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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 09/05/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER | 401 WEST SECOND STREET , SIOUX FALLS, South Dakota, 57104 |

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| F0000 | INITIAL COMMENTS<br><br>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/2/25 through 9/5/25. Good Samaritan Society Sioux Falls Center was found not in compliance with the following requirements: F655, F677, F689, F800, F806, F812, and F880.<br><br>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/2/25 through 9/5/25. Areas surveyed included resident safety related to an elopement, quality of care and potential resident abuse and neglect related to extended call light wait times, bathing and wound care, following the physician's orders for the initiation of CPR, and the development of a pressure injury, resident behaviors and misappropriation of property, and dietary services related to the quality of the food. Good Samaritan Society Sioux Falls Center was found not in compliance with the following requirements: F600 and F678. | F0000 | The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law. | |
| F0600<br>SS = D | Free from Abuse and Neglect<br><br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br><br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; | F0600 | Call light is currently being answered timely. Resident #4 has uplifted two concerns that have been fully investigated with resident stated resolution at the time.<br><br>Social services will conduct a counseling session with Resident #4 to address emotional distress and to offer ongoing emotional support services.<br><br>A facility-wide review of call light response times will be initiated for all residents on 10/3/2025.<br><br>Any residents with call lights lasting longer than 15 minutes will be interviewed to ensure no adverse effects occurred due to prolonged call light wait times. | |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | Administrator | 12/5/2025 |

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| F0600 SS = D | Continued from page 1<br>~~This REQUIREMENT is NOT MET as evidenced by:~~<br><br>Based on South Dakota Department of Health (SD DOH) complaint review, record review, interview, and policy review, the provider failed to protect the resident's right to be free from neglect and abuse for one of one sampled resident (4) who complained of prolonged wait times for his call light to be answered by staff and felt that had caused him to be incontinent of urine or bowel at times. The resident expressed that those instances caused him to feel less than human.<br><br>Findings include:<br><br>1. Review of the 2/7/25 SD DOH complaint intake report regarding resident 4 revealed:<br><br>*Resident 4 had slept so long that he was incontinent of urine.<br><br>*He turned on his call light, and after 30 minutes no one answered so he called the front desk.<br><br>*He waited an additional 30 minutes before someone came to assist him.<br><br>*He sat in urine for over an hour.<br><br>2. Review of resident 4's electronic medical record (EMR) revealed:<br><br>*His Brief Interview for Mental Status (BIMS) assessment score on 12/5/24 was 15 which indicated his cognition was intact.<br><br>*His Braden score on 12/2/24 was 16 which indicated he had a mild risk for skin breakdown.<br><br>*He had diagnoses of:<br><br>-Mixed incontinence (a condition of stress and urge voiding).<br><br>-Open wound to right buttock (skin breakdown).<br><br>-Spinal stenosis (narrowing of spaces between spinal bones).<br><br>-Adjustment disorder (inability to adapt to situations in society).<br><br>-Hypertensive heart disease with heart failure (high | F0600 | Any additional concerns identified were immediately addressed and documented.<br><br>Based on investigation of prolonged call light times at breakfast and lunch, we will assign a staff member to answer call lights on Long-Term Care Unit<br><br>All direct care staff will complete mandatory in-service training by the administrator by 10/3/2025 on:<br>Call Light Response Times Expectations.<br>Empathetic care and dignity.<br>All staff will be educated by 10/3/2025 and will be signed off on completion sheet prior to their next scheduled shift.<br><br>Administrator, DNS and social worker reviewed the abuse and neglect policy with no revisions needed.<br><br>New process was established in conjunction with the policy for assigned staff members to answer call lights on LTC unit during breakfast and lunch.<br><br>To monitor compliance, Administrator/designee will audit call light wait times on 5 residents on Long Term Care unit, including resident 4, who are dependent in ADL cares. This will occur weekly x 4 weeks, every other week x 4 weeks, and monthly x 2 months. Administrator or designee will report findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring.<br><br>Substantial compliance will be achieved on 10/14/2025 | 10/14/2024 |

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| F0600 SS = D | Continued from page 2<br>blood pressure which damages the heart over time).<br><br>-Morbid Obesity (excessive weight that significantly impacts health and well-being).<br><br>-Major depressive disorder, single episode, severe (feeling of sadness and loss of interest that interfere with daily living).<br><br>-Generalized anxiety disorder (persistent worry and fear about everyday situations).<br><br>*His right buttock wound discovered on 1/15/25 and was due to incontinence.<br><br>-He had orders to receive Triad Hydrophilic wound dressing paste (wound healing product) to the wound and to cover the wound with Mepilex dressing once daily and as needed.<br><br>*Numerous documentations in his progress notes indicated his refusal of activities of daily living, repositioning, medications and treatments.<br><br>*Resident 4's care plan indicated he was bedfast all or most of the time and he preferred bed baths. That was initiated on 9/19/24.<br><br>-His bathing preference was updated on 2/7/25 that indicated his preferred a shower weekly on Thursday morning.<br><br>3. Review of resident 4's call light log from 1/19/25 to 2/7/25 revealed these times that were over 20 minutes in length:<br><br>*On 1/20/25 at 12:57 a.m. his call light was on for 23 minutes.<br><br>*On 1/20/25 at 8:20 a.m. his call light was on for 43 minutes.<br><br>*On 1/22/25 at 5:11 a.m. his call light was on for one hour and seven minutes.<br><br>*On 1/26/25 at 12:16 p.m. his call light was on for 25 minutes.<br><br>*On 2/3/25 at 5:10 a.m. his call light was on for 22 minutes.<br><br>*On 2/3/25 at 8:52 p.m. his call light was on for 39 minutes. | F0600 | | |

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| F0600 SS = D | Continued from page 3 | F0600 | | |

*On 2/6/25 at 9:54 p.m. his call light was on for 24 minutes.

4. Interview on 9/3/25 at 8:08 a.m. with resident 4 revealed:

*He had some depression and anxiety.

*He showered once a week on Thursday morning.

*He had been left lying in urine and bowel movement several times in his bed after turning his call light on and waiting for assistance.

*He required a treatment to his right buttock open area daily.

*His call light could be on for 20 minutes to two hours before it was answered at times.

*He stated, "He felt disgusting and less then human when they do not answer his call light, how can another person do that to another person."

Interview on 9/3/25 at 10:55 a.m. with certified nursing assistant (CNA) K revealed:

*She has worked at facility for about three years.

*Resident 4 did not exhibit negative behaviors toward her.

*She had at times observed resident 4 screaming at other staff and throwing things in his room.

*Resident 4 had periods when he would cry and bang on things.

*Resident 4 had refused cares such as toileting, and bathing at times.

*The expected time for staff to answer a resident's call light was two minutes.

Interview on 9/3/25 at 5:00 p.m. with certified medication aide (CMA) L revealed:

*Resident 4 had episodes when he will yell and scream at staff at times.

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| F0600 SS = D | Continued from page 4<br>*She felt resident 4 had a hot temper and could go from being calm to "hot" in a short period of time.<br><br>*Resident 4 was able to use his call light.<br><br>*If resident 4 had an incontinent episode it could "set him off" and he will get upset.<br><br>Interview on 9/4/25 at 2:28 p.m. with director of nursing (DON) B revealed:<br><br>*Resident 4's preference for bathing prior to 2/7/25 was to take a bed bath to allow for his smoking time preference.<br><br>-He changed to a weekly shower on 2/7/25.<br><br>*Resident 4 would at times refuse staff assistance with toileting, bathing, showering, repositioning, and wound care.<br><br>*Resident 4 does attend care conferences.<br><br>*She thought the staff answering a call light was within 20 to 30 minutes of it being turned on would be a prompt response and that was her expectation.<br><br>Interview on 9/4/25 at 3:10 p.m. with administrator A revealed:<br><br>*His expectation regarding the staff answering a resident call light, was it would be answered in an appropriate time, and that would depend on the resident and the resident's needs.<br><br>*When asked if an hour was too long to wait, he stated that would depend on what the resident's needs would be.<br><br>5. Review of the provider's revised 7/8/25 Call light Policy revealed:<br><br>*"Purpose to ensure residents always have a method of calling for assistance and to promptly answer resident's call light."<br><br>Review of the provider's revised 4/7/25 Abuse and Neglect policy revealed:<br><br>*"The resident/client has the right to be free from | F0600 | | |

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| F0600 SS = D | Continued from page 5<br>~~abuse, neglect, misappropriation of resident/client~~ property and exploitation. This includes but is not limited to freedom from corporal punishment and involuntary seclusion. Residents/clients must not be subjected to abuse by anyone, including but not limited to, location employees, other residents/clients, consultants or volunteers, employees of other agencies serving the individual, family members or legal guardians, friends or other individuals." | F0600 | | |
| F0655 SS = E | Baseline Care Plan<br><br>CFR(s): 483.21(a)(1)-(3)<br><br>§483.21 Comprehensive Person-Centered Care Planning<br><br>§483.21(a) Baseline Care Plans<br><br>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-<br><br>(i) Be developed within 48 hours of a resident's admission.<br><br>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-<br><br>(A) Initial goals based on admission orders.<br><br>(B) Physician orders.<br><br>(C) Dietary orders.<br><br>(D) Therapy services.<br><br>(E) Social services.<br><br>(F) PASARR recommendation, if applicable.<br><br>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-<br><br>(i) Is developed within 48 hours of the resident's admission.<br><br>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this | F0655 | Resident 14, 64, 67 & 85 were presented with their baseline care plans on 9/4/2025 following identification of non-compliance by MDS Coordinator.<br><br>Residents admitted in the past 3 months will be reviewed by DNS/designee to ensure all other residents were offered a copy of their Baseline Care Plan. Any concerns will be addressed.<br><br>Rehab MDS Coordinator and long-term care MDS Coordinator were educated by DNS on baseline care plan policy on 9/30/2025 with a full review of the baseline care plan policy completed by DNS, both MDS Coordinators and the administrator. No revisions were needed at time of review.<br><br>A prompt to ensure baseline care plan being offered will be added to the Morning Stand-Up agenda. The MDS nurse/designee will report out when a copy of the baseline care plan is offered.<br><br>DON/Designee will audit baseline care plans on five residents who had admitted to the facility within the audit timeframe to ensure baseline care plans have been developed and a written summary of the baseline care plan was presented to the resident and/or representative within 48 hours of the resident's admission to the facility. Audits will occur weekly x 4 weeks, every other week x 4 weeks, and monthly x 2 months. DON/designee will report findings to the QAPI Committee monthly. The QAPI Committee will determine on-going interventions and monitoring. | |

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| F0655 SS = E | Continued from page 6<br>section).<br><br>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:<br><br>(i) The initial goals of the resident.<br><br>(ii) A summary of the resident's medications and dietary instructions.<br><br>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.<br><br>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, record review, and policy review, the provider failed to complete a baseline care plan and provide a written summary of the baseline care plan to the resident within 48 hours of their admission to the facility for four of six newly admitted sampled residents (14, 64, 67, and 85) reviewed who admitted to the facility in August 2025.<br><br>Findings include:<br><br>1. Observation and interview on 9/2/25 at 2:50 p.m. with resident 14 in his room revealed he:<br><br>*Was frustrated about the communication he had received about his care since he had been admitted to the facility. He felt that the nursing staff had not given him enough information about his wound care and his positioning needs.<br><br>*Felt that the dietary staff had not provided him with the correct diet or with the foods he preferred to eat.<br><br>*Had not received a list of his medications or a copy of his baseline care plan when he was admitted to the facility approximately two weeks ago.<br><br>*Pointed to an admission packet and stated that was the information he had received when he was admitted to the facility. That information did not contain a baseline care plan.<br><br>Review of resident 14's electronic medical record (EMR) | F0655 | Substantial compliance will be achieved on 10/14/2025. | 10/14/2025 |

