the facility was required to provide appropriate assessment and prevention of pressure ulcers, as well as treatment when necessary. 9. Review of the provider's updated 6/30/26 Wound and Pressure Ulcer Management policy revealed the facility was to provide current and consistent standards of practice in wound care management. "Wound care management may include the management and treatment of surgical wounds, pressure ulcers, diabetic ulcers, skin conditions, as well as arterial and venous ulcers. These are the most common types of wounds that occur. [Redacted provider's name] wound care programs, pressure ulcer guidelines, and protocols have been developed and implemented to provide quality service to residents. Promotion of healing, pain management, and prevention of complications is extremely important, as well as accurate assessment and documentation."	F0686	**F0584 - Safe, Clean, Comfortable, and Homelike Environment** Environmental concerns identified during the survey, including damaged drywall, peeling paint, resident room repairs, and bathroom privacy concerns, were addressed through the facility maintenance process. The bathroom door for residents #18 and #32 was repaired and reinstalled by July 16, 2026. The facility will ensure all damaged drywall areas identified during the survey are repaired to restore a safe, clean, and homelike environment. Areas of peeling paint identified during the survey will be repainted to maintain a sanitary and well-kept physical environment.	August 14th, 2026
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in	F0584		

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F0584 SS = E	Continued from page 6 good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure a homelike environment was maintained for two of fourteen sampled residents (18 and 32) who did not have a bathroom door and four of fourteen sampled residents (10, 24, 35, and 44) whose walls in their rooms had exposed drywall and peeling paint. Findings include: 1. Observation on 7/14/26 at 9:28 a.m. in resident 24's room revealed an approximately ten-inch area between her end table and stationary chair with peeling paint, more than five gouges in the drywall, and two three-to-four-inch areas where the drywall was exposed. 2. Observation and interview on 7/14/26 at 11:19 a.m. with residents 18 and 32 in their shared room revealed that they did not have a bathroom door. The bathroom was directly across from where resident 18 sat in her recliner and resident 32 sat in her wheelchair. Resident 18 stated that the door was removed a few days ago to be repaired. She was unsure if the door was removed before or after the weekend. She went across the hallway into the empty resident room's bathroom to use the bathroom if she wanted to close the door. She felt that going across the hall to use the bathroom gave her the privacy that she needed but wondered when their bathroom door would be repaired. She often got up one to two	F0584	All resident room repairs identified by surveyors, including structural or cosmetic damage, will be completed to ensure resident rooms remain clean, comfortable, and homelike. Bathroom privacy concerns, including missing or improperly functioning doors, locks, or barriers, will be corrected promptly to protect resident dignity and privacy. The Administrator and Maintenance Director completed a facility-wide environmental assessment of resident rooms, bathrooms, hallways, and common areas. Identified concerns were entered into the maintenance tracking process for repair.	August 14th, 2026

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F0584 SS = E	Continued from page 7 times during the night to use the bathroom and hoped that their bathroom door would be repaired soon so she could use their bathroom. Resident 32 stated that when she used the bathroom, if resident 18 was in their room, the staff members would try to remember to pull the curtain around resident 18 and her bed, and the staff members closed the bedroom door to the hallway. 3. Observation and interview on 7/14/26 at 12:51 p.m. with resident 10 in her room that she shared with resident 35 revealed there was a large area behind her recliner between her bed and resident 35's bed where there were more than five three-to-four-inch gouges in the wall with exposed drywall and peeling paint. She pointed at the area behind the recliner and stated it was "like that" when she moved from another room in the facility into that room a couple of weeks ago. She thought that the staff members were aware of the area because it was visible from anywhere in the room. 4. Observation and interview on 7/15/26 at 8:28 a.m. with resident 44 in her room revealed that she sat in a chair between her bed and the window, and she did not share the room with another resident. There were several areas behind resident 44's recliner where the paint was peeling, and the drywall was exposed. On the side of the room closest to the window, there were more than five eight-inch-long areas on the heat register where the paint was peeling, and the metal was exposed. There were more than ten scratches on the wall by the window, with deep scratches, peeling paint, and exposed drywall. Resident 44 did not know how long the areas on her wall or on the heat register were damaged. 5. Observation and interview on 7/15/26 at 8:30 a.m. with maintenance mechanic J regarding residents 10, 18, 24, 32, 35, and 44's rooms revealed that he was unaware of the areas of exposed drywall and peeling paint. He stated that the facility's management team conducted "angel rounds" (a process of going room to room to observe for resident and environmental concerns). He expected that when the staff members observed environmental concerns like peeling paint or exposed drywall, they would document the need for repairs on the Maintenance Request Sheets. Maintenance mechanic J reviewed the Maintenance	F0584	All staff will be re-educated by the Administrator, Shalee Pitman, on prompt reporting of environmental concerns, completion of maintenance work requests, protecting resident privacy while repairs are pending, and reporting unresolved maintenance concerns to facility leadership. Staff unable to attend the initial education will complete make-up education prior to their next worked shift.	August 14th, 2026

