STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435104	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 SOUTH MADISON POST OFFICE BOX 327, NEW UNDERWOOD, South Dakota, 57761

(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 12/1/25 through 12/4/25 and on 12/8/25. Good Samaritan Society New Underwood was found not in compliance with the following requirements: F550, F565, F657, F658, F689, F732, F812, F865, and F880.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F0550	1. Unable to correct past deficient practice. Resident 1 and Resident 3 are currently receiving cares according to their preferences regarding resident rights. RN F was verbally educated during survey by Director of Nursing. RN F is scheduled to complete 3 day nursing onboarding training course on 1/6/26-1/8/26. 2. All residents are at risk for deficient practice. During angel rounds, two weeks post survey, no residents identified resident concerns with resident rights related to cares. 3. Education provided by Director of Nursing to all staff including ancillary staff to include closing doors, window curtains, and privacy curtains during cares. Clinical Learning and Development Specialist will skills validate nurses regarding privacy, closing doors, curtains, and widows during cares. 4. DON/designee will audit staff interactions with residents, including personal cares and treatments to ensure privacy and dignity are maintained 3x's/week for 1 month, then 2x' s/week for 2 months then 1x'week for 1 month. Audits will be taking to QAPI by DON/designee monthly for 4 months for Interdisciplinary team review and revision as warranted.	1/14/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	LNHA	12/30/2025

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F0550 SS = D	Continued from page 1 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure the staff protected the resident's right to personal privacy for: *One of one sampled resident (1) during administration of her medications through an alternative method by one of one registered nurse (RN) (F). *One of one sampled resident (3) during her skin treatment by one of one RN (F). Findings include: 1. Observations on 12/1/25 at 2:20 p.m. of registered nurse (RN) F in resident 1's room revealed that resident 1 was seated in her wheelchair facing the television. A window on the left side of the resident faced a parking lot and a road. The door to her semi-private room was open to the hallway on her right side. Resident 1's roommate was lying in bed and could see resident 1. Without closing the room door, drawing the privacy curtain between resident 1 and her roommate, or closing the window curtain, RN F lifted the front of resident 1's shirt, exposed the resident's abdomen to reach her feeding tube (a tube surgically placed in the abdomen for administration of liquid nutritional formula). After RN F flushed the feeding tube with water, she lowered the resident's shirt and exited the room. 2. Observation on 12/1/25 at 5:15 p.m. of RN F with resident 3 and in her room revealed RN F closed the resident's door after she entered the private room. The resident was lying in her bed. There was a window facing a parking lot and a road to the resident's right side. Clinical care leader (CCL C was present in the resident's room. Without first drawing the window curtain closed, RN F lifted the resident's shirt, exposing her abdomen, and	F0550		

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F0550 SS = D	Continued from page 2 began the resident's skin treatment. CCL C asked resident 3 if she wanted the curtain closed while her care was provided, and the resident responded "yes." The window curtain was closed, and the skin treatment was completed. 3. Observations on 12/3/25 at 9:32 a.m. of RN F with resident 1 and in her room revealed: *The resident was seated in her wheelchair watching television when RN F knocked and entered the semi-private room. *The resident's roommate was lying in her bed, and the privacy curtain between the residents was open, which allowed her to see resident 1. *The curtains and blinds on the window were open to a view of the outside, and the door to the room was left open to the hallway. *Without closing the room door, drawing the privacy curtain between resident 1 and her roommate, or closing the window curtain, RN F lifted her shirt, exposed her abdomen and feeding tube, and administered the resident's scheduled water flushes and medications through that tube. 4. Observation 12/3/25 at 12:45 p.m. of registered nurse (RN) F in resident 1's room revealed that resident 1 was seated in her wheelchair facing the television. A window on the left side of the resident faced a parking lot and a road. The door to her semi-private room was open to the hallway on her right side. Without closing the room door or closing the window curtain, RN F lifted the front of resident 1's shirt and exposed the resident's abdomen to reach her feeding tube. After RN F flushed the feeding tube with water, she lowered the resident's shirt and exited the room. 5. Interview on 12/2/25 at 10:30 a.m. with CCL C regarding the above observation revealed RN F was expected to have maintained resident 1's privacy by closing the resident's window curtain before she started the resident's skin treatment. 6. Interviews on 12/3/25 at 12:45 p.m. and on 12/4/25 at 1:59 p.m. with RN F regarding the above observations	F0550		

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F0550 SS = D	Continued from page 3 with residents 1 and 3 revealed she agreed she had not protected their privacy during their personal care when she had not closed the room door, drawn the privacy curtain, or closed the window curtains before providing those residents' care. 7. Interview on 12/4/25 at 8:30 a.m. with DON B regarding the above observations revealed she expected the staff to protect all residents' right to privacy and dignity when providing care and treatments. That included closing room doors, window curtains, and privacy curtains. Review of the provider's revised 12/11/2024 Resident Dignity policy revealed: *"Purpose:" -"To maintain the dignity of all residents." -"To promote, encourage, support and enhance the residents' self-esteem." -"To promote a sense of self-worth." -"To assist with respecting and ensuring resident rights." *"Policy:" -"The location will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality." *"Procedure:" -"….e. Respecting resident's private space and property." Review of the provider's 10/4/16 Resident's Rights For Skilled Nursing Facilities revealed: *"Resident Rights:" -"(a) The resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including each of the following rights:"	F0550		

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F0550 SS = D	Continued from page 4 -"(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident." -".....(h) The resident has the right to personal privacy and confidentiality regarding his or her personal and medical records." -"(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident."	F0550		
F0565 SS = E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.	F0565	1. Unable to correct deficient practice. Resident #15 was updated by Licensed Social Worker about change in grievance process. 2.All residents with grievances/concerns are at risk for deficient practice. Licensed Social Worker/Director of Nursing audited all grievances from past 6 months were audited to ensure all concerns were addressed. 3. Education provided to all staff by Director of Nursing regarding expectation of grievance mitigation, intervention and review. Those staff unable to attend the scheduled training will be trained by next scheduled shift. Clinical Care Leader or designee will track education completion and next scheduled shift. Tracking log updated to identify documentation of intervention and follow up. 4. Licensed Social Worker will audit all grievances weekly x 4, then monthly x 4. Audits will be taking to QAPI by Licensed Social Worker monthly for 4 months for Interdisciplinary team review and revision as warranted.	1/14/25

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F0565 SS = E	Continued from page 5 §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on interview, review of Resident Council minutes, and policy review, the provider failed to ensure that grievances regarding long call light response wait times reported at resident council meetings were addressed and documentation reflected: *The staff's efforts to resolve those grievances. *Efforts to resolve those grievances were approved as effective resolutions by the resident council. Findings include: 1. Interview on 12/2/25 at 10:45 a.m. and again on 12/8/25 at 12:15 p.m. with resident 15 revealed she was an active resident council participant. The group had monthly meetings. The council's concern since May 2025 was long call light response times, especially during the late afternoon and early evening hours. That response time ranged between 30 minutes to one hour. Resident 15 was able to move within the facility independently, use her call light, and verbally advocate for herself. She felt the call light response times did not impact her as much as other residents, like her roommate. Her roommate had significant physical and verbal impairments. Sometimes, resident 15 activated her own call light to seek assistance for her roommate when her roommate's call light was unanswered by staff for extended periods of time. Resident 15 said director of nursing (DON) B and administrator A attended past resident council meetings to address the ongoing call light response time concern. Their response to the council was "people don't want to work." Resident 15 stated that the council was not updated about changes that were implemented to mitigate or resolve the call light response time concern. Reporting the same call light response time concern month after month during resident council meetings without any known attempts to resolve the issue made her feel like the council's concern was not listened to or addressed by the management team. 2. Review of the provider's June 2025 through November 2025 Suggestion or Concern forms revealed:*On 6/19/25, the resident	F0565		

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F0565 SS = E	Continued from page 6 council "expressed concerns lengthy call light wait times in the evening hours."Investigation: "Will discuss in All Staff meeting."Resolution: Wait times were identified as occurring during the evening shift change, which coincided with the evening meal. "Encourage staff to answer [the call light], reset [the] call light, and give [the resident] approx [approximate] time of return." "Will audit call lights if this comes up in Aug [August] 2025."Follow-up: The resident council indicated call light wait times remained a concern, and a new Concern form was completed. The above-written response was "declined" by the council. *On 7/17/25, "Concerns expressed [by the resident council] with long call light wait times during evening and weekend hours, indicating they can wait 30+ [30 or more] minutes at a time."Investigation: "[Call light wait time] Continues to be a concern for certain residents regardless of staffing, or improvements made in schedule/evening routine."Resolution: "Continue [to have] staff assess and anticipate needs for residents who require assistance and are dependent [on staff]. Answer call lights timely and have positive interactions [with residents]."Follow-up: The resident council indicated call light wait times remained a concern, and a new Concern form was completed. The above-written response was "declined" by the council. *On 8/21/25, "Concerns expressed [by the resident council] with long call light wait times during evening hours indicating they can wait for 30+ minutes at a time."Investigation: "Residents [in their rooms] want to go to bed or have assistance when [other] residents are still in [the] dining room."Resolution: "Continue to encourage staff to anticipate needs and assist residents who request assistance in a timely manner."Follow-up: The resident council indicated call light wait times remained a concern in the evening, and a new Concern form was completed. The above-written response was "declined" by the council. *On 9/18/25, "Concerns expressed [by the resident council] with long call light wait times during evening hours indicating they can wait for 30+ minutes at times, also communicated during evening shift change they are being told someone will be back and no one comes back."Investigation: "High traffic times in evening hours-during HS [evening] cares and ADL [activities of daily living] completion."Resolution: Staff were educated "about returning to resident room if they are told you will be back. This instills a trusting relationship [between staff and residents]".Follow-up: Not completed. *On 10/15/25, the resident council reported "lengthy call light wait times in the evening hours."Investigation: "Call light audits ongoing. Meal times become lengthy. Will continue to encourage staff to make rounds and	F0565		