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| F0655 SS = E | Continued from page 7<br>revealed:<br><br>*He was admitted on 8/20/25.<br><br>*His 8/25/25 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact.<br><br>*There was no documentation that indicated the resident's baseline care plan was developed and reviewed with him, or that he had been provided or offered a copy of his baseline care plan within 48 hours of his admission.<br><br>2. Interview on 9/4/25 at 1:15 p.m. with resident 67 in his room revealed he:<br><br>*Had not received a list of his medications or a copy of his baseline care plan when he was first admitted to the facility.<br><br>*Felt that there was miscommunication between his therapy team and the nursing staff regarding his discharge goals.<br><br>Review of resident 67's EMR revealed:<br><br>*He was admitted 8/11/25.<br><br>*His 8/17/25 BIMS assessment score was 15, which indicated his cognition was intact.<br><br>*There was no documentation that indicated the resident's baseline care plan was developed and reviewed with him, or that he had been provided or offered a copy of his baseline care plan within 48 hours of his admission.<br><br>3. Interview on 9/2/25 at 2:20 p.m. with resident 64 in her room revealed she did not recall having received a baseline care plan when she was first admitted to the facility.<br><br>Review of resident 64's EMR revealed:<br><br>*She was admitted on 8/15/25.<br><br>*Her 8/21/25 BIMS assessment score was 15, which indicated her cognition was intact. | F0655 | | |

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| F0655 SS = E | Continued from page 8<br>*There was no documentation that indicated the resident's baseline care plan was developed and reviewed with her or that she had been provided or offered a copy of her baseline care plan within 48 hours of her admission to the facility.<br><br>4. Review of resident 85's EMR revealed:<br><br>*She was admitted on 8/5/25.<br><br>*Her 8/11/25 BIMS assessment score was 15, which indicated her cognition was intact.<br><br>*There was no documentation that indicated the resident's baseline care plan was developed and reviewed with her or that she had been provided or offered a copy of her baseline care plan within 48 hours of her admission to the facility.<br><br>A request was made on 9/4/25 at 7:43 a.m. to administrator A for documentation that baseline care plans had been developed and the resident or their representative was offered a copy within 48 hours of their admission to the facility for newly admitted residents 14, 64, 67, and 85. No further documentation was provided.<br><br>Interview on 9/4/25 at 12:54 p.m. with director of nursing (DON) B revealed:<br><br>*Baseline care plans had been completed, but had not been provided to residents 14, 64, 67, and 85.<br><br>*DON B expected that the resident's baseline care plans would be completed within 48 hours of their admission to the facility, and a copy would be provided to the resident.<br><br>*Baseline care plans for residents 14, 64, 67, and 85 were to be completed by the Minimum Data Set (MDS)/registered nurse (RN) U.<br><br>Interview on 9/4/25 at 1:20 p.m. with MDS/RN U revealed she:<br><br>*Would initiate the comprehensive care plan in the EMR on the day that the resident was admitted to the facility.<br><br>*Completed all the sections of the care plan, printed | F0655 | | |

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| F0655 SS = E | Continued from page 9<br>~~that care plan, and provided a copy of it to the~~ resident. She would document in the EMR when she had completed the baseline care plan and had provided the care plan to the resident.<br><br>*Had been on leave from the facility for approximately three weeks. Residents 14, 64, 67, and 85 were admitted to the facility while she was on leave.<br><br>*Stated that residents' 14, 64, 67, and 85's baseline care plans had been completed by MDS/RN T, but had not been provided to them or documented as having been completed.<br><br>Review of the provider's 12/2/24 Care Plan policy revealed:<br><br>*"Baseline care plan- Includes instructions needed to provide effective and person-centered care to the resident that meet professional standards of quality care."<br><br>*"A baseline care plan will be developed upon admission according to federal and state regulations. The location must provide the resident and the resident representative with a written summary of the baseline care plan. Use the PN Care Conference Note ... to document that the meeting occurred with the resident and representative and any significant discussion that occurred." | F0655 | | |
| F0677 SS = D | ADL Care Provided for Dependent Residents<br><br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, record review, and policy review, the provider failed to ensure bathing was provided and documented for two of two sampled residents (14 and 64) who were dependent on staff assistance with bathing.<br><br>Findings include:<br><br>1. Observation and interview on 9/2/25 at 2:50 p.m. and again on 9/4/25 at 8:32 a.m. with resident 14 in his room revealed: | F0677 | Resident 14 & 64 were immediately offered a bath during the survey process. On 9/4/205, resident 14 received a bed bath and on 9/4/2025, resident 64 received a shower. Both instances of a bath and shower were documented for both residents.<br><br>Care plans were reviewed and updated to reflect their preferences and needs related to bathing frequency, time of day, and staff assistance required.<br><br>A facility-wide review will be conducted for the month of September on all residents who require staff assistance for bathing by 10/3/2025. Any concerns or trends noted will be addressed immediately by DNS/designee. | |

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| F0677 SS = D | Continued from page 10<br><br>*He was told that he could shower, but he had not received a shower since he was admitted to the facility.<br><br>*He had only received bed baths since he was admitted, but he felt that the bed baths were not very thorough. He wanted his hair washed.<br><br>*On 9/4/25, a staff member had washed his back in the morning, and he wondered if that was considered his bath for the day.<br><br>Review of resident 14's electronic medical record (EMR) revealed:<br><br>*He was admitted on 8/20/25.<br><br>*His 8/25/25 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact.<br><br>*His diagnoses included paraplegia (partial or complete loss of movement and/or sensation in the legs and lower part of the body), multiple sclerosis (a chronic autoimmune disease that causes symptoms, including vision problems, muscle weakness, fatigue, numbness, balance and coordination issues, and cognitive difficulties), and pressure ulcers (injury to skin and underlying tissue from prolonged pressure).<br><br>*His 8/20/25 care plan indicated "Resident requires [the use of a] shower chair, [and] 2 staff assist [assistance of two staff]."<br><br>*An 8/20/25 physician order indicated "May shower, do not allow direct water pressure to dressing/incision. Keep dressing clean and dry. No tub until directed."<br><br>*His 8/25/25 Minimum Data Set (MDS) assessment (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) indicated he felt choosing between a tub bath, shower, bed bath, or sponge bath was "Somewhat important."<br><br>*The bathing task documentation options included "shower", "tub [bath]", "whirlpool [bath]", "sponge bath", "shampoo only", unavailable and refused.<br><br>There was no documentation that resident 14 had received a "shower", "tub [bath]", "whirlpool [bath]", a "sponge bath", a "shampoo only", or that he was | F0677 | Education to be provided by Administrator or designee to all nursing staff regarding the bathing policy and new process on 10/2/2025. Back up bath process established at the facility by DON effective on 10/3/2025.<br><br>To monitor compliance, DON/Designee will audit bathing/showering documentation for 10 residents, including residents 14 and 64, to ensure completion of baths/showers at least weekly. Audits will occur weekly x 4 weeks, every other week x 4 weeks, and monthly x 2 months. DON or designee will report findings to the QAPI Committee monthly. The QAPI Committee will determine on-going interventions and monitoring.<br><br>Substantial compliance will be achieved on 10/14/2025. | 10/14/2025 |

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| F0677 SS = D | Continued from page 11<br>unavailable or refused bathing, since he was admitted.<br><br>2. Interview on 9/2/25 at 2:20 p.m. with resident 64 in her room revealed she:<br><br>*Had only received one shower since she had been admitted to the facility. She would have liked to have received more showers because her hair felt dirty and her skin felt very dry.<br><br>*Showered three times a week at home. She thought that she would have received one or two showers each week while at the facility.<br><br>*Thought that she was not offered showers because she required more assistance than the staff could provide.<br><br>Review of resident 64's EMR revealed:<br><br>*She was admitted on 8/15/25.<br><br>*Her 8/21/25 BIMS assessment score was 15, which indicated her cognition was intact.<br><br>*Her 8/15/25 care plan indicated, "Resident requires bathing options, shower chair 1 staff assist [assistance of one staff]."<br><br>*Her 8/21/25 MDS assessment indicated she felt choosing between a tub bath, shower, bed bath, or sponge bath was "Very important."<br><br>*Her bathing task documentation indicated she had received a shower on 8/24/25.<br><br>-There was no documentation that resident 64 had received a "tub [bath]", "whirlpool [bath]", a "sponge bath", a "shampoo only", or that she was unavailable or refused bathing, since she was admitted.<br><br>3. Review of the current Sunrise Suites Bath Schedule revealed:<br><br>*Residents' bathing was assigned by room number.<br><br>*"All [new resident] admits [admissions] [are] to receive a bath the day after [their] admission- this is REQUIRED..."<br><br>*"Makeups can be completed on Sunday- openings on Wednesday/Thursday evening for [new] admits." | F0677 | | |

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| F0677 SS = D | Continued from page 12<br><br>*Resident 14 was scheduled for bathing on Mondays and Thursdays during the evening shift.<br><br>-Resident 14 had not been provided his scheduled bathing on 8/21/25 (the day after his admission), 8/25/25, 8/28/25, or 9/1/25.<br><br>*Resident 64 was scheduled for bathing on Mondays and Thursdays during the evening shift.<br><br>-Resident 64 had not been provided her scheduled bathing on 8/16/25 (the day after her admission), 8/18/25, 8/21/25, 8/25/25, 8/28/25, or 9/1/25.<br><br>4. Interview on 9/4/25 at 10:58 a.m. with licensed practical nurse (LPN) O regarding resident 64's bathing revealed:<br><br>*Resident 64 was allowed to shower if her dialysis port dressing was covered.<br><br>*She stated that certified nursing assistant (CNA) N had assisted resident 64 to shower that morning (9/4/25).<br><br>*LPN O expected that resident 64's showers provided or refusals to shower would have been documented in the EMR.<br><br>5. Observation and interview on 9/4/25 at 11:12 a.m. with CNA N and occupational therapist (OT) S in resident 64's room revealed:<br><br>*CNA N had just finished assisting resident 64 with showering. This was the first time she had assisted resident 64 to shower.<br><br>*CNA N documented when she completed a resident's shower in the resident's EMR under bathing tasks.<br><br>*OT S stated that she had not assisted resident 64 with showering. When therapy provided residents assistance with bathing or showering, they would tell the CNA so that shower would be documented in the residents' EMR.<br><br>6. Interview on 9/04/25 at 11:13 a.m. with LPN O regarding resident 14's bathing revealed:<br><br>*Resident 14 was allowed to shower as long as his wound dressings remained dry. She was unaware of any reason | F0677 | | |