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F0584 SS = E	Continued from page 8 Request Sheets on the maintenance clipboard and stated that there were no requests made for those areas to be repaired. If those areas were reported to him, he would "fix" them. He thought that there were several resident rooms with damaged sheetrock and peeling paint. He thought the damaged areas on the walls were caused by the resident recliners being pushed up against the wall, and when he fixed those areas, they just happened again. He confirmed that the area of drywall damage and peeling paint in resident 24's room was not behind a recliner and thought that there was once a recliner in that spot in her room. He thought that the peeling paint and drywall damage in resident 44's room was caused by a resident's bed being placed too close to the heat register and the wall. He stated there was not a current plan in to repair those areas. Maintenance mechanic J was aware that residents 18 and 32 did not have a bathroom door because he removed it so that he could repair it. The repair was not finished, and he was unsure when the door would be rehung. 6. Observation and interview on 7/16/26 at 9:19 a.m. with certified nursing assistant (CNA) H revealed that when the surveyor knocked on the bedroom door to resident 18 and 32's shared bedroom, CNA H informed them that resident 32 was seated on the toilet and then entered that room. Resident 32 was seen seated on the toilet in the shared bathroom from the doorway when CNA H entered the room. CNA H thought that it was a few days since residents 18 and 32 had a bathroom door. CNA H tried to make sure to pull the curtain around resident 18's bed and close the bedroom door to the hallway when residents 18 and 32 were both in the room. The curtain was not pulled because resident 18 was not in the room at that time. CNA H stated that resident 32 preferred to use the bathroom in the empty resident room across the hall from her room, because she wanted to use a bathroom with a door. There was a clipboard located in an office near the nurses' station where she would document when there was a problem that maintenance needed to fix. She was aware of the areas of exposed drywall and peeling paint in residents 10, 24, 35, and 44's bedrooms but did not report them to the maintenance department because she thought that administrator A and maintenance mechanic J already knew about those areas, as the management staff members took turns checking the rooms each week.	F0584	Leadership will continue documenting weekly Angel Rounds utilizing an environmental audit tool to identify and track needed repairs until completed. The Administrator or designee will conduct weekly environmental audits of the entire facility for four weeks, bi-weekly for four weeks, and monthly for two months until substantial compliance is achieved. Audits will include resident room condition; walls, paint, flooring, and furnishings; bathroom privacy; and completion of maintenance requests within established timeframes.	August 14th, 2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0584 SS = E	Continued from page 9 She did not document when she noticed that residents 18 and 32 did not have a bathroom door because the residents told her that maintenance mechanic J removed the door. 7. Observation and interview on 7/16/26 at 4:13 p.m. with administrator A revealed she was aware of the damaged drywall and peeling paint in residents 10, 24, 35, and 44's rooms and that residents 18 and 32 did not have a bathroom door. Management level staff members completed Angel Rounds weekly to look at the residents' rooms and the environment for damage or other concerns. She expected the staff members who completed those rounds to document environmental areas of concern on the Maintenance Request Sheet. She thought that an external contractor would need to complete the repairs to the walls in residents 10, 24, 35, and 44's rooms due to the extent of the damage and felt that it was difficult to schedule those repairs due to "time constraints" and the contractor's schedule. Those repairs were not scheduled to occur. Administrator A expected the staff members to pull the curtain around residents 18 and 32's beds and to shut residents 18 and 32's hallway door when they needed to use the bathroom in their shared room. Administrator A acknowledged that pulling the curtain did not provide privacy if someone entered the room from the hallway while resident 18 or 32 were seated on the toilet, as the curtain extended around the residents' beds and did not provide privacy from the hallway door. Administrator A confirmed that a new resident moved into the previously empty resident room across the hall from residents 18 and 32 on 7/16/26 and was unsure which bathroom resident 32 would have to use if she wanted to use a bathroom with a door. She stated that the repair to residents 18 and 32's bathroom door was scheduled to take several days, was not completed, and that it was a "challenge." 8. Review of the provider's 3/26/26 through 7/15/26 Maintenance Request Sheet revealed that no documentation indicated that there was drywall damage in residents 10, 24, 35, and 44's rooms. On 7/7/26, it was reported that residents 18 and 32's "Bathroom door is really bad [and] falling apart. Safety Hazard." The Maintenance Comments	F0584	Audit findings will be documented and reviewed monthly during QAPI. The Administrator will report compliance rates, identified trends, and corrective actions to QAPI for review and follow-up. **Compliance Date: August 14th, 2026**	**August 14th, 2026**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435098	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/16/2026