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F0565 SS = E	Continued from page 7 assist all residents in rooms and prior to assisting [residents] in [the] dining room."Resolution: "Call light wait times have been a continued issue during meal times-no complaints after [the] kitchen is done serving. Educate/encourage staff to assist resident [residents who are] in [their] rooms prior to assisting [residents] in dining room."Follow-up: "Dietary will also be encouraged to answer call lights during meal time/room tray delivery." *On 11/20/25, the resident council "Expressed concerns with lengthy call light wait times in the evening."Investigation: "Call light times reflective of completion of dinner and when residents want to go to bed. Additional staff added [hired] to mitigate during assisting with meals."Resolution: "Will continue to encourage collaboration with dietary staff to minimize downtime during dinner."Follow-up: "Continue to monitor processes weeks and [during] QAPI [Quality Assessment and Performance Improvement] review." 3. Interview on 12/2/2025 4:13 p.m. and again on 12/8/25 at 9:00 a.m. with social services supervisor (SSS) D revealed it was her responsibility to document resident council concerns on the Suggestion/Concern form. She routed those forms to the appropriate department head for their investigation, resolution, and/or recommendations regarding that grievance. SSS D reviewed the department head's responses with the resident council at their meetings. Administrator A completed the final review and sign-off (review and approve) of those forms. He was the facility's grievance official. Regarding action plans that had been developed and implemented in response to the Council's ongoing concern regarding call light response times, SSS D stated, "I don't know that anything other than education and trying to get more staff" had occurred. 4. Interview on 12/8/25 at 10:15 a.m. with administrator A revealed that he was the grievance official. It was his responsibility to ensure prompt resolution to grievances occurred. He stated the long call light wait response times occurred around the evening shift change and at the time when residents were being prepared for, taken to, and assisted in the dining room. Some residents chose to eat their evening meal in their rooms. That made it difficult for the staff in the dining room to answer their call lights activated during the meal service. After the meal service, residents wanted assistance with their evening needs so they could go to bed. The 6:00 p.m. to 6:00 a.m. shift usually had three caregivers who were either licensed nurses or certified nurse aides on duty. The facility added a 6:00 p.m. to 10:30 p.m. staff shift to support the evening staff; however, that position was unfilled. Staff were educated regarding the facility's expectation for answering resident call lights. Dietary staff were	F0565		

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F0565 SS = E	Continued from page 8 asked to assist residents with non-care requests when they delivered evening meals to those residents who chose to eat in their rooms. Administrator A confirmed there was no data to support how or if these interventions had been effective in lessening the call light response times in the evening. Administrator A stated that two evenings per week, he was working from noon to 8:00 p.m. to support the evening shift staff. Changing the times of meals, medication administration, treatments, and/or residents' evening cares was not discussed or attempted as a potential resolution to the residents' call light response complaints. Administrator A knew there were a few residents who routinely activated their call lights even if staff had just answered their call lights. The facility attempted to regularly check in with these residents before they activated their call light. There was no data to support whether this intervention was effective. Administrator A agreed that the June 2025 through November 2025 Suggestion/Concern forms did not include detailed resolution efforts, or that efforts were effective to resolve the resident council's evening call light response time grievance. 5. Review of the provider's 12/2/24 Grievances, Suggestions or Concerns policy revealed: *Definition:-The Grievance Official was "responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility...." -"Prompt efforts to resolve-facility acknowledgment of a grievance and actively working toward a resolution of the grievance."*Procedure:-"7. An investigation must be completed for all grievances." -8. The grievance official was expected to issue a written grievance decision to the individuals filing the concern that included "...the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued."-"10. If the individual is not satisfied with the response and/or resolution to the grievance or concern, the grievance official will notify the administrator."	F0565		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F0609		

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F0609 SS = D	Continued from page 9 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to: *Report an incident to the South Dakota Department of Health (SD DOH) for one of one sampled resident (5) who left the facility without staff knowledge (eloped) on 11/24/25. Findings include: Refer to citation writing at F689.	F0609	1.Unable to correct deficient practice. DOH aware of Resident #5 elopement during survey. Resident # 5 has not had any further elopement attempts. 2. All residents at risk for elopement are at risk for deficient practice by reporting standards. LSW audited all elopement and reportable type events in last 60 days to ensure all reports were made to DOH as warranted. No other events noted that had not been properly reported. 3. All staff educated by DON on Elopement reporting process and timeline regarding allegations to DOH. Clinical Care Leader or designee will track education completion and next scheduled shift. 4. DON or Designee will audit all elopements to ensure reporting to DOH weekly x 4, monthly x 4, and DON/designee will report to QAPI monthly x 4 for interdisciplinary team review and revision as warranted.	1/14/26
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F0657		1/14/26

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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
F0657 SS = D	Continued from page 10 (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, interview, record review, and policy review, the provider failed to ensure the care plans were reviewed and revised to reflect the current care needs for four of six sampled residents (5, 12, 19, and 20).Findings include: 1. Observation and interview on 12/1/25 at 2:11 p.m. in the north hall with resident 20 in her room revealed: *Resident 20 was in her room, sitting in her wheelchair with her feet resting on the wheelchair foot pedals. *Resident 20 stated she was unable to walk due to a broken left leg and that she had open sores on her heels. *There was a pair of black and gray soft padded boots on top of her bed. -She stated she was supposed to wear them throughout the day, but she didn't like them. *There was no precaution sign posted outside or inside the door of her room related to the open sores on her heels. *There was no personal protective equipment (PPE), such as gloves and gowns, available for use inside resident	F0657		

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F0657 SS = D	Continued from page 11 20's room or near her door. 2. Review of resident 20's electronic medical record (EMR) revealed: *She had a pressure sore (injury to skin and underlying tissue from prolonged pressure) on her left heel that resolved on 9/17/25. *She was receiving wound care treatment twice weekly and as needed for an open traumatic wound on her left heel that occurred on 10/22/25. *A 10/23/25 physician's order for her to wear the heel protector boots as needed for healing and protection. *A 5/7/25 physician's order for her to weight-bear as tolerated, with toe touch (touching toes on the floor to balance without bearing weight) on the left lower leg. 3. Review of resident 20's current care plan (personalized plan that addresses a resident's care needs, goals, and interventions) dated 11/6/25 revealed: *An initial focus area identified on 5/8/25 for activities of daily living and self-care performance deficits related to her history of a left femur fracture. *An intervention initiated on 8/6/25 for her bilateral heel lift boots to be worn at all times, except during transfers for pressure relief. *An intervention for transfers initiated on 8/14/25 for her to use a sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position) with the assistance of one staff person. *An initiated 9/24/25 focus area on the potential for skin impairment related to dementia, obesity, poor bed mobility, evidenced by need for a sit-to-stand lift for transfers, inability to reposition independently, and protein-calorie malnutrition. *Her care plan was not updated to reflect that she was to weight-bear as tolerated, with toe-touch on the left lower leg. *Her care plan was not updated to reflect that she was to use heel protector boots on both of her heels.	F0657	1. Immediate intervention: Care plans updated for resident 20, 19, 12, 5. Correct signage applied to all EBP rooms during survey by DON. 2. All resident with EBP are at risk and audited. Care plans updated during survey. 3. Education provided by Director of Nursing to all nursing staff regarding care plan interventions and EBP requirements. Clinical Care Leader or designee will track education completion prior to next scheduled shift. Kardex will reflect all residents on EBP and will be updated/managed by DON/designee. Situations requiring EBP posted at Nurses Station for reference. 4. Director of Nursing/ designee will audit all EBP resident rooms for appropriate signage, PPE, and trash locations weekly x 4, monthly x 4, and quarterly x 1. Director of Nursing/designee will report to QAPI monthly x 4 for interdisciplinary team review and revision as warranted.	1/14/26