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| F0677 SS=D | Continued from page 13<br>~~that the resident would not have been provided a shower~~ or a bed bath.<br><br>*LPN O thought that resident 14 had been refusing to shower and those refusals should have been documented in the EMR.<br><br>*LPN O was unable to find documentation that resident 14 refused showering.<br><br>*LPN O stated that resident 14 had been provided bed baths and those bed baths should have been documented in the bathing task section of the EMR. She was unable to find documentation that resident 14 had received bed baths.<br><br>7. Interview on 9/5/25 at 9:10 a.m. with director of nursing (DON) B regarding resident 64's bathing revealed:<br><br>*Resident 64 was allowed to shower if her dialysis port was covered.<br><br>*DON expected resident 64 to have showers twice a week and expected those showers to have been documented in the EMR.<br><br>8. Interview on 9/5/25 at 10:36 a.m. with DON B regarding resident 14's bathing revealed:<br><br>*There was no documentation that resident 14 had received a bed bath or a shower.<br><br>*Resident 14 had been refusing to get out of bed or shower.<br><br>*DON B expected those refusals to shower to have been documented.<br><br>*She thought that resident 14 was provided with a bed bath when he refused to shower and expected those bed baths to have been documented.<br><br>*If a resident was unavailable or refused a shower or a bed bath, she expected the CNA to have offered the resident a shower or a bed bath on another day, and any bathing activity to have been documented in the EMR.<br><br>Review of the provider's 8/29/25 Bathing policy revealed: | F0677 | | |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F0677 SS = D | Continued from page 14<br>*"Purpose- To promote cleanliness and general hygiene, To promote comfort, relaxation, and well-being, To observe [the] resident's condition, To assist [the] resident with personal care..."<br><br>*"Perform...document[ion] where/when appropriate." | F0677 | Resident 100 no longer resides at the facility.<br>All residents have the potential to be impacted by this deficient practice.<br>All current residents have been reviewed by DNS to ensure Code Status is readily available and present in a binder on the crash carts if needs are identified.<br><br>DON/Designee educated all nursing staff including licensed nurses, CNAs and CMAs,regarding code blue process on 12/26/2024. Code blue drills completed for all shifts to ensure compliance with policy/procedure. DON implemented new facility process after reviewing the facility policy to incorporate where CPR will not be initiated until dual confirmation of advanced directive takes place. Since implementation of process, subsequent code blue drills completed at the facility with no concerns identified. To ensure CPR is not delayed when needed, all licensed nurses, CNAs and CMAs have been educated in the urgency to provide the crash cart with the code status binder and confirm the code status with the nurse who is initiating CPR so CPR can begin. Drills will be conducted at the facility by the clinical lead development specialist to ensure all nursing staff are competent in the facility process per the policy.<br><br>To monitor compliance, DON/Designee will complete code blue drills monthly on both day shift and night shift x 4 months. DON or designee will report findings to the QAPI committee monthly. The QAPI Committee will determine on-going interventions and monitoring after completion of the audits per the plan of correction to ensure compliance is sustained.<br><br>Substantial compliance will be achieved on 10/14/2025. | 10/14/2025 |
| F0678 SS = D | Cardio-Pulmonary Resuscitation (CPR)<br><br>CFR(s): 483.24(a)(3)<br><br>§483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, record review, and interview, the provider failed to withhold cardiopulmonary resuscitation (CPR) for one of one resident (100) who had a do not resuscitate (DNR) code status (specifies the type of emergent treatment a person wishes to receive if their heart or breathing would stop) and was found unresponsive.<br><br>Findings include:<br><br>1. Review of the provider's 12/24/24 SD DOH FRI revealed:<br><br>*On 12/24/24, resident 100 was found unresponsive by restorative nursing aide (RNA) V.<br><br>*Director of nursing (DON) B initiated the provider's "code blue process."<br><br>*"CPR [cardiopulmonary resuscitation] was initiated [by a facility staff member] and EMS [Emergency medical services] [was] called prior to the [resident's] DNR order being brought to the resident room. Code status was found via the advanced directive binder on the crash cart (a cart that stores medication and equipment for use during a medical emergency) per policy/procedure."<br><br>*"Upon EMS's arrival at the facility, the resident's code status was confirmed to be DNR."<br><br>*"[The provider's] Policy was followed..." | F0678 | | |

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| F0678 SS = D | Continued from page 15<br>2. Review of resident 100's electronic medical record (EMR) revealed:<br><br>*She was admitted to the facility on 7/6/21.<br><br>*An 11/25/22 physician's order for "ADVANCE DIRECTIVE: Do Not Resuscitate (DNR)."<br><br>3. Interview on 9/5/25 at 11:20 a.m. with DON B, who worked on 12/24/24, revealed:<br><br>*On 12/24/24, RNA V found resident 100 unresponsive during the morning water pass.<br><br>*DON B's office was in the area of resident 100's room. She entered that room, assessed resident 100, and determined she was not breathing.<br><br>*DON B asked certified nursing assistant (CNA) K resident 100's "code status," and was told by CNA K that the resident's code status was a full code (all life-sustaining measures, including CPR, should be used during a medical emergency to attempt to restart a patient's heart and lungs).<br><br>*Registered nurse (RN) W brought the crash cart to resident 100's room, and gave a second "verbal confirmation" that resident 100 was a "full code."<br><br>*DON B initiated CPR on resident 100, requested the automated external defibrillator (AED), and requested 911 to be called.<br><br>*DON B provided CPR to resident 100 until emergency medical technicians (EMTs) arrived and assumed resident 100's emergency treatment.<br><br>*DON B looked at the advanced directives binder and read that resident 100 had a DNR code status.<br><br>*That written DNR code status was provided to the EMTs, and CPR was stopped.<br><br>*DON B stated if she had known that resident 100 had a DNR code status, she would not have started CPR on resident 100. "There had been a miscommunication."<br><br>4. Interview on 9/5/25 at 9:31 am with CNA K, who worked on 12/24/24, revealed:<br><br>*She had responded to resident 100's room after resident 100 was found unresponsive. | F0678 | | |

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| F0678 SS = D | Continued from page 16<br><br>*CNA K told DON B that resident 100 was a "full code".<br><br>*CNA K had not looked at the advanced directives binder when she told DON B that. She thought that resident 100 was a full code.<br><br>5. Interview on 9/4/25 at 10:43 p.m. with clinical learning development specialist (CLDS) F revealed:<br><br>*She was a CPR instructor and conducted the nursing staff skills fair and competencies.<br><br>*When a resident was found unresponsive, staff were trained to check the resident's vitals (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate), obtain the crash cart and the advance directives binder to confirm the resident's code status before initiating CPR.<br><br>*The advance directives binder and the residents' EMR identified each resident's physician-ordered code status.<br><br>*She expected that CPR would not be initiated if a resident had a DNR code status.<br><br>*She stated that it was the facility's policy for the nurse to check the resident's code status before starting CPR.<br><br>*Review of the provider's 10/29/24 Advance Directive including Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator (AED) policy, revealed:<br><br>*"If cardiac arrest occurs, CPR must be initiated unless the resident has: a. A valid DNR order on file that includes the medical order issued by a physician..." | F0678 | | |
| F0689 SS = D | Free of Accident Hazards/Supervision/Devices<br><br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br><br>The facility must ensure that -<br><br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and | F0689 | Non-compliant air mattress removed from the bed of resident 44 on 9/4/2025 and replaced with an air mattress that was the appropriate size to fit the bed frame. | |

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| F0689 SS = D | Continued from page 17<br>~~§483.25(d)(2)Each resident receives adequate~~ supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, record review, and policy review, the provider failed to ensure an air mattress safely fit the resident's bed frame and did not impede the use of assist bars for one of one sampled resident (44) who had an air mattress to relieve pressure from a pressure ulcer and used assist bars for mobility and positioning while in bed, which may have put the resident at risk for accidents and injury.<br><br>Findings include:<br><br>Based on observation, interview, record review, and policy review, the provider failed to ensure that the air mattress for one of one sampled resident (44) was safely fitted to the bed frame and did not present an accident hazard.<br><br>1. Observation and interview on 9/3/25 at 8:50 a.m. with resident 44 revealed:<br><br>*Her bed had an air mattress on it that extended approximately five inches over the open side of the bed frame.<br><br>*The air mattress was covered with a smooth nylon cover and designed to be used without a bottom sheet.<br><br>*She had been using the air mattress for several months because she had a pressure ulcer (skin and/or underlying tissue injury from prolonged pressure).<br><br>*There were assist bars (bed/side rails) attached to both sides of the bed frame but she was only able to use the one on the wall side of the bed.<br><br>*She used the assist bar on the bed's wall side to help turn over.<br><br>*She previously used the assist bar on the open side for assistance with turning and getting up from the bed.<br><br>*The assist bar on the open side of the bed was no longer able to be used due to the air mattress being larger than the bed frame. | F0689 | All other resident beds with air mattresses will be reviewed by Admin/designee by 10/3/2025 to ensure:<br><br>The mattress fits securely on the bed frame. The assist bars (if used) are not impeded or rendered unsafe.<br>Any issues identified will be corrected immediately and residents will be assessed for harm or risk.<br><br>Administrator/designee will educate maintenance supervisor, lead maintenance mechanic and maintenance mechanic on 10/3/2025 to ensure compliance when placing air mattresses on resident beds.<br><br>To monitor compliance, administrator/designee will audit 5 air mattresses, including resident 44, to ensure the air mattresses safely fits the resident's bed frame and do not impede the use of assist bars. Audits will occur weekly x 4 weeks, every other week x 4 weeks, and monthly x 2 months.<br>Administrator/designee will present findings to QAPI meeting month. The QAPI Committee will determine on-going interventions and monitoring.<br><br>Substantial compliance will be achieved on 10/14/2025. | 10/14/2025 |

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| F0689 SS = D | Continued from page 18<br>*The nursing staff would place the long side of her bedside table against the bed at night to remind her not to get too close to the edge.<br><br>*She was afraid of falling out of bed, and she felt it disturbed her sleep.<br><br>2. Interview on 9/4/25 at 9:45 a.m. with director of nursing (DON) B revealed:<br><br>*She had created the "work order" for an air mattress to be placed on resident 44's bed.<br><br>*Maintenance staff would install an air mattress when there is a work order for one.<br><br>*She was not aware of an issue with the air mattress size or that the assist bar on the open side of the bed could not be used.<br><br>*She agreed that an air mattress that was larger than the bed frame would be an accident hazard.<br><br>3. Interview and observation on 9/4/25 at 9:50 a.m. with maintenance mechanic (MM) Z and maintenance technician (MT) C revealed:<br><br>*They agreed that resident 44's mattress did not fit properly and was not safe.<br><br>*The air mattress being too large for the bed frame was an accident hazard.<br><br>*Resident 44 could slide out of bed and onto the floor.<br><br>*The bed rail on the open side of the bed could not be raised.<br><br>*MM Z did not know who had installed the air mattress on resident 44's bed.<br><br>4. Review of work order #2822 revealed:<br><br>*The request to add an air mattress to resident 44's bed was created by DON B on 6/10/25.<br><br>*It was assigned to MM Z on 6/11/25 at 8:53 a.m. and marked "set to: completed" on the same date and time by LMM AA. | F0689 | | |