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GOOD SAMARITAN SOCIETY TYNDALL	2304 LAUREL STREET , TYNDALL, South Dakota, 57066

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F0584 SS = E	Continued from page 10 indicated "Have [a] new one coming." 9. Review of the provider's 5/22/26 through 6/26/26 Angel Room Rounds documentation revealed that on 5/22/26 the walls in residents 10, 35, and 44's rooms contained damage. On 6/26/26, the walls in residents 10, 35, and 44's rooms did not contain damage. There was no documentation of the condition of resident 24's bedroom walls. 10. Review of the provider's revised 12/29/25 Resident Environment policy revealed "the center will provide a safe, clean, comfortable homelike environment..."	F0584	**F0684 - Quality of Care (Call Light Response)** Residents identified during the survey as having concerns related to call light response will be followed up with to clarify concerns, address unmet needs, and revise individualized interventions as indicated. Call light devices in resident areas will be checked to ensure they are fully functional and within easy reach for each resident. Any malfunctioning or inaccessible call light will be corrected promptly and interim measures implemented as needed.	
F0684 SS = E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and policy reviews, the provider failed to ensure staff members responded to call lights promptly for two of two sampled residents (2 and 4) who reported concerns regarding extended call light wait times. Findings include: 1. Interview on 7/14/26 at 3:41 p.m. with resident 4 revealed she felt her call lights were often answered slowly, especially due to her room being located at the far end of the hallway. She had two instances of incontinence due to a delayed response from the staff. 2. Review of resident 4's electronic medical record (EMR) revealed she was admitted on 2/27/25. Her 6/5/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. Her 6/3/26 care plan	F0684		**August 14th, 2026**

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F0684 SS = E	Continued from page 11 (personalized plan that addresses a resident's care needs, goals, and interventions) indicated she required one staff member to assist her and a front-wheeled walker and gait belt (a waist strap gripped as support for safe mobility and transfers) to be transferred to the toilet. 3. Review of resident 4's 6/17/26 through 7/16/26 call-light report (a data report that measures how long it takes nursing home staff to answer a patient's call button) revealed 15 call-light response times exceeded 20 minutes, and the longest call-light response time was 44 minutes. 4. Interview on 7/15/26 at 9:46 a.m. with resident 2 revealed that he experienced delays when he requested the staff assistance, which included requesting medication for pain. He stated the facility often appeared short-staffed to him. 5. Review of resident 2's EMR revealed he was admitted on 5/18/26. His 5/22/26 BIMS assessment score was 14, which indicated his cognition was intact. His 5/18/26 care plan indicated that he required one staff member to assist him with a non-mechanical stand aid (a caregiver-assisted transfer device that relies on the resident's own strength to move from a seated to a standing position) and a gait belt for toilet transfers and assistance with dressing and bathing. 6. Review of resident 2's 6/17/26 through 7/16/26 call-light report revealed 10 call-light response times that exceeded 20 minutes, and the longest call-light response time was 27 minutes. 7. Interview on 7/16/26 at 2:22 p.m. with certified nursing assistant (CNA) I revealed that resident call lights were expected to be answered "as soon as they can," but acknowledged the staff were delayed when caring for other residents. 8. Interview on 7/16/26 at 3:54 p.m. with resident 4 revealed that her longest wait time for the staff to respond to her call light during the past month was approximately one hour. She stated that was embarrassing for her. 9. Interview on 7/16/26 at 4:06 p.m. with director of	F0684	The facility will conduct routine audits of call light device functionality to ensure ongoing operability, proper signal transmission to staffed locations, and prompt identification of malfunctioning equipment. All nursing staff will be re-educated on prompt call light response; prioritizing resident safety and urgent needs; requesting assistance when unable to respond immediately; communicating with residents when additional time is needed; purposeful rounding; and reporting recurring or unresolved concerns to the charge nurse or nurse leader. Staff unable to attend the initial education will complete make-up education prior to their next worked shift. The DON or designee will monitor call light response and device functionality through routine audits and resident follow-up. Results and trends will be reviewed through QAPI. **Compliance Date: August 14th, 2026**	**August 14th, 2026**