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F0657 SS = D	Continued from page 12 *Her care plan was not updated to reflect her treatment needs for her left open heel traumatic wound. *Her care plan did not include a focus area, goal, or interventions for enhanced barrier precautions, which require glove and gown use when providing contact care (EBP) related to her open wound on her left heel. 4. Observation on 12/1/25 at 2:34 p.m. in the north hall outside resident 19's room revealed: *There was a white three-drawer bin in the hall next to resident 19's door. *It was stocked with gowns, gloves, and red trash bags. *There were two precaution signs posted on the door of her room. -A sign for contact precautions (measures used to prevent spreading germs through direct touch or touching contaminated surfaces). -A sign for enhanced barrier precautions. 5. Interview on 12/1/25 at 3:15 p.m. with DON B revealed: *Resident 19 was on EBP as a precaution because of Methicillin-resistant Staphylococcus aureus (MRSA) in her urine from 11/1/20. Resident 19's care plan dated 11/15/25 was not updated to reflect that she was on EBP. 6. Observation on 12/1/25 at 2:42 p.m. in the north hall outside resident 12's room revealed: *There was a white three-drawer bin and a large white trash can with a lid in the hall next to resident 12's door. *It was stocked with gowns, gloves, and red and white trash bags. *There was no precaution sign posted outside or inside the door of his room. 7. Interview on 12/1/25 at 3:15 p.m. with director of	F0657		

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F0657 SS = D	Continued from page 13 nursing (DON) B revealed: *Resident 12 was on EBP as a precaution because he tested positive for MRSA in his nares.in March 2023. Resident 12's care plan dated 10/7/25 was not updated to reflect that he was on EBP. 8. Observation and interview on 12/2/25 at 8:46 a.m. with resident 5 in his room revealed: *An oxygen concentrator (a device that filters room air into purified oxygen) at the foot of his bed with oxygen tubing in a plastic bag secured to it. -The concentrator was shut off. * He stated that he wore his oxygen whenever he wanted and he decided when he would wear it. *He was sitting in his wheelchair, ready to go out for breakfast. * He left his room to attend breakfast and was not wearing oxygen. 9. Review of resident 5's EMR revealed: *He had a physician's order for oxygen to be administered at a rate of two liters per minute via nasal cannula (tubing with prongs that deliver oxygen into the nose), titrated (adjusted) to keep his oxygen saturation level (percent of oxygen in the blood) between 88 and 92% every shift. *He exhibited behavioral and mood changes frequently and would often resist wearing his oxygen. 10. Review of resident 5's care plan dated 11/28/25 revealed: *His care plan had not been updated to reflect his oxygen, his refusal to wear oxygen, and interventions for staff to try when he refused to wear his oxygen. 11. Interview on 12/8/25 at 10:40 a.m. with Minimum Data Set (MDS)/registered nurse (RN) I revealed: *She completed the residents' care plans when they admitted to the facility, and updated the care plans	F0657		

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F0657 SS = D	Continued from page 14 quarterly or when there was a significant change in a resident's status. *She agreed that the residents' care plans should be person-centered. *She would receive residents' changes or updates from staff during "huddle" or "stand up" meetings held every morning. *She would update resident care plans with the information she received from the meetings that same day. *She agreed that resident 5's use of oxygen should have been included in his care plan as an intervention for his ADL and fall risk areas, but was not. 12. Interview on 12/1/25 at 3:15 p.m. and again on 12/8/25 at 11:10 a.m. with director of nursing (DON) B revealed: *She confirmed that the care plans for residents 20, 19, 12, and 5 had not been updated to reflect their current needs. *She expected resident's care plans to be reviewed and updated by MDS/RN I to reflect their current care needs. Review of the providers revised 1/31/25 Comprehensive Care Plan and Care Conferences policy revealed: *"Purpose:" -"To develop a person-centered care plan for each resident that includes measurable objectives and timetables to meet his or her physical, mental, spiritual, and psychosocial well-being." -"To provide an ongoing method of assessing, implementing, evaluating, and updating the resident's care plan to help maintain the resident's highest practicable level of function, including culturally competent and trauma-informed care." *"Definitions:" -"Responsible Employees:" --"MDS coordinator (MDS coordinator or designated employee);"	F0657		

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F0657 SS = D	Continued from page 15 --"Care plan coordinator (social worker or designated employee)."	F0657	1. Unable to correct deficient practice . RN F educated during survey by DON on following physician's orders for skin/wound treatment. RN F was verbally educated during survey by Director of Nursing. RN F is scheduled to complete 3 day nursing onboarding training course on 1/6/26-1/8/26. RN H is no longer employed with GSS New Underwood. 2. All residents with treatments are at risk for deficient practice. 3. Education provided to nurses by Director of Nursing regarding following physicians orders and treatment completion and medication administration documentation. Clinical Learning and Development Specialist/designee will validate skills to all nurses regarding treatment completion, physician's orders and documentation compliance. Clinical Care Leader or designee will track education completion prior to next scheduled shift. During morning clinical meeting, medication administration/documentation will be reviewed by DON/designee for completion. 4. Director of Nursing/designee will audit treatment and documentation completion weekly x 4, monthly x 4 and Director of Nursing /designee will report to QAPI monthly x 4 for interdisciplinary team review and revision as warranted.	1/14/26
F0658 SS = E	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- (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 that nursing professional standards were followed by: *One of one observed registered nurse (RN) (F) who did not following the physician's order for one of one sampled resident (3) during a skin wound treatment. *One of one RN (H) who did not document if three doses of an antibiotic were administered to one of one sampled resident (3) as ordered. Findings include: 1. Interview on 12/1/25 at 1:30 p.m. with resident 3 revealed she was hospitalized in September 2025 because her suprapubic catheter (flexible tubing surgically placed through the abdomen into the bladder to drain urine) was not working properly. She required intravenous (IV) antibiotics after she was discharged from the hospital and returned to the facility. 2. Review of resident 3's electronic medical record (EMR) revealed that on 9/25/25, she was transferred to the emergency department (ED) for evaluation of a "non-functioning catheter." She was admitted to the hospital and treated for septic shock (a severe infection that triggers a life-threatening emergency). Resident 3 was discharged from the hospital and returned to the facility on 10/3/25. Her hospital discharge orders included two IV antibiotics. One of those antibiotics, Daptomycin, was scheduled for administration every 48 hours for ten days. The second antibiotic, Zosyn, was scheduled for administration two	F0658		

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F0658 SS = E	Continued from page 16 times a day (at 6:00 a.m. and 6:00 p.m.) for 11 days. That was a total of 22 Zosyn administrations. Resident 3's October 2025 medication administration record (MAR) revealed that the Daptomycin was documented as having been administered as ordered. There was no documentation to support that the resident was administered her morning doses of Zosyn on 10/5/25, 10/9/25, or 10/11/25. 3. Interview on 12/4/25 at 12:45 p.m. with director of nursing (DON) B revealed the facility received 22 doses of Zosyn from the pharmacy, and none of those doses had been returned to the pharmacy. DON B determined registered nurse (RN) M was responsible for administering and documenting the 10/5/25, 10/9/25, and 10/11/25 morning Zosyn doses. The facility no longer employed RN M. DON B stated she had interviewed resident 3 regarding the above post-hospital IV antibiotic administrations. She stated resident 3 had known what her post-hospital IV antibiotic medications and administration schedule were. Resident 3 confirmed that she had not missed any of those IV antibiotic administrations. DON B believed resident 3's morning Zosyn doses were administered on 10/5/25, 10/9/25, and 10/11/25, but RN M failed to document those administrations. Licensed nurses were expected to document medication administrations on the resident's MAR after each medication administration was completed. That had not occurred. Nursing staff who had documented their administrations of resident 3's 6:00 p.m. Zosyn doses on 10/5/25, 10/9/25, and 10/11/25 should have noticed and reported to DON B the missing morning IV medication administration documentation for investigation. 4. Observation on 12/1/25 at 5:15 p.m. of RN F completing resident 3's stoma (a surgically created opening in the abdomen that allows a feeding tube to deliver liquid nutrition) care revealed she removed the medical tape that held two, two-inch by two-inch (2 X 2) sponge dressings from around the resident's stoma site and then removed the two sponge dressings. She discarded the tape and the dressings. She used a wound spray cleanser to moisten the stoma area and wiped that area with gauze pads. RN F then placed two clean 2 X 2 sponge dressings around the stoma site without securing	F0658		

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F0658 SS = E	Continued from page 17 the 2 X 2s to the resident's abdomen. Resident 3 reminded RN F to secure the sponge dressings to her skin before she completed her skin treatment, but RN F did not secure them with tape. 5. Review of resident 3's EMR revealed a 6/25/25 physician's order for her stoma care that read: "Change 2 X 2 split sponge and cleanse area, apply zinc [an over-the-counter skin cream protectant that forms a protective barrier on the skin] to 2 X 2 and place over stoma, tape in place..." 6. Interview on 12/3/25 at 12:45 p.m. with RN F regarding the above observations revealed she did not follow the physician's order for resident 3's skin treatment. She did not apply zinc to the 2 X 2 sponge dressings, and she did not secure those dressings to the resident's abdomen with tape to ensure the dressings remained in place. 7. Interview on 12/4/25 at 12:45 p.m. with DON B regarding the above observation revealed RN F was expected to have read the physician's orders for resident 3's skin treatment before she completed that treatment and followed that physician's order as it was written. Review of the providers' revised 4/6/25 Physician/Practitioner Orders policy revealed: *"Purpose:" -"To provide individualized care to each resident by obtaining appropriate, accurate, and timely physician/practitioner orders." -"To provide a procedure that facilitates the timely and accurate processing of physician/practitioner orders." *"Policy:" -"A physician, physician's assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care, consistent with the resident's present physical and mental status and needs." *"Procedure:" -"Physician/Practitioner orders are a critical component to providing quality care to residents.	F0658		