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| F0689 SS = D | Continued from page 19<br>5. Review of the 6/13/25 bed and side rail inspection log completed by MM Z revealed the areas:<br><br>*Inspect mattress gap between side rails/assist bars.<br><br>*Verify side rail[s] are fully functional and free of obstructions.<br><br>6. Interview on 9/4/25 at 12:30 p.m. with lead maintenance mechanic (LMM) AA revealed:<br><br>*Resident 44's bed frame was not an acceptable size for that air mattress.<br><br>*They had bed frames that were the appropriate size for the air mattress.<br><br>*It would not be acceptable for the bed rails not to be used.<br><br>*The bed and side rail inspection log completed by MM Z on 6/13/25 was not accurate.<br><br>*Agreed that it was an unsafe environment for the resident.<br><br>Review of resident 44's electronic medical record (EMR) revealed:<br><br>*Resident 44 had a Brief Interview for Mental Status (BIMS) Assessment score of 15, which indicated that her cognitive function was considered normal and not impaired.<br><br>*A 6/5/25 physician's order to provide an air mattress for resident 44 due to a stage II (2; open wound or blister with partial-thickness skin loss) pressure ulcer.<br><br>*Her current care plan had a 6/4/25 initiated focus area of an ADL self-care performance deficit related to her deconditioning post hospital stay, with interventions that indicated she:<br><br>-Used assist/grab bars to position up in bed, turn side to side, move from lying to sitting, and to move from sitting to lying, which were initiated on 6/5/25.<br><br>-Was able to utilize assist/grab bars appropriately, which was initiated on 6/5/25.<br><br>*Had an air mattress for pressure relieving, which was | F0689 | | |

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| F0689 SS = D | Continued from page 20<br>initiated on 6/5/25 and revised on 9/4/25.<br><br>*Her current care plan had a 6/5/25 initiated focus area that indicated the resident was at risk for falls related to new onset atrial fibrillation and her deconditioning post hospital stay.<br><br>-An intervention for that focus area indicated that staff members were to educate the resident and her family about safety reminders.<br><br>5. Interview on 9/5/25 at 9:50 a.m. with minimum data set (MDS)/registered nurse (RN) revealed:<br><br>*She had completed the education with resident 44 as indicated on the physical device and restraint evaluation on 8/24/25.<br><br>*She pushed the air mattress out of the way with her shoulder to be able to raise the rail.<br><br>*Resident 44 would not have been able to raise the rail herself.<br><br>*She recognized that the air mattress was too big for resident 44's bed frame and had meant to let nursing or maintenance know.<br><br>*She had not notified anyone about the air mattress being too big for the resident's bed frame.<br><br>6. Interview on 9/5/25 at 10:15 a.m. with administrator A revealed:<br><br>*An assessment would be required to ensure the proper fit of the mattress to the bed frame and ensure the safety of the resident.<br><br>*The air mattress assessment completed by MM Z was not accurate.<br><br>Review of the physical device and/or restraint evaluation and review for resident 44 revealed:<br><br>*It was signed as completed by Minimum Data Set/Registered Nurse (MDS/RN) T on 8/24/25.<br><br>*It indicated a recommendation for the use of an assist rail (quarter rail used for turning and mobility).<br><br>*It indicated that informed consent had been obtained | F0689 | | |

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| F0689 SS = D | Continued from page 21<br>for use of the assist rail.<br><br>*It indicated that general device education was provided and specifically that she showed the resident how to use/remove the assist rail.<br><br>Review of the provider's 2/2/24 reviewed/revised bed safety and side rail entrapment resource policy revealed:<br><br>-"Hazards refer to elements of the resident environment that have the potential to cause injury or illness."<br><br>-"Free of accident hazards as possible" refers to being free of accident hazards over which the facility has control."<br><br>*"F689 [federal regulation] states: The facility must ensure that the resident's environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents."<br><br>*"A resident's bed should be a place of comfort and relaxation, a safe place. When the bed system does not fit correctly ... the resident's bed is no longer a safe place."<br><br>*"The bed system includes the bed frame and mattress as well as any side rails or assistive devices."<br><br>*Review manufacturer's guidance for use of the various types of mattresses such as air mattresses.<br><br>*"It is important to remember that not all rails and mattresses fit all bed frames".<br><br>-Inspect the bed system for proper fit of mattress in the bed frame.<br><br>The air mattress manufacturer's instructions were requested from the provider but not received prior to survey exit on 9/5/25. | F0689 | | |
| F0800 SS = E | Provided Diet Meets Needs of Each Resident<br><br>CFR(s): 483.60<br><br>§483.60 Food and nutrition services.<br><br>The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, | F0800 | Resident #44, 81 and 82 will be interviewed by Director of Dietary Services (DDS) to identify their food preferences and concerns. | |

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| F0800 SS = E | Continued from page 22<br>taking into consideration the preferences of each resident.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation and interview, the facility failed to ensure that three of three residents (44, 81, 82) were provided with a nourishing, palatable, well-balanced diet that met their daily nutritional and dietary needs.<br><br>1. Interview on 9/3/25 at 8:50 a.m. with resident 81 revealed:<br><br>*Hot food is frequently served cold.<br><br>*She would sometimes not eat an item if it was not at an acceptable serving temperature because it was unpleasant to her.<br><br>*The previous evening, they were served a cold sandwich and a cold bean salad.<br><br>*No fruit or dessert was provided.<br><br>2. Interview on 9/3/25 at 8:50 a.m. with resident 44 revealed:<br><br>*They are served cold sandwiches for three to four suppers every week.<br><br>*She would prefer something warm in the evenings.<br><br>*When she asked for something warm, she was not given a choice but provided mashed potatoes and gravy.<br><br>*She dislikes hot dogs and doesn't like it when they are served.<br><br>*She is not aware of other food choices.<br><br>3. Interview on 9/3/25 at 9:15 a.m. with resident 82 revealed:<br><br>*The food is frequently very dry and hard for her to eat due to her lack of teeth.<br><br>*Foods that should be served hot are more often cold than they are hot.<br><br>4. Interview on 9/3/25 at 4:00 p.m. with director of | F0800 | Substitutions – All dietary staff educated by the administrator on need to provide food that is offered on the menu by 10/3/2025. All substitutions must be approved by RD.<br><br>Room tray temps – limit room trays to 4 at a time to ensure timely delivery and maintain food temperatures. Trays will not be prepared until care partners are ready to deliver. Workflows in the kitchens were adjusted to ensure steam tables are turned on to keep food at proper holding temperature. All Dietary staff were educated on standards for food temperatures and log completion.<br><br>A facility wide review of all resident menu cards will be completed by the Consultant Dietitian and DDS by 10/3/2025 to ensure accuracy of diet orders, preferences, allergies and adaptive equipment.<br>All residents will be provided a Food Preference questionnaire regarding their food preferences, requests and any pertinent related requests by the director of dining services by 10/3/2025. All new residents are provided a food preference questionnaire within 72 hours of admission by the director of dining services.<br>Information is reviewed by the director of dining services and the registered dietician to ensure the residents receive a proper diet while also providing resident centered care.<br><br>Corrective action/training will be addressed with all dietary staff members. Morrison Dining will train staff using state-guided training materials as well as on the job visual training. New staff will have the same training upon onboarding,<br>All dietary staff were educated and competencies were reviewed and tested on policies regarding menu substitutions, food temperature logs, and food safety by 9/12/25. | |

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| F0800 SS=E | Continued from page 23<br>~~dietary services (DDS) G about resident menu complaints~~ revealed:<br><br>*There was ham on the breakfast menu for Monday, but sausage patties were served.<br><br>*There was bacon on the breakfast menu for Wednesday, but sausage patties were served.<br><br>*He did not feel they had the equipment to prepare ham or bacon for the number of residents they served.<br><br>*It was easiest to cook and hold the temperature of the sausage patties.<br><br>*He agreed that the menu did not match the food served.<br><br>*They were not required to get a substitution approved if it was a like item such as a meat substituted for a meat or toast substituted for a muffin.<br><br>*He attributed complaints about cold food were due to the certified nursing assistants (CNAs) taking too long to deliver room meal trays.<br><br>*He did not believe that hot food served in the dining room was cold.<br><br>*Cold sandwiches were served for many suppers were because they were on the summer menu.<br><br>5. Interview on 9/4/25 at 9:30 a.m. with CNA K revealed:<br><br>*She and other CNAs expressed frustration over frequent corrections needed for the residents' meal trays despite the kitchen staff having access to the same resident menu cards (a card used at each meal that describes the resident's physician-ordered diet, choice from the menu, food preferences, allergies, and dislikes) as the CNAs.<br><br>*She explained that each resident had a menu card. The nurse managers were to give the residents' diet information to DDS G, who updated the menu cards, and that was considered as the first check that the meal served to the residents was correct.<br><br>*Cooks and FSWs preparing and plating the meals was considered the second check, and the CNAs serving those meals was considered the third check that the resident was served the correct meal. | F0800 | All staff will be educated on new process for creating and delivering room trays by 10/2/25 at all-staff meeting. Staff that are not present at meeting will be required to review information and sign off understanding<br><br>Meal Accuracy Audit to be completed on 10 resident's trays weekly x4, every other week x2, monthly 1 and quarterly x1 rotating meals by director or designee beginning 9/10/25. Meal accuracy audits consist of ensuring that the resident receives the meals that they order along with ensuring that the meal is made per the resident's specific diet order. Any items out of compliance will be corrected immediately and staff educated to ensure compliance.<br><br>Test Tray Audit to be completed on 10 resident's trays weekly x4, every other week x2, monthly 1 and quarterly x1 rotating meals by director or designee beginning 9/10/25. Test tray audits consist of ensuring that the temperature, consistency and texture of the meals are appropriate for the resident's specific diet and preferences. Any items out of compliance will be corrected immediately and staff educated to ensure compliance. Substitution Log will be completed by director and reviewed weekly by RD for approval. RD weekly review of substitution log will be presented to to the QAPI committee and the QAPI Committee will determine on-going interventions and monitoring after completion of the audits per the plan of correction to ensure compliance is sustained<br><br>Dietary manager or designee will report findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring.<br><br>Substantial compliance will be achieved on 10/14/2025. | 10/14/2025 |

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| F0800 SS = E | Continued from page 24<br>*Menu cards were frequently not updated by the kitchen staff.<br><br>*She felt the kitchen staff disregarded residents' diet needs and preferences and failed to provide them with adaptive items some of the residents needed to eat.<br><br>6. Interview on 9/4/25 at 1:00 p.m. with DDS G revealed:<br><br>*He agreed that the menu cards contained important resident information, including food preferences, ordered diets and food textures, and food allergies, which were critical to the residents' safety.<br><br>Interview on 9/4/25 at 2:00 p.m. with social worker (SW) HH revealed:<br><br>*She had been an employee at the facility for approximately three weeks.<br><br>*She had heard three meal-related complaints from residents that included:<br><br>-They were not receiving meat for breakfast.<br><br>-They were not receiving the food item that the menu showed.<br><br>-A complaint regarding the serving of succotash.<br><br>*She had discussed these complaints with the lead social worker.<br><br>7. Interview on 9/4/25 at 2:05 p.m. with lead social worker (LSW) II revealed:<br><br>*She thought the resident's food complaints occurred in intermittent streaks.<br><br>*Food complaints were to be discussed during the resident food council meetings.<br><br>*She thought that since the contracted company provided the food service, communication options were limited beyond the food council meetings, which were a monthly meeting separate from the resident council meeting for residents, facility leadership, and DDS G to talk about the food served at meals.<br><br>*DDS G attended the resident food council meetings. | F0800 | | |

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*Residents had expressed dissatisfaction with the effectiveness of the food council recommendations.

Observation and interview on 9/4/25 at 3:05 p.m. with DDS G revealed:

*He agreed that kitchen staff should ensure the residents' dining meal trays reflected the correct resident preferences, diets, and adaptive equipment.

*He was solely responsible for adding the residents' diet orders to the menu cards.