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F0684 SS = E	Continued from page 12 nursing (DON) B revealed all staff were responsible for answering the residents' call lights and should notify specific staff members depending on the residents' needs. 10. Interview on 7/16/26 at 5:36 p.m. with administrator A revealed that she expected resident call lights to be answered as soon as possible, depending on the resident's needs. She reviewed the call-light reports weekly and conducted random audits of call light response times. 11. Review of the provider's revised 7/8/25 Call Light policy revealed the facility was required to ensure residents always had a method to call for assistance and that call lights were to be answered promptly.	F0684	**F0695 - Respiratory Care / CPAP Management** Resident #18's CPAP equipment, physician orders, care plan, and documentation will be reviewed by the DON or designee. Equipment condition, required supplies, resident tolerance, and current respiratory-care interventions will be verified and corrected as indicated. The DON or designee will complete a facility-wide review of residents receiving respiratory care, including CPAP, BiPAP, oxygen therapy, nebulizer treatments, and other respiratory devices.	**August 14th, 2026**
F0695 SS = D	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 interview, observation, record review, policy review, and manufacturer user guide review, the provider failed to ensure respiratory care was provided one of one sampled resident (18) who had a physician's order for Continuous Positive Airway Pressure (CPAP) therapy (a treatment for obstructive sleep apnea by delivering a steady, gentle stream of pressurized air through a tube and mask) when she slept, and could not use it due to the mask unsnapping during the night. Findings include: 1. Interview and observation on 7/14/26 at 11:19 a.m. with resident 18 in her room revealed that she was supposed to wear a CPAP mask at night when she slept. For the past couple of months, she was unable to wear that CPAP mask because the strap	F0695		

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F0695 SS = D	Continued from page 13 that held the CPAP mask on came "unsnapped" at night while she tried to sleep, and she could not tolerate wearing it. She felt that the mask coming unhooked and having to sleep without her CPAP therapy disrupted her sleep. She did not have a good night's sleep for the past couple of months. She could not remember which nurse she had informed that her CPAP mask came unsnapped and fell off when she slept. She had told them that she needed a new CPAP mask, but they said, "it's not time yet." 2. Review of resident 18's electronic medical record (EMR) revealed she admitted to the facility on 7/23/25. Her 6/30/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. Her diagnoses included sleep apnea (a common, potentially serious disorder where breathing repeatedly stops and starts during sleep), chronic obstructive pulmonary disease (COPD) (a group of lung diseases that block airflow and make it difficult to breathe), and coronary artery disease (CAD) (narrowing of the blood vessels of the heart that causes inadequate oxygen flow to the heart). She had a 7/23/25 physician's order to wear her CPAP mask, "on at HS [bedtime], off in AM," for her sleep apnea. A 5/11/26 nurse's progress note indicated "...resident's CPAP nasal mask has a tear in it and we are needing a replacement mask/head piece. Resident has a ResMed AirFit nasal mask (N20) size small. The head piece [headpiece] is attached to the nasal mask. Got the "after hours" answering service. They will message the office tomorrow and someone will be calling us back." Her CPAP mask was unable to be worn as ordered by the physician. A 6/18/26 nurse's progress note indicated that resident 18 was refusing to wear her CPAP mask. "Mask and tubing [were] hanging in [the] bathroom. Resident [18]'s roommate is [on] contact precautions [infection control measures used to prevent the spread of diseases that transmit through direct or indirect contact with an infected person or contaminated surfaces] and resident [18] states that [her] mask should not be hanging in [the] bathroom due to cross contamination. Resident verbally upset and wants to know which staff placed [her] mask and tubing in the bathroom. Mask removed from resident's room at this time. DON [director of nursing B was] updated on [the]incident. A 7/11/26 nurse's progress note indicated "Resident [18] states that her CPAP mask is not	F0695	All licensed nursing staff who perform respiratory care, including CPAP, BiPAP, oxygen therapy, or nebulizer treatment, will complete and document a competency validation to demonstrate proper technique, equipment handling, infection-control practices, and adherence to professional standards of practice. The Director of Nursing will develop and post a respiratory-care training schedule to ensure all licensed nursing staff complete the required competency validation by August 14, 2026.	August 14th, 2026