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F0658 SS = E	Continued from page 18 Accurate processing of physician/practitioner orders is important. The nursing services and health information management departments each have responsibilities for processing physician/practitioner orders in a timely and accurate manner. Teamwork and communication between the two departments is essential." *"Physician/Practitioner Orders Content:" -"1. Clarification orders are needed when reviewing any type of physician/practitioner orders that are incomplete or raise questions." -"Orders may need to be clarified for the following reasons:" --"missing diagnosis/medical reason." -"If any question arises, nursing services are responsible for obtaining clarification." -"3. Medication orders must include:" --"Diagnosis or medical reason/indication for use." Review of the providers' Nursing Documentation Guidelines,Timelines policy revealed: *"Purpose:" -"To ensure appropriate documentation is completed in a timely manner." Review of the revised 5/12/25 RN Long Term Care job description revealed: *An essential function of that job included "Documents current patient medication, medication administered, and reactions/results." *A competency of that job included "Knowledge of how to read and interpret patient [resident] charts regarding medication sheets, diets, history and physicals, tests; ability to apply this knowledge appropriately to patient care." *Implements intervention identified and carries out safely, reliably, and in a timely manner." *Documents evaluation results." *Uses resources and collaborates with others to	F0658		

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F0658 SS = E	Continued from page 19 implement plan." *Implements physician and nursing orders." *Awareness of isolation precautions."	F0658		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to: *Identify and implement interventions to help prevent elopement for one of one sampled resident (5) who eloped (left the facility without staff knowledge) when he pressed the exit bar on the door long enough to release it. Findings include: 1. Review of a nurse progress note dated 11/24/25 at 3:30 p.m. titled 'Safety Event-Incident Report' regarding resident 5 revealed: *Resident 5 left the facility through the southwest door. *He propelled his wheelchair out onto the sidewalk and into the gazebo. *An unidentified dietary staff member arriving at work saw resident 5 outside and helped him back into the building through the southwest door. *He was evaluated after the event, and his condition remained unchanged. *Resident 5 complained that it was cold.	F0689	1.DOH aware of resident #5 elopement during survey. Elopement UDA completed and Resident # 5 care plan has been updated to reflect current elopement risk. 2.All residents are at risk for deficient practice. Director of Nursing reviewed elopement binder, all residents at risk for elopement are identified in binder. Licensed Social Worker to review all reportable type events for accuracy of reporting. 3. Education provided by Director of Nursing to all staff regarding elopement policy and reporting procedure. Elopement drills to be completed on all shifts by Director of Nursing. Those staff unable to attend the scheduled training will be trained prior to their next scheduled shift. Clinical Care Leader or designee will track education completion and next scheduled shift.4. Licensed Social Worker or designee to audit all reportable type incidents weekly x 4, monthly x 4, and LSW or designee will bring to QAPI monthly x 4 for interdisciplinary team review and revision.	1/14/26

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F0689 SS = D	Continued from page 20 Resident 5 refused education when the nurse tried to discuss the risks of leaving the facility unattended. *A 72-hour safety check and charting were started for every shift. *The physician was notified via fax. *A telephone call was made to his spouse regarding the incident. 2. Review of resident 5's electronic medical record (EMR) revealed: *He was admitted on 6/12/25. *His 9/11/25 Brief Interview of Mental Status (BIMS) assessment score was 8, which indicated his cognition was moderately impaired. *His diagnoses included vascular dementia (a type of cognitive decline caused by reduced blood flow to the brain from strokes or clogged vessels) with agitation and anxiety disorder. *He had a history of behaviors, including unprovoked verbal expressions of anger, poor listening skills, and resisting care. *He moved around the facility as he desired in his wheelchair independently. *He enjoyed sitting in the hallway or at the nurse's station and watching the staff. *His 6/12/25 and 9/9/25 Elopement Risk Assessments revealed he had no wandering behaviors and was at no risk for elopement. *He was taking quetiapine fumarate (an antipsychotic medication used to treat mental health conditions) 75 milligrams (mg) by mouth three times a day, related to his vascular dementia with agitation. *Resident 5's 6/18/25 and 9/11/25 Minimum Data Set (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) (MDS) had no wandering behavior coded on the assessments. Resident 5's progress notes indicated:	F0689		

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F0689 SS = D	Continued from page 21 On 6/13/25 at 22:35 (10:35 p.m.), "He [resident 5] did state that he wanted to call his wife to pick him up. He lived 3 miles from here and is ready to leave." On 6/17/2025 at 14:02 (2:02 p.m.), "After finishing breakfast resident sat at DR [dining room] table making several ph [phone] calls. Nurse heard him say "I've got to get the hell outta here" and proceeded to call his wife." Wife could be heard telling [resident 5] that there "was nothing" she could do about it. [Resident 5] was not pleased with response and hung up his phone." On 6/27/2025 at 22:30 (10:30 p.m.), "Resident is refusing HS care assistance and has not been cooperative or pleasant with staff. He wants to leave and would like his wife to come pick him up. One on one time and attention was provided with this resident. Will continue to monitor and provide comfort and support." On 7/2/2025 at 15:58 (3:58 p.m.), "Resident has been loud and demanding today. Demanded to see [physician] and then yelled when he was informed that he wasn't on the physician's schedule until next Friday. [Resident 5] stated he won't be here for another week." On 7/10/2025 at 13:05 (1:05 p.m.), "[Resident 5] was very angry this morning, called his wife and told her that nurse said he could leave the facility for three hours and she should come pick him up. Wife, called and said when she told [resident 5] no, he cursed at her and hung up. Advised [wife] this nursed did not tell [resident 5] that he could leave facility and we do not have orders from MD (doctor) for him to leave facility. Resident told dining room staff that he is going to get his shoes on and leave facility." On 8/14/2025 at 17:53 (5:53 p.m.), "Resident upset with physician assistant-certificed (PA-C) this shift as she wouldn't allow him to go home on day pass to visit wife. PA-C explained for his safety it would be best for his wife to visit him here. Resident threatened to walk out of facility and walk home. Staff advised him not to. Resident used walker this afternoon instead of w/c.[wheelchair]." On 9/4/2025 at 20:10 (8:10 p.m.), "Resident had conversation with PA-C today and argued with her about going home on a pass. PA-C explained that it is not safe for him to go home at this time. Resident argued awhile longer and ended up throwing his cane at/toward PA-C. Administrator came and visited with resident along with PA-C."	F0689		

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F0689 SS = D	Continued from page 22 On 9/5/2025 at 20:21 (8:21 p.m.), "Resident called his wife after his MD (doctor) visit and told her that he said he could go home after his Xray on 9.10.25 and that the doctor said the only thing keeping him from doing so would be if she didn't want him to come home. Resident has been demanding and impatient with staff all shift, repeating his on demand requests over and over again despite interaction and communication with him on waiting his turn." On 9/9/2025 at 20:38 (8:38 p.m.), "Resident states he wants to leave this place. Resident has been verbally aggressive and did not accept redirection well." On 9/11/2025 at 09:14 (9:14 a.m.),"Continue to monitor and discuss behaviors in IDT. Resident becomes easily agitated d/t wanting to discharge to home." On 11/15/2025 at 15:42 (3:42 p.m.), "After lunch he went to the door at the end of the hallway and pushed on the exit bar, setting off the alarm. When CNA asked resident to move away from the door, resident yelled "I'm right where I want to be Goddamn it". CNA was then able to move resident away from exit door and to the dining room for lunch." On 11/24/2025 at 13:26 (1:26 p.m.), "Resident continues to ambulate throughout facility as desires. Does like to sit in the hallway and watch staff as well as in the dining room. Continue to monitor for episodes of increased wandering and pacing." 3. Review of resident 5's 11/28/25 care plan revealed: *There were no interventions in place for staff to follow before resident 5's elopement on 11/24/25 to ensure his safety from elopements. *His care plan was updated on 11/24/25 after resident 5 eloped, which included: -The placement of a WanderGuard (a wearable door alarm device) below the seat of his wheelchair. -72-hour monitoring to maintain his safety. -Offering to take him for a walk outside when the weather was appropriate. -Monitoring for signs and symptoms of wandering and exit seeking. -Monitoring closely when resident was near exit doors.	F0689		