*He thought the CNAs were responsible for managing residents' meal preferences.

Observation on 9/5/25 at 8:00 a.m. during the breakfast meal service in the dining room revealed the CNAs had requested corrections on 14 of 15 prepared resident meal trays before they could be served to the residents.

8. Interview on 9/5/25 at 8:30 a.m. with dietitian BB revealed:

*She was the dietitian for the contracted food service responsible for preparing the residents' lunch and supper meals at the facility's central kitchen.

*She approved all of the menus at the central kitchen.

*The oversight of the facility's dining service was designated as the responsibility of DDS G.

*Breakfast was to be prepared based on the menus she approved.

*The substitution of "like items" such as a meat for a meat or toast for a muffin did not require her approval, but she expected the menu to be followed as closely as possible.

*She disagreed with substituting sausage patties for all breakfast meat items solely for ease of preparation.

*She agreed that the kitchen staff were responsible for following the residents' menu cards, including the residents' diet orders, allergies, assistive device needs, and preferences.

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| F0800 SS = E | Continued from page 26<br>*She agreed that the documented temperatures of the scrambled eggs, biscuit and gravy, or milk on the sample tray did not meet safe food serving temperatures.<br><br>9. Interview on 9/5/25 at 10:15 a.m. with administrator A revealed:<br><br>*He expected kitchen staff to:<br><br>-Adhere to facility policies regarding hair and facial hair coverings, hand washing and glove use, kitchen cleaning, food temperature monitoring, and hygiene.<br><br>-Follow physician diet orders, address allergies, accommodate assistive device needs and honor food preferences.<br><br>-Be responsive to food council suggestions and resident choices to the extent possible.<br><br>Was aware of complaints about hot food being served cold and the frequent serving of cold food items such as sandwiches.<br><br>*He stated the process for gathering feedback on food choices was the food council, and they conduct informal audits of five residents at a time about food taste, food temperature, and choice. | F0800 | | |
| F0806 SS = E | Resident Allergies, Preferences, Substitutes<br><br>CFR(s): 483.60(d)(4)(5)<br><br>§483.60(d) Food and drink<br><br>Each resident receives and the facility provides-<br><br>§483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences;<br><br>§483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice;<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, and record review, the provider failed to provide meals to meet the residents' satisfaction for eight of twenty-five sampled residents | F0806 | Resident #14: Dietary manager and consulting dietitian will meet with resident by 10/2/2025 to review his diet order, preferences, and "Nutrition and Wound Healing" guidelines. His diet card and care plan will be updated by the dietary manager and consulting dietitian to reflect a Consistent Carbohydrate / High Protein diet, food dislikes and preferred vegetables.<br><br>Resident #67: Allergy to corn and preference restrictions (no spicy/processed foods, gall bladder surgery diet) will be updated on his diet card and EMR by the dietary manager and registered dietitian by 10/2/2025. Menu preferences will be reviewed and substitutions offered. | |

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| F0806 SS = E | Continued from page 27<br>(14, 34, 44, 49, 52, 53, 67, and 82) who expressed dissatisfaction with the meal service regarding food quality, temperature, repetition, choices, and not accommodating the residents' food preferences and ordered diets..<br><br>Findings include:<br><br>1. Observation and interview on 9/2/25 at 2:50 p.m. and again on 9/4/25 at 8:32 a.m. with resident 14 in his room revealed:<br><br>*He ate his meals in his room and was frustrated about the food that he received. He had filled out a menu with his food choices, but the kitchen had not sent the food that he requested.<br><br>*He was concerned that the dietary staff had not provided him with the correct diet or with the foods he preferred to eat.<br><br>*No one had asked him about his meal preferences and the foods he liked to eat, so he often refused the fried food items they served until he requested that his diet be changed to include more protein. He felt that since that change, all he received was meat, usually sausage patties or hamburger patties, eggs, and milk.<br><br>*He pointed to a sheet of information that he had brought from the hospital regarding "Nutrition and Wound Healing" and stated that he had hoped to discuss that information with the dietitian so that he received the foods that he preferred to eat.<br><br>*He would tell the certified nursing assistants (CNAs) what he wanted to eat, but he was unsure if that information was relayed to the kitchen.<br><br>*He avoided carbohydrates and did not want potatoes or corn, but would have liked broccoli, cauliflower, beans, or peas. He could not recall having been served any vegetables in the last week.<br><br>*He stated that on 9/3/25, he was served a hamburger patty and two small pieces of chicken with a bone in them. He had been served french fries and breaded shrimp, and he was angry about that because he had told the staff several times that he would not eat fried foods because they "mess up" his blood sugars.<br><br>*On 9/4/25, he was served a cheese omelet and milk and had not been provided with bacon or sausage. He thought that bacon had been on the menu that day, and he would | F0806 | Residents #34, 44, 49, 52, 53, and 82:<br>Each resident will be interviewed by the dietary manager by 10/2/2025 to update food dislikes, preferences, and substitute requests. Care plans and diet cards will be corrected by the dietary manager by 10/2/2025 to include these preferences. Residents received assurance that they will be offered appealing alternatives when items are refused.<br><br>A full review of all resident diet cards, diet orders, allergy documentation and food preference sheets will be conducted by DDS and Dietician by 10/2/2025.<br>All residents will be surveyed to ensure their food preferences.<br><br>Within 72 hours of admission, DDS/designee will complete a food preference and allergy confirmation interview with each new resident (or representative) and enter it into diet card program.<br><br>Consulting Dietitian will review all diet orders and food preference documentation within 72 hours of admission and at each care plan meeting.<br><br>Standardized diet cards will list diet order, allergies, supplements, adaptive equipment, dislikes and food preference. Diet cards will be reviewed weekly by the dietary manager to ensure accuracy. Diet cards will be updated by the dietary manager as changes to diet orders, food preferences, allergies, supplements with meals, and adaptive equipment occur.<br><br>A written, approved "Always Available" menu with hot and cold options will be posted and distributed to all residents and staff. Staff will be trained to offer these items when a resident refuses or dislikes a meal. | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 09/05/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER | 401 WEST SECOND STREET , SIOUX FALLS, South Dakota, 57104 |

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| F0806 SS = E | Continued from page 28<br>have liked to receive that.<br><br>Review of resident 14's electronic medical record (EMR) and paper medical records revealed:<br><br>*He was admitted on 8/20/25.<br><br>*His 8/25/25 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact.<br><br>*His diagnosis included Diabetes Mellitus (a condition involving disruptions in how the body regulates blood sugar), esophageal reflux (a condition where stomach contents flow back into the esophagus causing irritation), and pressure ulcers (skin and/or underlying tissue injury from prolonged pressure).<br><br>*His 8/20/25 physician's orders indicated he was to be provided with "CCHO [Consistent Carbohydrate] diet...All protein diet," and "Boost Glucose Control with all meals."<br><br>*An 8/20/25 Diet Notification Form (a form used by nursing to communicate diet orders to the kitchen) indicated he was to be provided a "Consistent Carbohydrate (Diabetic Diet)," but it did not indicate his need for a high protein diet, supplements, or his food preferences.<br><br>*His undated diet card indicated "CCHO." The food preferences, dislikes, and supplements sections had not been filled in on that card. A yellow sticky note attached to that card indicated "extra protein, no carbs, no desserts."<br><br>*His 8/20/25 care plan indicated a goal that the "resident will express that his/her nutritional needs are being met, and he/she feels supported in dining decisions." His food preferences were not listed in his care plan.<br><br>*His "Amount Eaten by Mouth" task documentation since his admission indicated that 33 out of 41 meals had been documented. Of those 41 meals, 16 were marked as "Resident Refused", "Not Applicable", or that he had eaten "0-25% (percent)" of the meal.<br><br>2. Interview on 9/2/25 at 5:01 p.m. and again on 9/4/25 at 1:15 p.m. with resident 67 in his room revealed he:<br><br>*Ate most of his meals in his room and was unhappy with | F0806 | Dietary staff, CNAs and Nurses will receive in-service training by the administrator by 10/3/2025 on:<br><br>Importance of honoring allergies, preferences and ordered diets.<br>Procedures for communicating requests and substitutions to the kitchen.<br>Correct use of adaptive equipment and monitoring of food temperatures.<br>All staff to sign acknowledgement sheet following education provided.<br><br>Meal Accuracy Audit to be completed on 10 resident meals rotating meals between breakfast, lunch and dinner by director or designee so all meals are audited. These audits will occur weekly x4, every other week x2, monthly 1 and quarterly x1 beginning 9/10/25. Any items out of compliance will be corrected immediately and staff educated to ensure compliance.<br><br>Test Tray Audit rotating meals by director or designee weekly x4, every other week x2, monthly 1 and quarterly x1 beginning 9/10/25. Any items out of compliance will be corrected immediately and staff educated to ensure compliance.<br><br>Dietary manager or designee will report findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring.<br><br>Substantial compliance will be achieved on 10/14/2025. | 10/14/2025 |

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| F0806 SS = E | Continued from page 29<br>~~the quality and quantity of food he had been offered.~~<br><br>*Stated there was a menu that he filled out with his food choices on Saturdays for the week. He thought that the menu was provided to the kitchen, but was unsure because he did not receive the items he had indicated on that menu.<br><br>*Recently had gall bladder surgery and had to be careful about what he ate. He avoided processed and spicy foods. He often selected the alternative items, but did not receive them.<br><br>*Recalled that one night they had a choice of chili dogs or a BLT (bacon, lettuce, tomato) salad. He ordered a double portion of the BLT salad but was told they had run out after serving the residents upstairs. He was offered the chilidog but felt he should not eat that, so he had ordered a sandwich from a restaurant to be delivered.<br><br>*Stated he had run out of money from ordering food out from restaurants, so a friend had brought him more money and some tuna.<br><br>*Told the CNAs who delivered his meal tray when he did not like certain foods or could not eat them. The CNAs would then offer to make him a bowl of soup or toast.<br><br>Review of resident 67's EMR revealed:<br><br>*He was admitted 8/11/25.<br><br>*His 8/17/25 BIMS assessment score was 15, which indicated his cognition was intact.<br><br>*His diagnosis included Diabetes Mellitus, cholecystectomy (removal of the gall bladder), esophageal reflux, and obesity (overweight).<br><br>*His 8/11/25 physician's orders indicated he was to be provided a "Regular diet."<br><br>*His allergies included corn.<br><br>*An 8/11/25 Diet Notification Form indicated "Regular Diet." It did not include his allergy to corn or his food preferences.<br><br>*His undated diet card indicated "Reg [regular diet]." It did not include his allergy to corn. The food preferences, dislikes, and special instructions sections had not been filled in on that card. | F0806 | | |