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F0695 SS = D	Continued from page 14 staying connected by the clips and velcro. It got "stuck" to her neck when staff put tape on it to keep it together and left a mark on her neck. Resident does have 2 [two] visible purplish marks to [the] left side of neck behind [her] ear. Resident [18] states that she cannot wear it, if it will continue to not stay on with the hardware. Writer addressed concern with Admin [administrator], DON via text to make aware of equipment." Resident 18's care plan (personalized plan that addresses a resident's care needs, goals, and interventions) indicated she had a goal to be free from signs and symptoms of complications of cardiac problems and wore a CPAP at night while she slept due to her altered cardiovascular status. She "has enhanced psychosocial well-being R/T [related to] individualized daily routine and honoring personal preferences: stating they had a good night's sleep, improved mood, expression of contentment, comfort and/or satisfaction, positive facial expressions, maintains activity interests, maintains positive relationships." 3. Interview and review of resident 18's progress notes on 7/16/26 at 12:13 p.m. with DON B revealed that she thought that resident 18's CPAP mask was replaced. She was not aware of the 5/11/26 documentation that indicated resident 18's CPAP mask was torn, and asked for time to follow up to find out what transpired after 5/11/26. 4. Interview on 7/16/26 at 4:13 p.m. with administrator A revealed that she thought clinical care leader (CCL) E had provided resident 18 with a new CPAP mask but was unable to find documentation of that. She expected that resident 18 would have been provided with a new CPAP mask when her CPAP mask was torn or would not stay on, so that she could wear her CPAP at night when she slept. Administrator A expected that when resident 18's mask was replaced, it would have been documented in her EMR. 5. Interview on 7/16/26 at 5:04 p.m. with DON B, registered nurse (RN)/Minimum Data Set (MDS) D and CCL E who participated by phone revealed CCL E was aware that resident 18 was having issues with her CPAP mask. She could not recall when she was first told about the CPAP mask being torn and coming unsnapped. RN/MDS D stated she had documented that she	F0695	The facility will verify that appropriate emergency backup respiratory supplies, including spare CPAP masks, tubing, filters, oxygen delivery components, and other resident-specific supplies as applicable, are available. Staff will follow required infection-control practices, including cleaning, disinfection, appropriate storage, and hand hygiene when handling respiratory equipment. Licensed nursing staff will be re-educated on routine inspection of respiratory equipment; reporting damaged or malfunctioning equipment; timely provider/vendor notification; monitoring resident tolerance; documentation; infection-control practices; and following current physician orders and individualized care plan interventions.	August 14th, 2026

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F0695 SS = D	Continued from page 15 contacted the oxygen supply company regarding resident 18's CPAP. She recalled the oxygen supply company sent nose pieces for the CPAP, and that she replaced the nose piece, but was unaware that the mask was coming unsnapped and that resident 18 was refusing to wear her CPAP at night because it disrupted her sleep. CCL E stated that she contacted the oxygen supply company on 7/13/26 about resident 18's CPAP but was unable to locate documentation of that call and did not receive confirmation that the replacement parts were ordered. 6. Review of the provider's reviewed 10/31/25 Non-Invasive Respiratory Support policy revealed "Inspect the device and be sure the enclosure is not broken, and all components are secure." 7. Review of the ResMed Air Sense 11 manufacturers undated user guide revealed that it referred to the mask's user guide for detailed information. That user guide was not provided before the survey exit.	F0695	Education and competency validation will be completed according to the posted respiratory-care training schedule. Staff unable to attend the initial training will complete make-up training and required competency validation prior to their next worked shift, with all required licensed nursing staff completing competency validation by August 14, 2026. The DON or designee will conduct ongoing audits of respiratory equipment, supplies, orders, care plans, documentation, resident tolerance, infection-control practices, and competency completion. Identified concerns will be corrected promptly. Audit results and trends will be reviewed through QAPI. **Compliance Date: August 14th, 2026**	**August 14th, 2026**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435098	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 07/16/2026