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F0689 SS = D	Continued from page 23 4. Interview and review of resident 5's EMR on 12/8/25 at 1:50 p.m. with director of nursing (DON) B revealed: *Staff would report incidents such as falls with injury, abuse allegations, and elopements to her or administrator A. *DON B or administrator A would begin an investigation and send an initial report to the Department of Health. *All incidents were discussed and reviewed with the interdisciplinary team (IDT) in morning stand-up/huddle meetings and reported to the regional office during their morning calls. *Nursing completed elopement assessments upon resident admissions to the facility and then quarterly. *She stated that resident 5 had never wandered and was not at risk of elopement before he left the facility on 11/24/25. *She reported that resident 5 told a staff member he was leaving the facility, but she did not know which staff member he told. *She confirmed that there was no documentation in resident 5's EMR indicating he told a staff member he was leaving the facility. *She stated that the IDT discussed resident 5's 11/24/25 incident and concluded it was not "a system failure," so it was not reported to the South Dakota Department of Health (SD DOH) as an elopement. -The facility's door alarm was triggered, serving as the basis for the decision not to report resident 5's elopement. *She confirmed that resident 5 left the facility without staff knowledge by holding down the exit bar on the southwest door long enough to release it. *She confirmed that resident 5 had propelled himself in his wheelchair out the southwest door, was found in the gazebo, and had not left the facility property. *She confirmed that an unidentified dietary aide, who had parked in the lot and was headed into work, brought resident 5 back through the southwest door of the facility within a few minutes of him leaving.	F0689		

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F0689 SS = D	Continued from page 24 *She was unaware of any previous statements or attempts from resident 5 that indicated his desire to leave the facility. *She agreed that resident 5 had prior statements, threats, and a near elopement attempt documented in his EMR, and that interventions should have been in place before his 11/24/25 incident due to his risk of wandering and actual elopement. *She confirmed that the facility did not have an investigation report available. *She agreed that resident 5's incident of leaving the facility on 11/24/25 at 3:30 p.m. was an elopement and should have been reported to the SD DOH as required. 5. Interview on 12/08/2025 at 2:05 p.m. with administrator A regarding facility-reported incidents and resident 5 revealed: *Administrator A stated that he reviewed the facility camera footage regarding resident 5 exiting the southwest door of the facility on 11/24/25 at 3:30 p.m. *An unidentified certified nursing assistant (CNA) was walking toward the southwest door to respond to the door alarm when an unidentified dietary aide, who was outside reporting to work, assisted resident 5 back into the building through the southwest door. -Resident 5 was outside for a couple of minutes and did not leave the facility property. *He stated, "our system worked," and the IDT determined that resident 5 exiting the facility on 11/24/25 was not an elopement. *When asked to explain the facility's system, he stated that as long as the door alarm activated, and staff responded, there was no "system failure". This was why the facility did not complete an investigation, an initial report, or report the incident to the SD DOH. He stated whether it was luck or not, it worked. *He confirmed that resident 5 exited the building through the southwest door in his wheelchair after he held the exit bar on the door long enough for it to release. *He confirmed that resident 5 left the facility without the staff's knowledge or supervision.	F0689		

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F0689 SS = D	Continued from page 25 Review of the provider's revised 4/7/2025 Elopements policy revealed: *"Purpose:" -"To assess and identify residents/clients at risk for elopement." -"To clearly define the mechanisms and procedures for monitoring residents/clients at risk for elopement." -"To provide a system of documentation for the prevention of, and in the event of, elopement." -"To minimize risk for elopement through individualized interventions." *"Definition:" -"Elopement-When a resident/client who needs supervision leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so." *"Policy:" -"The SNF [skilled nursing facility] location and each Adult Day Program will be responsible for maintaining a system that clearly defines the mechanisms and procedures for monitoring residents/clients at risk for elopement. These include identifying, evaluating and analyzing environmental hazards and risks; and implementing, monitoring and modifying interventions as needed." *"Procedure:" -"Elopement Search:" --"1. In the event of a suspected missing resident/client:" ---".....f. If the resident/client is found, the lead staff member will notify employees on duty. The resident will be evaluated for injuries and the physician contacted as appropriate." ---"...j. Notify other agencies as required by state and/or federal regulation." Review of the provider's revised 8/29/25 Alarms-Bed,	F0689		

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F0689 SS = D	Continued from page 26 Chair, and Door policy revealed: *"Policy:" -"The center will ensure that a system is in place for all bed, chair and door alarms and these alarms are in proper working order." *"Procedure:" -"1. Alarms are to be checked for proper operation and/or battery charge as follows:" --"Wandering alert door alarms- Environmental Services are to check weekly." -"2. Nursing staff will be responsible for visually checking placement of alarms daily." -"3. All staff will be responsible for physically checking on the resident when an alarm goes off."	F0689	1. Unable to correct deficient practice. 2. No residents at risk for deficient practice d/t non clinical requirement. Director of Nursing educated on accurate nursing staffing reporting requirements by surveyors. 3. Education provided by Director of Nursing to nursing staff responsible for staff posting, regarding staffing requirements and adjusting time/schedules as they occur. Those staff unable to attend the scheduled training will be trained prior to their next scheduled shift. Clinical Care Leader or designee will track education completion and next scheduled shift. DON/ or designee will review posting for accuracy prior to filing. 4. Director of Nursing or designee will audit staff postings weekly x 4, monthly x 4, and bring to QAPI monthly x 4 for interdisciplinary review and revision.	1/14/26
F0732 SS = D	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data	F0732		

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F0732 SS = D	Continued from page 27 specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the provider failed to ensure the posted daily staff information included the total number and the actual hours worked by registered nurses, licensed practical nurses, licensed vocational nurses, and certified nursing assistants per shift. Findings include: 1. Observation on 12/2/25 at 9:30 a.m. of the posted nurse staffing information revealed: *It was posted near the front entrance door and on a wall near the nurses' station. *There were three sections for each shift and four categories of staff listed in each section: RN (registered nurse), LPN (licensed practical nurse), LVN (licensed vocational nurse), and CNA (certified nurse aide). *The nurse category sections listed the number of nursing staff scheduled for each shift. *There were no documented actual hours or total number of nurse staffing hours worked on the form. 2. Interview on 12/4/25 at 2:33 p.m. with director of nursing (DON) B revealed:	F0732		

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F0732 SS = D	Continued from page 28 *She was unsure of all the required details for the posted nurse staffing data, such as the total number and actual hours worked per nursing discipline. *A posted daily nurse staffing policy was requested, but they did not have a policy that addressed that.	F0732	1. Food observed in circulation after the use-by date was disposed of immediately. All opened food or food storage containers have been marked with a use by date label. Open food packages are stored in airtight containers. 1 hand scoop per food storage container is now stored outside each storage container as necessary. 2. All residents had the potential to be impacted. No other residents were identified as having been negatively affected by findings. An immediate kitchen walk-through was conducted to ensure all stored food products were covered, identified, and date labeled appropriately, or discarded. Break room refrigerator audited by Administrator to ensure no food is improperly labeled. 3. Dietary staff were educated by Administrator/ or designee on the requirement of F812 and Sanford Food Storage Policy to ensure a safe and sanitary environment in which food is prepared, stored, and distributed. Examples from this citation were used for this education. Signage posted outside food storage indicating need to label or discard or use within 72 hours of opening. 4. An audit was developed to ensure ongoing and sustained compliance with the requirement and examples outlined in this citation. The Dietary Manager and/or designee will conduct food storage audits 2x per week x 4, and then weekly x 2 months. Findings will be immediately addressed and reported to the QAPI committee for further review and recommendation.	1/14/26
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to follow food safety standards related to food storage practices of packaged food in the kitchen, dry food storage area, food service station area, and walk-in refrigerator. Findings include: 1. Observations on 12/1/25 between 11:00 a.m. and noon and again at 4:40 p.m. revealed: *In the kitchen above a service window, there was a clear, plastic tub. The label affixed to the tub identified the contents in that tub as "Food Thickener." There was no date marking on that label to support when it was opened and put in	F0812		