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| F0806 SS = E | Continued from page 30<br><br>*An 8/12/25 care plan goal, "Residents will show evidence of adjustment to nursing home by eating meals and dining room..." and an intervention, "Provide resident with as many choices as possible which give control over [the] resident's environment and care delivery."<br><br>*His "Amount Eaten by Mouth" task documentation since his admission indicated that 56 out of 65 meals had been documented. Of those 56 meals, 19 were marked as "Resident Refused," or "Not Applicable."<br><br>3. Interview on 9/2/25 at 5:45 p.m. with cook H in the Sunrise Suites dining room revealed:<br><br>*All of the residents on the first floor who ate in the dining room or in their rooms were served the same meal, except for one who just received hamburger patties for dinner.<br><br>*Dinner that night, 9/2/25, was to include a cold sandwich, broccoli salad, and mandarin oranges. Three-bean salad had been on the menu, but he had dropped it on the floor and made a broccoli salad instead.<br><br>*There was no alternative meal available that day because the frier was not working.<br><br>*If a resident asked for something else, they could have had soup, a sandwich, or a burger, and "sometimes there was salad."<br><br>4. Interview on 9/2/25 at 6:01 p.m. with CNA R in the Sunrise Suites dining room revealed she:<br><br>*Confirmed that for dinner that evening, all but one resident had received the same meal.<br><br>*Stated that if the residents refused their meal when she brought it to them, she would make them a bowl of soup.<br><br>5. Interview on 9/4/25 at 8:58 a.m. with CNA N regarding meal service in the Sunrise Suites dining room revealed:<br><br>*There was no meal ticket system (where resident meal preferences were recorded) like they used in the upstairs dining room because the residents admitted and | F0806 | | |

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| F0806 SS=E | Continued from page 31<br>discharged more quickly.<br><br>*The main kitchen brought the food that the residents were served, and they all received the same thing unless they refused it.<br><br>*Residents did not receive a meal choice at breakfast, but a menu was provided for lunch and dinner. She was unsure if the kitchen used that menu to prepare the residents' meals.<br><br>*The residents would tell her what they liked, and she would try to make sure they got what they wanted.<br><br>*She would know their diet orders because it was listed in the EMR on the residents' care plan. She was unaware if there was a list of residents' food preferences, but when they told her what they preferred, she tried to remember that.<br><br>6. Interview on 9/4/25 at 2:39 p.m. with director of dietary services (DDS) G regarding meal services in the rehab unit revealed:<br><br>*He received the Diet Notification Form from nursing that indicated the resident's diet and allergies. With that information, he made a diet card that was kept in the rehab unit dining room. He expected staff to use that card to know the resident's ordered diet and allergies when serving the resident their meals.<br><br>*The residents who resided in the rehab unit received the "standard menu" items at each meal.<br><br>*The dietary staff did not meet with the residents to discuss their food preferences or dislikes. He expected the CNAs who served the residents to let the kitchen know if the resident did not like the meal they were served.<br><br>*The residents could come to the kitchen and let the dietary staff know if they did not like something.<br><br>*He was aware that the residents who ate in their rooms on the first floor or in the rehab unit dining room had complained about getting "too many sandwiches."<br><br>*He was aware that the kitchen sometimes ran out of food before the rehab unit residents were served. When they ran out of food, he expected the cook to fill out a substitution log and prepare "something else."<br><br>*He was unaware that residents had stated that they | F0806 | | |

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| F0806 SS = E | Continued from page 32<br>ordered food from restaurants and had it delivered because they could not get the food they wanted at the facility.<br><br>*He expected that the facility would meet the residents' nutritional needs and felt that the menus were "adequate."<br><br>*Dietitian BB oversaw the central kitchen where the meals were prepared and developed the menu.<br><br>*He expected that contract dietitian FF would have met with the residents and ensured that their nutritional needs were met.<br><br>7. Interview on 9/5/25 at 8:34 a.m. with dietitian BB revealed she:<br><br>*Oversaw the development of the central kitchen menu.<br><br>*Had no clinical oversight of the residents whose meals were provided in this location. She expected that dietitian FF managed the clinical needs of the residents.<br><br>8. Interview on 9/5/25 at 11:42 a.m. with dietitian FF revealed:<br><br>*She was a contracted dietitian who worked at the facility one to two days a week.<br><br>*She received the residents' scanned information from the facility, reviewed their EMR, and then met with the residents.<br><br>*She could not recall when she had met with residents 14 and 67, but thought that it had been "a while ago."<br><br>*When she met with residents, she addressed dietary restrictions or allergies, chewing or swallowing needs, insulin use, and skin concerns. She did not discuss the resident's food preferences or dislikes with the resident.<br><br>*She expected that the resident's meal preferences would be obtained by the dietary department. "It could be the dietary manager or one of the food service workers." She expected that would have occurred within 72 hours of their admission to the facility.<br><br>9. Interview on 9/3/25 at 8:50 a.m. with resident 44 | F0806 | | |

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| F0806 SS = E | Continued from page 33<br>revealed:<br><br>*They are served cold sandwiches for three to four suppers every week.<br><br>*She would prefer something warm in the evenings.<br><br>*When she asked for something warm, she was not given a choice but provided mashed potatoes and gravy.<br><br>*She did not receive any fruit or dessert the previous evening.<br><br>*She dislikes hot dogs and does not like when they are served.<br><br>*She is not aware of other food choices.<br><br>10. Interview on 9/3/25 at 9:15 a.m. with resident 82 revealed:<br><br>*The food is frequently very dry and hard for her to eat due to her lack of teeth.<br><br>*Foods that should be served hot are more often cold than they are hot.<br><br>11. Observation on 9/2/25 beginning at 4:00 p.m. in the kitchen of handling of resident menu cards during the evening meal service revealed:<br><br>*The resident menu cards were a half sheet of paper in a plastic sleeve.<br><br>*They listed the residents' diet orders, assistive device needs, allergies, and food preferences.<br><br>*CNAs gave the menu card to director of dietary services (DDS) G or cook H when the resident arrived to the dining room.<br><br>12. Interview on 9/2/25 at 4:31 p.m. with DDS G revealed the residents' menu cards are filled out with their food choices on Saturdays for the next week but sometimes the nursing staff did not pick them up and give them to the kitchen.<br><br>13. Observation on 9/2/25 at 5:34 p.m. with food service worker (FSW) GG revealed: | F0806 | | |

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| F0806 SS = E | Continued from page 34<br>*A sandwich was returned to him by certified nursing assistant (CNA) K who stated the resident couldn't have cheese.<br><br>*FSW GG removed the cheese and returned the sandwich to CNA K to serve to the resident.<br><br>14. Observation and Interview on 9/2/25 at 5:45 p.m. with CNA K revealed the CNAs who were serving residents' meals had frequently experienced issues with the kitchen staff following the residents' diet requirements and fulfilling the residents' requests correctly, so the CNAs knew to check the menu card closely.<br><br>15. Interview on 9/3/25 at 4:00 p.m. with DDS G about resident menu complaints revealed:<br><br>*There was ham on the breakfast menu for Monday, but sausage patties were served.<br><br>*There was bacon on the breakfast menu for Wednesday, but sausage patties were served.<br><br>*It was easiest to cook and hold the temperature of sausage patties.<br><br>*He agreed that the menu did not match the food served.<br><br>*They were not required to get a substitution approved if it was a like item, such as a meat substituted for a meat or toast substituted for a muffin.<br><br>*He felt the residents' complaints about cold food were due to the CNAs taking too long to deliver room trays.<br><br>*He did not think hot foods served in the dining room was cold.<br><br>*Cold sandwiches were served for many suppers were because they were on the summer menu.<br><br>*He did not know when the fall menu would start.<br><br>*The fryer had been inoperable on 9/1/25 and 9/2/25, but had been fixed today (9/3/25).<br><br>16. Interview on 9/4/25 at 9:30 a.m. with CNA K revealed:<br><br>*She had been trained as a food service worker, and had helped in the kitchen. | F0806 | | |

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| F0806 SS = E | Continued from page 35 | F0806 | | |

*She and other CNAs were frustrated with having to ask for many corrections to the meal trays when kitchen staff were seeing the same menu card as the CNAs, and it led to delays serving the residents.

*The menu card process is for nurse managers to give the diet to DDS G, who updates the menu card as the first check that the meal being served is correct.

*Cooks and FSWs are the second check, and the CNAs serving are the third check that the resident is being served the correct meal.

*Menu cards frequently don't get updated by the kitchen with changes.

*Kitchen staff disregard resident's likes and dislikes and forget to use adaptive items.

*CNAs had to make sure that the residents' meal trays contain the divided plates, covered cups, or assistive silverware that residents need, as those items were frequently missed by the kitchen staff.

17. Interview on 9/4/25 at 2:00 p.m. with social worker (SW) HH revealed:

*She had been an employee at the facility for approximately three weeks.

*She had heard meal complaints from three residents that included:

-They were not receiving meat for breakfast.

-They were not receiving the food item that the menu showed.

-A complaint about the serving of succotash.

*She had discussed those complaints with the lead social worker.

18. Interview on 9/4/25 at 2:05 p.m. with lead social worker (LSW) II revealed:

*She thought that residents' food complaints seemed to occur in intermittent streaks.

*Food complaints were to be discussed at the resident food council meetings, which were held in addition to

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| F0806 SS = E | Continued from page 36<br>the resident council and attended by residents, administration, and DDS G.<br><br>*She thought that since the contracted company provided the food service, communication options were limited beyond the food council.<br><br>*Residents had expressed dissatisfaction with the effectiveness of the food council recommendations.<br><br>19. Observation on 9/5/25 at 8:00 a.m. of the breakfast service in the dining room revealed:<br><br>*The CNAs asked the kitchen staff for corrections on 14 of 15 residents' meal trays before they could serve them.<br><br>*Corrections included telling the kitchen staff they needed a clean plate instead of just removing the scrambled eggs due to a resident's egg allergy.<br><br>*Other corrections included the need for a divided plate, a Kennedy cup (a spill-proof drinking cup used with a straw), lids for cups, and the removal of items that the residents had marked as a dislike or had not marked as a choice.<br><br>20. Observation and testing on 9/5/25 at 8:12 a.m. of a sample breakfast tray from the kitchen revealed:<br><br>*The menu for the day included biscuits and gravy, scrambled eggs, oatmeal, and a banana.<br><br>*The meal tray had scrambled eggs, a biscuit with a tan gravy, and several bits of sausage, a banana, a glass of milk, and a cup of coffee on it. It did not contain oatmeal.<br><br>21. Interview on 9/5/25 at 8:30 a.m. with dietitian BB revealed:<br><br>*She was the dietitian for the contracted food service that prepares the lunch and supper meals at the central kitchen.<br><br>*She approved all menus at the central kitchen location.<br><br>*The oversight of the facility dining service would be the responsibility of DDS G. | F0806 | | |

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| F0806 SS = E | Continued from page 37<br>*She did not agree that sausage patties should be substituted for all breakfast meat items, as they were easier for the kitchen to prepare.<br><br>*She agreed that the kitchen staff were responsible for following the menu card for resident diet orders, allergens, assistive device needs, and preferences.<br><br>*She did not think the CNAs having to correct a large quantity of meal trays, including 14 of 15 at breakfast that morning, reflected a good food service process.<br><br>*She agreed that not serving all items on the menu could reduce the nutritional value of the meal.<br><br>*She expected that resident preferences be strongly considered when making breakfast choices or when ordering lunch and supper from the central kitchen.<br><br>*She would not expect the facility to be running out of food items for lunch and supper unless they did not order enough from the central kitchen.<br><br>22. Interview on 9/5/25 at 10:15 a.m. with administrator A revealed he would expect the kitchen staff to:<br><br>*To accommodate the residents' physician diet orders, allergies, device needs, and food preferences.<br><br>*Be responsive to the food council suggestions and resident choices to the extent possible.<br><br>*The process for gathering information about food choices was the food council, an their informal auditing of five residents at a time about food taste, food temperature, and choices.<br><br>23. Observation and interview on 9/5/25 at 10:55 a.m. with DDS G revealed he was not aware that CNAs had requested items from the always available menu (a menu of food options available to residents who did not want the scheduled meal) but did not receive them, particularly in the rehab unit dining room.<br><br>24. Interview on 9/2/25 at 4:55 p.m. with resident 52 revealed:<br><br>*"The food here isn't very good."<br><br>*"They serve chicken at least three or four times a week" | F0806 | | |