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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 7/16/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Good Samaritan Society Tyndall 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 K200 and K321 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000	The facility submits this Plan of Correction as an allegation of compliance. Preparation and submission of this Plan of Correction does not constitute an admission that the deficiencies identified during the survey exist or that the facility agrees with the survey findings. The facility submits this Plan of Correction as an allegation of compliance. Preparation and submission of this Plan of Correction does not constitute an admission that the deficiencies identified during the survey exist or that the facility agrees with the survey findings. K0200 - Means of Egress Requirements - Other The north exit door adjacent to the dietary department was immediately evaluated by the Maintenance Director. The magnetic locking system was reviewed and corrected to ensure the exit door complies with applicable Life Safety Code requirements. Required exit signage and release mechanisms, including the "Push to Exit" device and emergency release functions, were verified and corrected as necessary. The door was tested to ensure appropriate release during normal operation, power failure, and fire alarm activation. To identify other potentially affected areas, the Maintenance Director completed a 100% audit of all facility exit doors equipped with magnetic locking systems. Each door was inspected to verify: Proper labeling. Required release devices. Emergency release functions. Fire alarm interface. Power failure release. Compliance with applicable Life Safety Code requirements. Any identified deficiencies were corrected immediately. The facility revised its preventive maintenance program to include inspection and functional testing of all access-controlled exit doors. The Maintenance Director was re-educated regarding Life Safety Code requirements for magnetically locked egress doors, including: Required "Push to Exit" release devices. Required emergency signage. Fire alarm release requirements. Power failure release requirements. Documentation of inspections and testing. Timely correction of identified deficiencies. This education was completed by the administrator on August 5th, 2026. A Life Safety Door Inspection Checklist was implemented to ensure all magnetically locked exit doors are inspected according to the preventive maintenance schedule. The Maintenance Director or designee will inspect and test 100% of magnetically locked exit doors monthly for four consecutive months. The inspection will verify: Proper door operation. Function of "Push to Exit" release devices. Emergency release upon fire alarm activation. Emergency release upon power failure. Appropriate signage. Proper documentation of testing. Results will be documented on the Life Safety Door Inspection Log. Audit results will be reported monthly by the Maintenance Director to the Administrator and QAPI Committee for four consecutive months. The QAPI Committee will review compliance rates, identify trends, and direct additional corrective action if deficiencies are identified. Compliance Date: August 14th, 2026	08/14/2026
K0200 SS = D Bldg. 01	Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 This STANDARD is NOT MET as evidenced by: Based on observation, testing, and interview, the provider failed to provide egress doors as required at one of one location (north EXIT door). Findings include: 1. Observation on 7/16/26 at 10:39 a.m. revealed the exterior north marked EXIT door adjacent to the dietary area was equipped with a magnetic lock that prevented egress. The door was not labeled as a delayed egress locked door. The door was equipped with a keypad to release the magnet (not compliant for a required EXIT door). The door was not equipped with a 'Push to Exit' button to release the magnet to comply with an access-controlled	K0200		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the ins safeguards provide sufficient protection to the patients. (See reverse for further instruct 90 days following the date of survey whether or not a plan of correction is provided. Fo 14 days following the date these documents are made available to the facility. If deficie program participation.

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shalee Pitman	Administrator	08/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435098	A. BUILDING **01 - MAIN BUILD...** B. WING	**07/16/2026**

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K0200 SS = D Bldg. 01	Continued from page 1 magnetically locked door. The door could not be tested due to the magnetic locking system being out of service the day of the survey. Interview with the maintenance director at the time of the observation confirmed that condition. Failure to provide egress doors as required increases the risk of death or injury due to fire or other emergencies. The deficiency affected one of three marked EXIT doors with magnetic locks. Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6.1(3)	K0200		
K0321 SS = D Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces	K0321	The facility submits this Plan of Correction as an allegation of compliance. Preparation and submission of this Plan of Correction does not constitute an admission that the deficiencies identified during the survey exist or that the facility agrees with the survey findings. K0321 - Hazardous Areas - Enclosure The kitchen pantry storage room corridor door was repaired and adjusted to ensure the door self-closes and positively latches upon closing in accordance with applicable Life Safety Code requirements. To identify other potentially affected areas, the Maintenance Director completed a 100% inspection of hazardous area doors throughout the facility, including storage rooms, laundry rooms, utility rooms, housekeeping rooms, soiled utility rooms, mechanical rooms, and other identified hazardous areas. Each door was tested to verify proper self-closing and positive latching. Any deficiencies identified during the inspection were corrected immediately. The facility revised its preventive maintenance program to include routine inspection and functional testing of all hazardous area doors. The Maintenance Director was re-educated regarding Life Safety Code requirements related to hazardous area enclosures by the administrator, Shalee Pitman, on Wednesday, August 5th, 2026, including: Self-closing door operation, Positive latching requirements. Identification of hazardous areas. Documentation of inspections and repairs. Prompt correction of identified deficiencies. A Hazardous Area Door Inspection Checklist was implemented to ensure all hazardous area doors are inspected according to the preventive maintenance schedule. The Maintenance Director or designee will inspect 100% of hazardous area doors monthly for four consecutive months. The inspection will verify: Proper self-closing function. Positive latching. Door integrity. Hardware functionality. Absence of obstructions preventing closure. Findings will be documented on the Hazardous Area Door Inspection Log. Audit findings will be reported monthly by the Maintenance Director to the Administrator and QAPI Committee for four consecutive months. The QAPI Committee will review compliance rates, identify trends, and direct additional corrective action if deficiencies are identified. Compliance Date: August 14th, 2026	08/14/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0321 SS = D Bldg. 01	Continued from page 2 (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation, testing, and interview, the provider failed to maintain the kitchen pantry storage room corridor door (would not self-close and latch) for the Harbor wing. Findings include: 1. Observation on 7/16/26 at 10:45 a.m. revealed the corridor door for the kitchen pantry storage room was standing ajar. Testing of the door at the time of the observation revealed the door would not self-close and latch. Interview with the maintenance director at the time of the observation confirmed that finding. The deficiency affected one of numerous requirements for hazardous rooms.	K0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435098	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/16/2026