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F0812 SS = F	Continued from page 29 that tub. A hand scoop was inside that tub. -Next to that tub was a clear glass dispenser with a piece of masking tape on it that read "thickner." There was no date marking on that dispenser. *Inside the dry food storage room, there were: -Seven boxes of unopened rice with no date markings on them. -One 16-oz opened bag of unopened Instant Mashed Potato flakes with a best by date of 2/10/25. -Twelve bags of unopened gravy mix with no date markings on them. -One undated bulk-sized, opened bag of Cherrios. -One unopened and undated 28-oz bag of cream soup base. -One opened and undated 28-oz bag of cream soup base. -One 28-oz bag of unopened Uncle Ben's cornbread stuffing mix with a best by date of 8/11/25. -One opened and undated bag of rice. -One 11-pound (lb) tub of chocolate fudge icing with an expiration date (product should be consumed on or before the date listed) of 11/12/25. -One box of six, 20-oz unopened squeezable strawberry fruit spread bottles with a best if used by date of 3/28/25, and three unopened and undated 14-oz squeezable ketchup bottles were in that same box. -Four unopened buttermilk biscuit mix boxes dated 8/10/24. *Underneath the counter of the food service station, there were three plastic drawers that each contained different types of dry cereal. Hand scoops were inside each of those drawers on top of the dry cereal. *Inside the walk-in refrigerator, there were: -Two 20-oz strawberry fruit spread squeeze bottles with best if used by dates of 3/28/25. -One 32-oz container of chopped garlic with a best if used by date of 8/30/25. -One undated, unlabeled plastic container of ham slices. -One 16-oz opened and undated bag of whipped topping. A piping tip protruded from one corner of the bag. 2. Observation on 12/3/25 at 10:15 a.m. of the above food storage areas and interview with nutrition and food service supervisor (NFSS) E revealed: *The expired food items and food items that exceeded their best if used by dates should have been discarded. *The above unlabeled food items were expected to have been date-marked for staff to have known when they were expected to have been discarded. *Opened food packages, such as the bag of rice and the bagged whipped topping, should have been stored in air-tight storage containers. *Hand scoops should not have been stored inside food containers due to the risk of cross-contamination. *Applicable bulk food items should have remained in their transport boxes. Those boxes had date-marked labels on them for staff to know if that food item was safe to use. *It was her and all the dietary staff's responsibility to ensure food was safely stored, food packages were properly labeled, and any outdated food was discarded, but there was no formal process to ensure those things occurred. 3. Review of the provider's 3/7/25 revised Food-Supply	F0812		

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F0812 SS = F	Continued from page 30 Storage-Food and Nutrition Services policy revealed: *Procedure: -"5.c. Stock items are individually dated with delivery date if removed from the original container." -"7. Foods that have been opened or prepared are placed in an enclosed container, dated, labeled, and properly stored." -"9. Use By and Freeze By (expiration) dates are checked on a regular basis; foods/fluids that have expired or are otherwise unsafe for use are discarded. -10. Foods that do not have a Use By or Freeze By date are rotated and used within one year of delivery or according to the Best If Used By/Best If Freeze By date."	F0812		
F0865 SS = D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and	F0865	1. Unable to correct deficient practice 2. All residents with grievances brought to resident council are at risk for deficient practice 3. Education provided by Director of Nursing to IDT team regarding QAPI policy and provisions set aside by a " good faith attempt" at measurable and diligent corrective action. Those staff unable to attend the scheduled training will be trained prior to their next scheduled shift. Clinical Care Leader or designee will track education completion and next scheduled shift. 4. Licensed Social Worker will audit grievances for clear and measurable interventions for each grievance weekly x 4, monthly x 4, and Licensed Social Worker or designee will bring to QAPI monthly x 4 for interdisciplinary review and revision.	1/14/26

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F0865 SS = D	Continued from page 31 §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;	F0865		

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F0865 SS = D	Continued from page 32 §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure an effective, comprehensive quality assurance and performance improvement (QAPI) program was implemented to track and measure performance; systematically analyze underlying causes of a systemic quality deficiency; develop and implement corrective actions or performance improvement activities; and evaluate the effectiveness of the corrective actions, and to revise those actions as needed. Findings include: 1. Interview on 12/2/25 at 10:45 a.m. and on 12/8/25 at 12:15 p.m. with resident 15 revealed she was an active resident council participant. Social Services Supervisor (SSS) D facilitated those monthly council meetings. Since May 2025, the council had been concerned about long call light response times, especially during the late afternoon and early evening	F0865		

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F0865 SS = D	Continued from page 33 hours. That response time ranged between 30 minutes to one hour. 2. Review of the provider's June 2025 through November 2025 resident council minutes confirmed that during each of those monthly meetings, the council had identified a concern regarding long call light response times. 3. Interview on 12/2/2025 4:13 p.m. and again on 12/8/25 at 9:00 a.m. with SSS D revealed it was her responsibility to document resident council concerns on the Suggestion/Concern (Grievance) form. She had completed Suggestion/Concern forms regarding call light response times each month since the June 2025 resident council meeting. Those forms are routed to the appropriate department head for their investigation, resolution, and/or recommendations regarding the grievance. SSS D attended the facility's QAPI committee meetings. The resident council's ongoing concern with call light response times was discussed during those meetings. Regarding what action plans had been implemented in response to the council's concern, SSS D stated, "I don't know that anything other than education and getting more staff" had occurred. 4. Review of the provider's June 2025 through November 2025 QAPI minutes revealed that each month, the following agenda item was listed: Resident/Family suggestion/concern trends. Beside that line item were the following columns: Discussion Points/Notes, Actions/Outcomes/Follow-up Needed, Responsible Person, and Follow-Up/Report Out Date. *The 7/16/25 QAPI minutes indicated the Resident Council's concern was "Trash isn't being taken out timely. Leaving trash for other shifts to remove." There was no mention of the Resident Council's concern regarding excess call light wait times. *The 8/28/25 QAPI minutes reflected the Resident Council's concern regarding "call light timeliness."-" Actions/outcomes/Follow-up needed: "Staff education/All Staff [meeting]."-During August 2025, several QAPI Ad Hoc meetings occurred to address the evening snack pass, lab orders, anti-microbial surveillance, and psychiatric services. There was no Ad Hoc meeting related to excess call light wait times. *There were no September 2025 QAPI meeting notes. *The 10/2/25 QAPI minutes indicated "Consistent reports of untimely call light response time. QAPI completed d/t [due to] frequency of report."-There was no mention of any data that had been collected or analyzed to support whether the staff education that was referred to in the 8/28/25 QAPI minutes had reduced call light wait times. -Actions/Outcome included "Angel Rounds." There was no explanation of what that was, its purpose, or who the target population was. The interdisciplinary members were identified as being the responsible persons for that action. It was to occur daily. *The 10/23/25 QAPI minutes reflected the same information as the 10/2/25 minutes concerning call	F0865		

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F0865 SS = D	Continued from page 34 light response time. There was no follow-up regarding the status of the "Angel Rounds" that was discussed on 10/2/25. *The 11/25/25 QAPI minutes made no mention of call light response times. There was no indication whether the Angel Rounds were implemented, what the data from that program revealed, if any recommendations related to that program were made, or if any new action plans had been developed regarding call light response times. 5. Interview on 12/8/25 at 12:45 p.m. with director of nursing (DON) B revealed she was responsible for overseeing the facility's QAPI program. She was new to that position and had received little education or training regarding the expectations of that position. The facility's corporate Quality Coordinator had reviewed the facility's QAPI program and "scrubbed it," indicating the process was ineffective in its current state and required improvement. *With regards to call light wait times, data collection and analysis, action plan initiation and revision, and the quality improvement process related to the Council's call light wait time concern, DON B stated: -The facility opened a 6:00 p.m. to 10:30 p.m. shift to support the evening shift, but they were unable to fill that position due to a lack of applicants. That was not reflected in the QAPI minutes. -All caregivers had been educated that if a call was answered and the caregiver had to leave and then return to the room to help the resident, the caregiver was expected to let the resident know their approximate return time. There had been no documented follow-up with residents after that education had occurred to know if that expectation was being followed or if it had an effect on the call light wait times. -Every Friday, she was completing call light audits. Her data indicated there were specific residents who regularly had call light response concerns. The purpose of the Angel Rounds was to have management staff proactively check in with those residents to anticipate and meet some of their needs before call light activation was needed. She agreed that the QAPI minutes failed to define Angel Rounds, made no mention of her audits, the analysis of her audit data, or any follow-up action related to that data. -Dietary staff who passed the evening in-room resident meal trays had been educated to offer non-direct care assistance to those residents before leaving the residents' room. QAPI minutes failed to include any information about the implementation of this action plan, any data, or analysis of data that was gathered after the action plan was initiated to determine if it impacted call light response times. Review of the provider's revised 5/20/25 QAPI policy revealed:*Program Design and Scope: -"1.a. The QAPI program is ongoing, comprehensive, and data-driven, and addresses the	F0865		

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F0865 SS = D	Continued from page 35 complexity and uniqueness of the care and services provided. -b. Capable of showing measurable improvement and focuses on safety, choice, outcomes, quality of care and quality of life as applicable to each location, -c. The QAPI program will measure, analyze, and track quality indicators, including adverse events, and other aspects of performance that enable the location to assess processes of care, services and operations." Refer to F565, findings 2 and 4.	F0865		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F0880		

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F0880 SS = E	Continued from page 36 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the staff followed standard infection control practices for: *Not having placed two of two sampled residents (4 and 20) on enhanced barrier precautions (EBP) (glove and gown use when providing contact care). *Posting clear signage indicating the type of precaution for three of three sampled residents (5, 12, and 19). *Appropriate hand hygiene (HH) (handwashing with soap and water or use of a hand sanitizer) and glove use by three of three staff members (registered nurse RN (F),	F0880	1. Enhanced Barrier Precautions provided to resident 4 & 20 immediately, Corrected signage posted for residents 5, 12, & 19 during survey. 2. Residents with open wounds, catheters, or MDROs are at risk for deficient practice 3. Education provided by Director of Nursing immediately to all staff regarding corrected signage, EBP, hand hygiene and barrier use per facility policy. Clinical Learning and Development Specialist/designee will validate skills in handwashing to current staff including ancillary by next scheduled shift. Kardex will reflect all residents on EBP and will be updated/managed by DON/designee. Situations requiring EBP posted at Nurses Station for reference. Additional hand hygiene audits will be completed monthly by Director of Nursing or designee. Those staff unable to attend the scheduled training will be trained prior to their next scheduled shift. Clinical Care Leader or designee will track education completion. 4. Director of Nursing /designee will audit EBP for correct PPE, Signage, Trash location, hand hygiene, barrier use, and treatment supply storage weekly x 4, monthly x 4, and report to QAPI monthly x 4 for interdisciplinary review and revision.	1/14/25