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| F0806 SS = E | Continued from page 38<br><br>*"We complain, but nothing changes. I take what they serve me."<br><br>25. Interview on 9/3/25 at 11:50 a.m. with resident 49 revealed:<br><br>*She reported that the food is often cold when it is served to her.<br><br>*She reported that this was her third meal in a row where she received chicken noodle soup.<br><br>-"They are serving chicken noodle soup because the fryer is broke."<br><br>*She reported that residents were not given adequate options for their meals.<br><br>Interview on 9/3/25 at 10:15 a.m. with resident 5, current president of the resident council, revealed he:<br><br>*Had been the resident council president for the past few years.<br><br>*Provided his permission to review the previous resident council meeting minutes.<br><br>*Stated residents had expressed concerns at the resident council meetings regarding the meal service and the food served.<br><br>*Felt the provider had responded to the concerns discussed at the resident council meeting.<br><br>26. Interview on 9/3/25 at 1:30 p.m. with residents 4, 11, 16, 24, 38, 47, 49, 52, 53, 56, 57, 62, 63, 75, and 83 revealed:<br><br>*One of the fifteen residents attended the resident council meetings on a regular basis.<br><br>*The other residents stated they had not attended the resident council meetings regularly, with the following responses given:<br><br>-The same concerns were addressed "over and over."<br><br>-They felt the meeting was "a waste of time" and was "just talk" with nothing getting resolved.<br><br>-The leadership staff that attended would respond with | F0806 | | |

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| F0806 SS = E | Continued from page 39<br>"I just don't [do not] know what I can say", and "I'll see what I can do," but then nothing was done.<br><br>*The residents agreed on the main food concerns they had included:<br><br>-The lunch and evening meals took too long to get served, with some residents having to wait up to one hour for their meal to get served.<br><br>-The provider would run out of peanut butter, individual coffee creamers, butter, sugar, bread, and milk.<br><br>-The provider's pop machine would also run out of pop, without being refilled timely.<br><br>27. Interview on 9/4/25 at 9:05 a.m. with activity director EE regarding the resident council revealed:<br><br>*She had worked at the facility for four years.<br><br>*She helped to coordinate the resident council meetings, which met every other Monday at 11:00 a.m.<br><br>*The residents' special dietary meetings were held monthly on the second to last or last Monday, depending on when the resident council met, to avoid having both meetings on the same day.<br><br>-The provider's contracted dietary services had asked that those special dietary meetings would continue to be held.<br><br>*After the resident council meeting, she would complete the resident council's meeting minutes and pass out copies of the meeting minutes to administration, dietary, social services, and nursing.<br><br>*She expected those departments to review the resident council meeting minutes and take action to address the concerns related to their department.<br><br>*She would ask those departments, before the next resident council meeting, and discuss any progress or resolution that department had made regarding the resident council's concerns.<br><br>28. Review of the resident council meeting minutes revealed that, on average, fourteen residents attended the resident council meetings: | F0806 | | |

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| F0806 SS = E | Continued from page 40<br><br>*On 7/15/24, the residents had concerns that the cranberry juice was watered down, they requested more fruit choices, and that the menus be changed more frequently. One resident expressed a concern with the staff not responding timely to his call light.<br><br>*On 8/26/24, the minutes reflected that a new process was being implemented for serving the meals in the dining room.<br><br>*On 9/23/24, the residents agreed that the Dietary Meetings would be held once a month moving forward.<br><br>*On 11/18/24, the residents expressed the concern for more flavor in the food that was served.<br><br>*On 12/2/24, the residents expressed appreciation for the dietary improvements made with food temperatures and the timeliness of the meal service.<br><br>*On 1/6/25, the residents expressed they would like to see more beef served and less chicken. They also indicated the table rotation was working out well for the meal service.<br><br>*On 2/3/25, the residents decided to discontinue the dietary meetings as their dietary concerns were mostly being worked out.<br><br>*On 2/17/25, the residents decided to continue the dietary meetings due to some changes that happened in dietary.<br><br>*On 4/28/25, the new DDS G was introduced.<br><br>*On 5/19/25, the residents requested that more meatloaf be included on the menus.<br><br>*On 6/16/25, the residents requested the following food items: drumstick ice cream treats, small pizzas, and brats be included on the menus.<br><br>*On 7/21/25, the residents requested that pork and beans be included on the menus.<br><br>*On 8/11/25, the residents expressed concerns regarding the temperatures of the food served and the quality of the food.<br><br>29. A review of the resident dietary meeting minutes | F0806 | | |

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| F0806 SS = E | Continued from page 41<br>revealed the group met:<br><br>*On 12/30/24 at 11:00 a.m., with 21 residents in attendance.<br><br>*On 1/29/24 at 11:00 a.m., with 13 residents in attendance.<br><br>*On 3/31/25 at 11:00 a.m., with 18 residents in attendance.<br><br>*On 6/30/25 at 11:00 a.m., with 14 residents in attendance.<br><br>*On 7/28/25 at 11:00 a.m., with 14 residents in attendance.<br><br>The dietary meeting minutes indicated concerns with the timeliness of the meal service, getting the food items requested, food temperatures with food not being served hot, fresh vegetable and fruit options, and the cleanliness of the dining room.<br><br>30. Interview on 9/2/25 at 4:03 p.m. with resident 53 in his room revealed:<br><br>*He was sitting in his wheelchair with his feet on his bed.<br><br>*He stated he worked in the restaurant business for several years, and the food was not good here.<br><br>*He preferred to eat in his room for most meals.<br><br>*He had a standing order for a cheeseburger and french fries for supper every night because he did not like the food options for the supper menu.<br><br>*The dietary staff had forgotten his supper meal on multiple occasions, so he did not receive a supper room tray.<br><br>*On one occasion, he had gone to the kitchen to request his cheeseburger and french fries and was told the kitchen was closed for the night.<br><br>*A CNA went to a fast food restaurant down the street and brought him a cheeseburger and french fries that evening.<br><br>*Those fries were hotter than the ones he had previously been served from the kitchen. | F0806 | | |

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| F0806 SS = E | Continued from page 42<br><br>31. Interview on 9/3/25 at 10:26 a.m. with resident 34 in her room revealed:<br><br>*She preferred to eat her meals in her room.<br><br>*She was served a cold brat with a bun for supper on Saturday.<br><br>*The plate was even cold, like it had been in a refrigerator.<br><br>*A CNA took it to the microwave and warmed it up.<br><br>*She stated there had been other days when her food was cold.<br><br>32. Interview on 9/4/25 at 2:31 p.m. with DDS G regarding food temperatures revealed:<br><br>*He was a contracted dietary manager and started working at the facility in May of 2025.<br><br>*He expected that the staff would take the temperature of the residents' food before all meals.<br><br>*Residents who requested room meal trays were served after the main dining rooms.<br><br>*Room meal trays were kept in the refrigerator if a resident was not in their room when it was delivered.<br><br>Review of the provider's 12/16/24 revised Food Temperature Monitoring policy revealed:<br><br>*"Food is cooked, reheated or cooled to ensure proper holding temperatures before each meal service." | F0806 | | |
| F0812 SS = F | Food Procurement,Store/Prepare/Serve-Sanitary<br><br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br><br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br><br>(i) This may include food items obtained directly from | F0812 | All dirty dishes were immediately removed from dining room tables and surfaces sanitized.<br><br>Paper towels were stocked at all handwashing sinks; sinks were cleaned and disinfected.<br><br>All opened food items in the freezer were discarded; food properly re-packaged and labeled. | |

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| F0812 SS = F | Continued from page 43<br>~~local producers, subject to applicable State and local~~ laws or regulations.<br><br>(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.<br><br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, record review, and policy review, the provider failed to follow standard food safety practices to ensure:<br><br>*A clean and sanitary environment was maintained to store, prepare, and serve food to residents in one of one kitchen, one of one kitchenette, one of one dining room serving counters, and two of two dining rooms.<br><br>*Proper hand-washing and glove use by any observed kitchen staff during the preparation and serving of residents' food items.<br><br>*Food temperatures were monitored and documented to ensure meals were served at a safe serving temperature to prevent the spread of food-borne illness.<br><br>*Two of two kitchen personnel (cook H and food service worker X) wore beard nets according to the provider's policy.<br><br>Findings include:<br><br>1. Observation on 9/2/25 at 1:15 p.m. of the main dining room revealed:<br><br>*More than half of the tables had dirty dishes from lunch on them.<br><br>*There were approximately 35 residents at tables getting ready for an activity, although there were still dirty dishes on those tables.<br><br>Observation on 9/2/25 at 1:50 p.m. of the kitchen | F0812 | All opened food items in the freezer were discarded; food properly re-packaged and labeled by dietary manager and support manager on 9/6/2025.<br>All dirty/greasy equipment (stove hood, grill, prep tables, shelves, plate racks, walls, and floors) were thoroughly cleaned and sanitized by dietary manager and support manager on 9/6/2025.<br><br>Staff observed with improper glove use, hand hygiene, or lack of beard nets were re-educated immediately by dietary manager, Morrison VP of operations or support manager and placed back on duty only after demonstrating competency with dietary manager, Morrison VP of operations or support manager signing off on the competency training.<br><br>Menu cards in use were cleaned and sanitized; a new procedure using single-use cards or sanitized laminated sleeves was implemented to avoid contamination by 10/14/2025. All staff educated by administrator on diet card process by 10/3/2025.<br>All meal items were immediately temp-checked and corrective actions taken for items outside the safe range.<br><br>A full kitchen and dining room sanitation was completed by Intek Cleaning and Restoration by 10/3/2025, including walls, floors, shelving, serving counters, and steam tables.<br><br>Dining areas were sanitized by dietary manager and support manager prior to meal service to ensure residents are not exposed to dirty or contaminated surfaces.<br>All plate covers used for room trays and will be properly sanitized between use by food service workers, cooks or dietary manager. | |