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E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 7/16/26. Good Samaritan Society Tyndall was found not in compliance with the following requirements: E004, E013, and E030.	E0000	The facility submits this Plan of Correction as an allegation of compliance. Preparation and submission of this Plan of Correction does not constitute an admission that the deficiencies identified during the survey exist or that the facility agrees with the survey findings. The facility submits this Plan of Correction as an allegation of compliance. Preparation and submission of this Plan of Correction does not constitute an admission that the deficiencies identified during the survey exist or that the facility agrees with the survey findings. E0004 - Emergency Plan Develop Emergency Preparedness Plan, Review and Update Annually The Emergency Preparedness (EP) Plan and Emergency Preparedness Binder were immediately reviewed to ensure all required components were present and current. The Emergency Preparedness Plan was revised to include all required regulatory elements and documentation of the annual review. The updated plan was placed in the Emergency Preparedness Binder maintained in the Administrator's office. To identify other areas potentially affected by the deficient practice, the Administrator completed a comprehensive review of the Emergency Preparedness Program, including the Emergency Preparedness Plan, Hazard Vulnerability Assessment, Emergency Operations Plan, Communication Plan, supporting documentation, and annual review requirements. Any identified deficiencies were corrected immediately. The Administrator completed a comprehensive review of the facility's Emergency Preparedness Program to determine whether other areas were potentially affected by the deficient practice. The review included: Emergency Preparedness Plan. Hazard Vulnerability Assessment. Emergency Operations Plan. Communication Plan. Emergency Preparedness Binder. Supporting Emergency Preparedness documentation. Annual review and update requirements. Any identified deficiencies were corrected as applicable. The Administrator was re-educated by Senior Director, Alex Dysthe, regarding CMS Emergency Preparedness regulations, including annual review requirements, documentation expectations, required components of the Emergency Preparedness Plan, and maintenance of the Emergency Preparedness Binder. The facility implemented an Emergency Preparedness Annual Compliance Calendar and Checklist requiring review of the Emergency Preparedness Plan each August and whenever operational changes require revisions. The checklist will document completion of the required review, identification of necessary updates, completion of revisions, and verification that the updated documents are maintained in the Emergency Preparedness Binder. The Administrator or designee will complete a 100% review of the Emergency Preparedness Binder monthly for four consecutive months to verify that all required documents are present, current, and consistent with the facility's Emergency Preparedness Plan. The audit will verify: Completion of the Emergency Preparedness Plan review. Current Hazard Vulnerability Assessment. Required annual documentation. Accuracy and currency of supporting Emergency Preparedness documents. Completion of the Emergency Preparedness Annual Compliance Checklist. Results will be documented on the Emergency Preparedness Audit Tool. Audit results will be reported monthly by the Administrator to the Quality Assurance and Performance Improvement (QAPI) Committee for four consecutive months. The QAPI Committee will review compliance rates, identify trends, and direct additional education or corrective action when deficiencies are identified. Compliance Date: August 14th, 2026	08/14/2026
E0004 SS = D	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an	E0004		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the ins safeguards provide sufficient protection to the patients. (See reverse for further instruct 90 days following the date of survey whether or not a plan of correction is provided. Fo 14 days following the date these documents are made available to the facility. If deficie program participation.

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shalee Pitman	Administrator	08/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435098	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/16/2026