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F0880 SS = E	Continued from page 37 certified nursing assistant CNA (G), and clinical care leader CCL (C) during treatment, care, and transition in care for three of four sampled residents (1,3, and 20). *Appropriate personal protective equipment (PPE) (gown and glove) application and removal by one of one CCL (C) and removal by one of one CNA (G). *Not having placed barriers by two of two staff RN (F) and CCL (C) during medication administration and treatments of two of two sampled residents (1 and 20). *The use and storage of skin treatment supplies by one of one RN (F) during one of one sampled resident's (3) skin treatment. Findings include: 1. Observation and interview on 12/1/25 at 2:11 p.m. with resident 20 in her room revealed: *The resident was in her room, sitting in her wheelchair with her feet resting on the wheelchair foot pedals. *The resident stated she was unable to walk due to a broken left leg and that she had open sores on her heels. *There was no precaution sign posted outside or inside the door of her room related to the open sores on her heels. *There was no personal protective equipment (PPE), such as gloves and gowns, available for use inside resident 20's room or near her door. *She was unsure whether the staff wore gowns and gloves when providing her care or changing her dressing. *CNA G entered the room at approximately 2:20 p.m. to assist resident 20 to the bathroom and did not put on gloves and a gown. Review of resident 20's electronic medical record (EMR) and the pocket care plan/walking care sheet (a document that identifies residents' care needs and interventions) revealed: *She was admitted on 5/7/25.	F0880		

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F0880 SS = E	Continued from page 38 *Her 11/4/25 BIMS assessment score was 5, which indicated her cognition was severely impaired. *Her diagnoses included a fracture of the shaft of the left femur (the long tubular part of the thigh bone). *She had a pressure sore (injury to skin and underlying tissue from prolonged pressure) on her left heel that resolved on 9/17/25. *She was receiving wound care treatment twice weekly and as needed for an open traumatic wound on her left heel that occurred on 10/22/25. *The pocket care plan/walking care sheet did not indicate she was on EBP. 2. Review of resident 4's EMR and the pocket care plan/walking care sheet revealed: *She was admitted on 11/9/23. *Resident 4 was positive for Methicillin-resistant Staphylococcus aureus (MRSA) in her nares on 7/7/24. *Resident 4 was not being treated for an active infection. *The pocket care plan/walking care sheet did not indicate she was on EBP. 3. Observation and interview on 12/1/25 at 2:34 p.m. with activities supervisor K outside of resident 19's room revealed: *There was a white three-drawer bin in the hall next to resident 19's door, stocked with PPE supplies (gowns, gloves, and red trash bags). *There was a contact precaution sign (measures used to prevent spreading germs requiring gloves and gowns to be worn) posted on the door, and an EBP magnet on the door frame. *Activities supervisor K did not know which resident in that room was on precautions when asked. Review of resident 19's EMR and pocket care plan/walking care sheet revealed: *She was admitted on 11/18/20.	F0880		

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F0880 SS = E	Continued from page 39 *She was positive for MRSA in her urine on 11/1/20. *Resident 19 was not being treated for an active infection. *The pocket care plan/walking care sheet did not indicate she was on EBP. 4. Interview on 12/1/25 at 3:13 p.m. with registered nurse (RN) F revealed: *RN F did not know which resident in resident 19's room was on precautions. *RN F stated that the precaution information was not given to her in the morning shift report and that it was not included on the pocket care plan/walking care sheet for the residents who resided in that room. *RN F agreed that she should have been provided with that information to ensure proper infection control processes were followed. 5 Observation and interview on 12/1/25 at 2:42 p.m. in the north hall with business officer coordinator (BOC) J outside resident 12's room revealed: *There was a white three-drawer bin stocked with gowns, gloves, and trash bags, and a large white trash can with a lid in the hall next to resident 12's door. *There was no precaution sign posted outside or inside the door of his room. *BOC J was asked if residents in the room were on precautions. *She stated she wanted to clarify and left the hallway to verify the information. *She returned and stated that social services supervisor (SSS) D verified the information and confirmed that resident 12 was on EBP. 6. Interview on 12/1/25 at 4:44 p.m. with resident 12 in his room revealed: *He stated that staff sometimes wore a gown and gloves when helping him with his care.	F0880		

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F0880 SS = E	Continued from page 40 Review of resident 12's EMR and pocket care plan/walking care sheet revealed: *He was admitted on 1/2/25. *He was positive for MRSA in his nares in March 2023. *Resident 12 was not being treated for an active infection. *The pocket care plan/walking care sheet did not indicate he was on EBP. 7. Observation and interview on 12/2/25 at 8:46 a.m. with resident 5 in his room revealed: *There was a white three-drawer bin stocked with gowns, gloves, and red trash bags, and a large white trash can with a lid in the hall next to resident 5's door. *There was no precaution sign posted outside or inside the door of his room. *He stated he had an open sore on the top of his right foot. *He stated that staff had been applying a dressing and that he was going to the VA to see a doctor. *He stated, "I think they [the staff] wear a gown, and I know they wear gloves when they do my dressings". Review of resident 5's EMR and pocket care plan/walking care sheet revealed: *He was admitted on 6/12/25. *He was receiving wound care treatment every other day and as needed for an open wound on his right lower leg that started on 9/12/25. *The pocket care plan/walking care sheet did not indicate he was on EBP. 8. Observation on 12/3/2025 at 9:32 a.m. of RN F preparing resident 1's feeding tube (a tube placed into the stomach or small intestine that delivers nutrition) treatment revealed: *She entered the supply room, gathered an enteral	F0880		

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F0880 SS = E	Continued from page 41 feeding gravity set bag, a graduated measurements container, a 60 milliliter (ml) syringe, tubing, and an end cap, and returned to the medication cart in the north hall. *Without performing hand hygiene (handwashing), RN F removed the packaging from the gravity set bag, tubing, and end cap. *Without cleaning the top of the medication cart or placing a clean barrier, she placed them on top of the cart and then dated the items. *She performed hand hygiene and prepared resident 1's medications. *An EBP sign was posted on resident 1's door. *A 3-drawer white bin containing PPE supplies was outside her door in the hall. *A trash can with a lid was next to the 3-drawer bin. *She placed resident 1's feeding tube supplies, medication cup, eye drop container, nasal spray bottle, and a mouthwash rinse bottle on top of the PPE supply cart outside the resident's room without first laying a clean barrier down. *Without first performing hand hygiene, RN F put on a gown and gloves and entered the resident's room. *Without placing a clean barrier, she placed resident 1's medications on the counter next to the sink. *RN F administered completed the flush, administered her medications mixed in water via the feeding tube, and administered another flush. *She then began resident 1's scheduled 250ml of water by gravity administration. *Without removing her gloves and performing hand hygiene, she administered resident 1's eye drops, nasal spray, and mouth rinse with those same gloved hands. *RN F clamped the feeding tube and bag set, grabbed the nasal spray bottle and mouthwash rinse bottle with those same gloved hands, and placed those items on top of the PPE supply cart outside the resident's room without a clean barrier under them. *RN F exited the resident's room, removed her gown and gloves in the hall, disposed of them in the trash can	F0880		

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F0880 SS = E	Continued from page 42 that was in the hall next to the resident's 3-drawer bin, and performed hand hygiene. *She returned the nasal spray and mouthwash rinse bottles to the medication cart without sanitizing them and placed them in a drawer that stored other resident medications. 9. Interview on 12/4/2025 at 1:59 p.m. with RN F regarding the above observations with resident 1's feeding tube treatment and medication administration revealed: *She should have performed HH before removing the packaging of the feeding tube supplies. *She should have cleaned the top of the medication cart or placed a clean barrier before placing the supplies on top of the cart. *She should have placed a clean barrier down before she placed the medications and feeding tube supplies on the 3-drawer PPE bin. *She should have performed hand hygiene before putting on her gown and gloves. *She should have placed a clean barrier down before she placed the medications and feeding tube supplies on the counter next to the sink. *She should have removed her gloves and performed hand hygiene before she administered resident 1's eye drops, nasal spray, and mouthwash rinse. *She should have taken off her gown and gloves in the resident's room and put them in the trash can inside resident 1's room. *She should have cleaned resident 1's medication bottles before returning them to the medication cart to prevent cross-contamination. 10. Observation and interview on 12/3/2025 at 2:11 p.m. with clinical care leader (CCL) C during resident 20's wound care revealed: *Without cleaning the top of the treatment cart or placing a clean barrier, she removed wound care supplies (bordered foam dressing, wound cleanser spray, scissors, two packages of sterile gauze, one package of collagen powder, and three to four alcohol wipes) and	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435104	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 SOUTH MADISON POST OFFICE BOX 327, NEW UNDERWOOD, South Dakota, 57761

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F0880 SS = E	Continued from page 43 placed them on top of the treatment cart. *She opened the dressing packages and, without cleaning the scissors, used them to cut the adhesive edges of the bordered foam dressing. She then dated and initialed the dressing and returned it to the package. *Without putting on a gown and gloves, she entered resident 20's room and placed the wound care supplies on a blanket at the foot of resident 20's bed without first placing a barrier down. *She washed her hands with soap and water and put on a pair of gloves. *She got paper towels from the bathroom and put them at the foot of resident 20's bed. *She gathered the wound wash and scissors and placed them on the paper towel barrier, while the other supplies remained on the blanket. *She finished the dressing treatment, took off her gloves, put them in the trash, tied the trash bag shut, and held it in her left hand. *Without performing hand hygiene, she picked up the wound wash, scissors, and a package of gauze with her right hand, opened resident 20's top drawer of the stand next to her bed with her right hand (while holding the items), and placed the gauze package inside. *She then grabbed the wound wash and scissors (which she was holding in her right hand) with her left hand, which was holding the trash bag, and left the room. *Without placing a barrier on the treatment cart, she placed the wound supplies on top of the cart, opened the door to the utility room, and placed the trash into a trash can. *Without performing hand hygiene, she put on a pair of gloves and cleaned the wound wash bottle and scissors with bleach wipes. *CCL C was unsure why a barrier was needed for all the wound care supplies in resident 20's room. *She agreed that she placed the wound cleanser and scissors on the blanket on the resident's bed before putting them on the paper towel barrier. *She agreed that she missed hand hygiene opportunities	F0880		

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F0880 SS = E	Continued from page 44 during resident 20's observed wound care treatment and that she did not follow EBP by putting on a gown and gloves before she entered her room. 11. Interview on 12/3/2025 at 2:53 p.m. with director of nursing (DON) B revealed: *She expected that hand hygiene would be performed before putting on gloves and after removing gloves. *She expected that clean barriers should have been used during the treatments above, before supplies and medications were placed on the PPE bin, the counter by the sink, the medication and treatment carts, and on the resident's blanket. *She expected that hand hygiene should have been performed before and after completing resident treatments, between transitions in resident care, and after discarding trash. 12. Interview on 12/4/2025 at 2:05 p.m. with certified medication aide (CMA) H regarding EBP revealed: *PPE should be worn by the staff when direct care was provided to residents on EBP. *The information for residents on EBP or other types of transmission-based precautions was shared during the morning huddle meetings. *Sometimes the information was recorded in the binder in the staff break room, but at times it could be unclear which residents were on precautions. 13. Interview on12/4/2025 at 2:10 p.m. with CNA G regarding EBP precautions revealed: *Staff should have been informed in the morning report who was on precautions. *The pocket care plan/walking care sheets should indicate who was on precautions. *She was trained to throw her gowns and gloves in the trash can in the hall. *She was unsure why other residents on EBP did not have trash cans outside their rooms in the hall.	F0880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 SOUTH MADISON POST OFFICE BOX 327, NEW UNDERWOOD, South Dakota, 57761

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F0880 SS = E	Continued from page 45 14 Interview on 12/4/2025 at 4:06 p.m. with DON B and CCL C regarding EBP revealed: *They both were unsure why some residents' rooms who were on EBP had trash cans outside in the hall, while others did not. 15. Observation on 12/1/25 at 2:20 p.m. of RN F outside of resident 1's room revealed there was contact precaution (a type of transmission-based precaution that requires gown and glove use when providing contact care) signage on that resident's door. Without first performing hand hygiene (HH) (handwashing with soap and water or using a hand sanitizer), RN F put on a gown and a pair of gloves, then entered the resident's room to provide feeding tube (a tube placed into the stomach or small intestine that delivers nutrition) care. 16. Observation on 12/1/25 at 3:30 p.m. of CNA G revealed that without first performing hand hygiene, CNA G put on a gown and a pair of gloves, entered resident 1's room with a mechanical lift, then closed the door. When she exited the room with the mechanical lift, she was carrying a closed garbage sack. CNA G removed her gown and gloves and placed them in a trash receptacle outside of the resident's room. She discarded the garbage sack in a soiled utility room, returned to the hallway by resident 1's room, and performed hand hygiene. She removed a pair of gloves from inside her smock pocket, put them on, and cleaned the mechanical lift with a disinfectant wipe. 17. Observation on 12/1/25 at 5:15 p.m. of RN F outside of resident 3's room revealed there was posted contact precaution signage outside of that room. RN F was preparing and completing resident 3's stoma care (a surgically created opening in the abdomen that allows a feeding tube to deliver liquid nutrition) and medication administration. She gathered two 2-inch by 2 inch (2 X 2) packaged sponge dressings, a wound cleanser spray bottle, several squares of loose gauze, and a medication cup with a powdered protein supplement in it. She placed those supplies directly on top of the PPE supply cart outside of the resident's room without first laying down a clean barrier between the supplies and the top of the cart.	F0880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 SOUTH MADISON POST OFFICE BOX 327, NEW UNDERWOOD, South Dakota, 57761

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F0880 SS = E	Continued from page 46 Without first performing hand hygiene, RN F put on a gown and a pair of gloves, then entered the resident's room with the supplies. The resident was lying in her bed, covered with a blanket. RN H set the treatment supplies directly on top of the resident's blanket without first laying down a clean barrier between the blanket and the supplies. RN F removed the medical tape that held the 2 X 2 dressings in place around the resident's stoma site, then removed the dressings. The dressings had spots of dark dried blood on them. RN F discarded the tape and the soiled 2 X 2 dressings. She used the wound spray cleanser to moisten the stoma area, and with gloved hands, she used the gauze pads to clean that stoma area. She then placed the two new 2 X 2 sponge dressings around the stoma site. With those same gloved hands, RN F mixed the contents of the medication cup with water for administration through the resident's feeding tube. RN F removed and discarded her gloves and gown inside resident 3's room and performed hand hygiene. She returned the wound care cleanser spray bottle to the treatment cart without first sanitizing it. 18. Interview on 12/3/25 at 12:50 p.m. of RN F regarding the above care observations with residents 1 and 3 revealed that she should have performed hand hygiene before putting on gloves. She should have changed her gloves, performed hand hygiene, and put on clean gloves between transitions in care, such as resident 3's skin treatment and medication administration. She also should have placed a clean barrier under resident 3's treatment supplies to avoid possible cross-contamination. 19. Interview on 12/4/25 at 4:00 p.m. with DON B and CCL C regarding infection control revealed: *Hand hygiene was expected to occur before staff put on gloves. Glove removal, hand hygiene, and then putting on a pair of clean gloves was expected to occur between transitions in resident care. Gloves were expected to be removed from glove dispensers and not from the	F0880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0880 SS = E	Continued from page 47 staff's clothing pocket. *PPE was expected to be removed and discarded inside the room of a resident who required transmission-based precautions. *A clean barrier was expected to be used underneath clean supplies that were used during resident care, such as skin treatments. Review of the provider's revised 11/13/25 Hand Hygiene policy revealed: *"Healthcare workers will use alcohol-based hand sanitizer or soap and water to clean their hands": -"Before donning sterile gloves." -"After contact with patient's non-intact skin, wound dressing, secretions, excretions, mucous membranes, as long as hands are not visibly soiled. -When moving from contaminated body site to a clean body site during patient [resident] care." Review of the provider's revised 7/7/25 Standard, Enhanced Barrier, and Transmission-Based Precautions policy revealed: *Procedure: -"Post clear signage indicating the type of precautions and required PPE (i.e., gown and gloves)." -"Position a trash and laundry receptacle inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room, or before providing care for another resident in the same room, or bag and remove trash and soiled laundry immediately." -"Incorporate process surveillance to determine adherence and need for additional training and education." -"Provide education to residents and visitors on the importance of hand hygiene, especially when entering and exiting the resident's room and the facility."	F0880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 12/2/2025. Good Samaritan Society New Underwood was found in compliance.	E0000		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	LNHA	12/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435104	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 SOUTH MADISON POST OFFICE BOX 327, NEW UNDERWOOD, South Dakota, 57761

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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 12/2/2025 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Good Samaritan Society New Underwood was found in compliance.	K0000		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	12/30/2025	

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
	10657	A. BUILDING: _____ B. WING _____	12/08/2025

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GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 S MADISON POST OFFICE BOX 327 NEW UNDERWOOD, SD 57761

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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 on 12/1/25 through 12/4/25 and on 12/8/25.. Good Samaritan Society New Underwood was found in compliance.	S 000		

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

TITLE
LNHA

(X6) DATE