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E0004 SS = D	Continued from page 1 emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is NOT MET as evidenced by: Findings include: 1. Record review revealed that the facility's Emergency Preparedness binder located in the administrator's office was not updated annually in 2024 and 2025. Interview with the administrator at the time of the record review confirmed that finding. The deficiency could affect 100% of the building occupants.	E0004		
E0013 SS = D	Development of EP Policies and Procedures CFR(s): 483.73(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.	E0013	with the survey findings. The facility submits this Plan of Correction as an allegation of compliance. Preparation and submission of this Plan of Correction does not constitute an admission that the deficiencies identified during the survey exist or that the facility agrees with the survey findings. E0013 - Emergency Preparedness Policies and Procedures Development of Emergency Preparedness Policies and Procedures The Emergency Preparedness policies and procedures were reviewed to ensure consistency with the facility's Emergency Preparedness Plan, Hazard Vulnerability Assessment, and Communication Plan. The Emergency Preparedness Binder was reviewed, and missing or outdated documentation was updated. The Memorandum of Understanding (MOU) for emergency water supply was reviewed and updated to ensure current emergency resources were available. To identify other potentially affected areas, the Administrator completed a comprehensive audit of all Emergency Preparedness policies, emergency agreements, vendor contracts, MOUs, and supporting documentation to verify compliance with CMS Emergency Preparedness requirements. The review included verification that emergency agreements and supporting documentation were current and available for use during an emergency. Any identified deficiencies were corrected immediately. The Administrator was re-educated by Senior Director, Alex Dysthe, regarding: Annual review of Emergency Preparedness policies. Maintaining current emergency agreements and Memoranda of Understanding. Verification of emergency resources and vendor agreements. Documentation requirements for Emergency Preparedness compliance. Maintaining consistency between Emergency Preparedness policies and the Emergency Preparedness Plan. An Annual Emergency Preparedness Review Schedule and Tracking Tool was implemented requiring verification of all Emergency Preparedness policies, agreements, MOUs, and supporting documentation each August and following any significant operational changes. The Administrator or designee will complete a 100% audit of the Emergency Preparedness Binder quarterly for four consecutive quarters. The audit will verify: Current Emergency Preparedness policies. Active and current emergency agreements and MOUs. Current emergency resources and vendor agreements. Documentation supporting Emergency Preparedness requirements. Consistency between Emergency Preparedness policies and the Emergency Preparedness Plan. Completion of required annual reviews and updates. Audit findings will be documented using the Emergency Preparedness Policy Audit Tool. Results will be reported quarterly by the Administrator to the QAPI Committee for four consecutive quarters. The QAPI Committee will review compliance rates, identify trends, and direct additional education or corrective action when deficiencies are identified. Compliance Date: August 14th, 2026	08/14/2026

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E0013 SS = D	Continued from page 2 *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is NOT MET as evidenced by: Findings include: 1. Record review revealed that the facility's Emergency Preparedness binder located in the administrator's office did not contain an updated Memorandum of Understanding (MOU) for an emergency water supply. The last updated MOU for water supply was dated 3/17/22. Interview with the administrator at the time of the record review confirmed that finding. The deficiency could affect 100% of the building occupants.	E0013	with the survey findings. The facility submits this Plan of Correction as an allegation of compliance. Preparation and submission of this Plan of Correction does not constitute an admission that the deficiencies identified during the survey exist or that the facility agrees with the survey findings. E0030 - Emergency Preparedness Communication Plan Names and Contact Information The Emergency Preparedness Communication Plan was immediately reviewed and updated to include current employee contact information. The revised employee contact list was placed in the Emergency Preparedness Binder maintained in the Administrator's office. To identify other potentially affected areas, the Administrator completed a comprehensive audit of the Emergency Preparedness Communication Plan to verify current contact information for: Facility employees. Physicians. Contracted service providers. Emergency management agencies. Other required emergency contacts. Any outdated or missing contact information was corrected. The Administrator was re-educated by Senior Director, Alex Dysthe, regarding Emergency Preparedness communication requirements, including maintaining current employee contact information, updating contact lists following staffing changes, annual review of Emergency Preparedness communication documents, and maintaining required communication information within the Emergency Preparedness Binder. A standardized Employee Contact Verification Log was implemented requiring review of contact information monthly and following staffing changes. The Administrator or designee will complete a 100% audit of the Emergency Preparedness Communication Plan monthly for four consecutive months. The audit will verify: Current employee contact information. Current physician contact information. Current contracted service provider information. Required emergency agency contacts. Required communication documentation. Completion of required updates following staffing changes. Results will be documented on the Emergency Preparedness Communication Audit Tool. Results will be reported monthly by the Administrator to the QAPI Committee for four consecutive months. The QAPI Committee will review compliance rates, identify trend and implement additional corrective actions when indicated. Compliance Date: August 14th, 2026	08/14/2026
E0030 SS = D	Names and Contact Information CFR(s): 483.73(c)(1)	E0030		

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	435098	A. BUILDING B. WING	07/16/2026

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E0030 SS = D	Continued from page 3 §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: (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.	E0030		

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E0030 SS = D	Continued from page 4 (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. *[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.	E0030		

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E0030 SS = D	Continued from page 5 (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: Findings include: 1. Observation and record review revealed that the facility's Emergency Preparedness binder located in the administrator's office did not contain a list of the employees' contact information. A list was found to be located with other documentation at the nurses' station. An interview with the administrator at the time of the record review confirmed that finding. The deficiency could affect 100% of the building occupants.	E0030		