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| F0812 SS = F | Continued from page 44<br>revealed:<br><br>*The hand-washing sink in the kitchen lacked paper towels.<br><br>*The hand-washing sink in the dish room had food stains and debris in the bowl and on the sides of the sink.<br><br>*The walk-in freezer contained opened boxes with the plastic liner pulled down over the outside of the box that exposed hamburger patties, mixed vegetables, uncooked chicken pieces, breaded chicken patties, garlic bread, and cookie dough.<br><br>*Grease buildup was observed on the light bulbs above the flat top grill and fryer.<br><br>*Cobwebs extended from the lights to the front of the stove hood above the flat top grill and fryer.<br><br>*Grime was present on the floor around the three-compartment sink and on the cleanout box.<br><br>*Food particles were visible on the floor and the tile grout throughout the kitchen.<br><br>*The clean plate rack had numerous food particles in the bottom where plates rested.<br><br>*The lower shelf and legs of the prep table were unclean.<br><br>*Dried liquid spills and food debris were present on the clean plate shelf under the steam table.<br><br>*Breadcrumbs were observed on the counter around the toaster and in the catch tray.<br><br>*Brown liquid was pooled on the dish room floor below the clean dish counter.<br><br>*The wall behind the prep table was greasy and sticky to the touch.<br><br>*The wall behind the flat top grill and stove was greasy and sticky to the touch.<br><br>*The oven handles were sticky and greasy.<br><br>Observation and interview on 9/2/25 at 2:00 p.m. in the kitchen with director of dietary services (DDS) G revealed: | F0812 | All dietary staff received immediate in-service training by Morrison VP of operations and Morrison HR Specialist on:<br><br>Handwashing and glove use (when to change gloves, when to wash hands).<br>Hair/beard covering policy.<br>Safe food handling and cross-contamination prevention.<br>Food temperature monitoring (at preparation, holding, and serving).<br>Cleaning and sanitation procedures for kitchen and dining rooms.<br>Food Procurement:<br>All foods are now stored in sealed containers or original packaging. No food will remain unwrapped or improperly stored in walk-in coolers/freezers.<br><br>Hand Hygiene/Glove Use:<br>New posted signage at all handwashing sinks reminding staff to wash before gloving and after glove removal.<br>Handwashing sinks are stocked and inspected by DDS/designee .<br>Staff competency checks on proper hand hygiene and glove use are now required quarterly. Quarterly hand hygiene and glove use competencies are completed by Morrison HR specialist and are documented in the employee's individual training file.<br><br>Food Temperature Monitoring:<br>Staff are required to temp-check foods at cooking, holding, and point-of-service; logs are signed by cook and reviewed by the DDS/designee each shift.<br>Food below or above safe temperature thresholds will be discarded. | |

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| F0812 SS = F | Continued from page 45<br>*The food was prepared at and would arrive from the central kitchen shortly after 4:00 p.m.<br><br>*Temperatures of the food items were taken and recorded on arrival, and those foods would be heated or cooled as appropriate for serving.<br><br>*No additional food temperatures were taken after that initial check.<br><br>Observation and interview on 9/2/25 at 4:00 p.m. in the kitchen with DDS G revealed the residents' supper meal food items had already arrived and consisted of all cold items "so it didn't need to be temped [temperature checked]."<br><br>Observation on 9/2/25 at 4:00 p.m. in the kitchen of food service worker (FSW) X revealed:<br><br>*He placed a clean pair of gloves and his phone on the counter next to the hand-washing sink.<br><br>*He washed his hands.<br><br>*He proceeded to the dish room, where he moved some empty dishwasher racks and a serving cart.<br><br>*He returned and put on the pair of gloves that were on the counter.<br><br>*With those gloved hands, he picked up his phone and put it in his pocket.<br><br>*He did not have his two-inch-long goatee hair covered.<br><br>Observation on 9/2/25 at 4:00 p.m. in the kitchen of the handling of resident menu cards revealed:.<br><br>*The resident menu cards were a half sheet of paper in a plastic sleeve.<br><br>*They listed the residents' diet orders, assistive device needs, allergies, and food preferences.<br><br>*Certified nursing assistants (CNAs) handed the menu card to DDS G or cook H when the resident arrived at the dining room.<br><br>*The menu cards were:<br><br>-Handled by DDS G and cook H with and without gloved | F0812 | Sanitation:<br>Daily, weekly and monthly cleaning schedules with assignment checklists implemented for kitchen and dining areas.<br>Steam tables, counters, and prep areas are sanitized between each meal.<br>Deep cleaning of hoods, shelves, and storage areas scheduled weekly and signed off by DDS/designee .<br>The Morrison Living General Manager will complete a weekly audit on dietary cleaning schedule completion to make sure the schedule is followed.<br><br>Training:<br>Hands-on orientation for new hires added with competency check-off by dietary manager, GM or Morrison HR specialist.<br>Food safety and sanitation audits will be conducted weekly x4, every other week x2, monthly 1 and quarterly x1 with staff by the Director. All issues identified will be addressed at the time of audit and staff educated on site.<br><br>Food temperature logs will be monitored daily and signed off as compliant by director or designee or (if not compliant) staff will be educated at time of service.<br>Labeling/dating and food storage rounding will occur twice daily by director or designee and signed off as complete.<br>Senior leadership will monitor the audits weekly x4, every other week x2, monthly 1 and quarterly x1 and implement any corrections or improvements as needed.<br>After shift and daily cleaning logs will be monitored and signed off by the director.<br><br>Dietary manager or designee will report findings to the QAPI Committee monthly.<br>The QAPI committee will determine on-going interventions and monitoring.<br><br>Substantial compliance will be achieved on 10/14/2025. | 10/14/2025 |

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| F0812 SS = F | Continued from page 46<br>hands.<br><br>-Dropped and picked up from the floor multiple times.<br><br>*Placed on the resident's meal tray for the CNA to take to the table.<br><br>*The CNA then returned the menu card to a container on the dining room serving counter.<br><br>Observation on 9/2/24 at 4:08 p.m. in the kitchen of cook H revealed:<br><br>*He wore a small chef beanie that did not cover any hair below his ears.<br><br>*He did not have his full beard covered.<br><br>*Placed frozen raw hamburger patties on the flat top grill.<br><br>*Pushed a serving cart to another area of the kitchen.<br><br>*Used a spatula to turn and remove burgers from the grill.<br><br>*Tore off aluminum foil, covered a pan of cooked hamburgers, and took the pan to the prep table.<br><br>*Pushed open the kitchen door and went to the dining room.<br><br>*He wore the same pair of gloves during all of the above observations.<br><br>Observation on 9/2/25 at 5:04 p.m. in the kitchen of cook H revealed that with his gloved hands, he:<br><br>*Leaned and touched both of his hands on the counter.<br><br>*Opened a drawer and removed a food serving scoop from the drawer.<br><br>*Returned that scoop to the drawer and retrieved another one from a different drawer.<br><br>*Removed buns from a bag with those same gloved hands and placed them on plates.<br><br>*Carried the plates with the buns to the prep table.<br><br>*Opened the kitchen refrigerator and retrieved a sleeve | F0812 | | |

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| F0812 SS=F | Continued from page 47<br>of cheese slices.<br><br>*Removed individual cheese slices from that package and placed them on the buns.<br><br>*Pulled the sleeve wrapper around the remaining cheese and returned it to the refrigerator.<br><br>*Removed his gloves and without washing his hands, he put on a new pair of gloves.<br><br>*He continued preparing residents' supper meal trays.<br><br>Observation on 9/2/25 at 5:13 p.m. in the kitchen of FSW X revealed that with his gloved hands, he:<br><br>*Pulled the silverware cart by the handle.<br><br>*Touched individual pieces of silverware while rolling them up in a napkin.<br><br>*Pushed open the kitchen door and delivered the rolled silverware to residents at tables.<br><br>*Re-entered the kitchen by pushing open the door.<br><br>*Repeated that same process of handling silverware, opening the kitchen door, and delivering the silverware to the residents.<br><br>*Placed bowls of fruit on residents' trays.<br><br>*Opened soup cans and slapped the bottoms to remove contents.<br><br>*Touched the microwave door and buttons.<br><br>*Served bowls with his thumb on the inside rim of the bowl.<br><br>*He used those same gloved hands during all of the observations above.<br><br>Observation on 9/2/25 in the kitchen beginning at 5:15 p.m. of dinner meal service revealed:<br><br>*Plate covers were placed on plated meals on a tray and delivered to the residents.<br><br>*The plate covers were stacked on a serving tray and reused. | F0812 | | |

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| F0812 SS = F | Continued from page 48<br>*Approximately 10 plate covers were reused throughout the meal service.<br><br>Observation on 9/2/25 at 5:21 p.m. in the kitchen of DDS G revealed that with his gloved hands, he:<br><br>*Touched the menu cards in a plastic sleeve that a CNA handed to him.<br><br>*Picked up a sandwich and placed it on a plate for a resident.<br><br>*Touched several menu cards that had been handed to him by CNAs.<br><br>*Opened the refrigerator door.<br><br>*Touched several menu cards again.<br><br>*Picked up and plated four ready-to-eat sandwiches for residents with those same gloved hands.<br><br>*Removed toast from the toaster with those same gloved hands and put it on a plate.<br><br>*DDS G used the same gloved hands during all of the above observations.<br><br>Observation on 9/2/25 at 5:22 p.m. in the kitchen of cook H revealed that with his gloved hands, he:<br><br>*Opened the refrigerator.<br><br>*Touched unwrapped, ready-to-eat sandwiches and put them on plates.<br><br>*Touched menu cards between handling sandwiches and plates.<br><br>*Repeated that process of serving the sandwiches with those same gloved hands.<br><br>*Removed a grilled cheese sandwich from the refrigerator and placed it on a clean plate.<br><br>*Touched the microwave door and control buttons to heat the sandwich.<br><br>*Touched several resident menu cards again.<br><br>*Removed a hamburger bun from a bag. | F0812 | | |

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| F0812 SS = F | Continued from page 49<br>*He wore the same gloves during all of those observations.<br><br>Observation on 9/2/25 at 5:34 p.m. of FSW GG in the kitchen revealed:<br><br>*While wearing the same pair of gloves he had used for serving residents' meals, he lifted the top piece of bread from a sandwich.<br><br>*He removed the cheese and placed that piece of bread back on top of the sandwich.<br><br>*He then returned to his serving position.<br><br>*A CNA at the window told him he needed to wash his hands.<br><br>*He then washed his hands and put on a clean pair of gloves.<br><br>Observation and interview on 9/2/25 at 5:45 p.m. in the main dining room with CNA K revealed:<br><br>*She was observed asking for corrections to several resident meal trays.<br><br>*The CNAs who were serving residents' meals had frequently experienced issues with the kitchen staff following the residents' diet requirements and fulfilling the residents' specific meal requests.<br><br>*As a result, they knew to check the menu cards and meal tray closely before serving the residents' meals to them.<br><br>Interview on 9/2/25 at 5:45 p.m. with cook H in the kitchen revealed:<br><br>*He was expected to wear gloves at all times while he was in the kitchen.<br><br>*He was unable to describe when gloves should be removed or when handwashing was required.<br><br>Observation on 9/3/25 at 4:55 p.m. of the main dining room and kitchen floors revealed:<br><br>*The main dining room was approximately 80 percent full of residents. | F0812 | | |

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| F0812 SS = F | Continued from page 50<br><br>*The floor was soiled with debris from previous meals.<br><br>*The kitchen floor appeared to be soiled with the same debris as observed the previous day (9/2/25).<br><br>Observation on 9/3/25 at 5:02 p.m. in the kitchen of FSW Y revealed that while wearing the same pair of gloves, she thumbed through menu cards, scooped ice into glasses from the ice well, and poured milk from a jug into glasses, which were served to the residents.<br><br>Observation on 9/4/25 at 8:00 a.m. of the kitchen revealed:<br><br>*Additional grime from previous observations was present below the three-compartment sink, around the cleanout box, and along the wall behind it.<br><br>*Food debris was present in the sink's drain, which appeared to be ravioli from the previous evening's meal.<br><br>*The walls behind the prep table were visibly dirty and sticky to the touch.<br><br>*The prep table was soiled with food debris and had a soiled wet towel and a food processor on it. The food processor had drips and food particles on its base and cord.<br><br>*The shelf above the prep table had substantial amounts of food particles, flour, and unknown debris on it, which could fall onto the food below it.<br><br>*Food debris was present on the clean bin shelf below the prep table.<br><br>Observation and interview on 9/4/25 at 10:18 a.m. in the kitchen with DDS G revealed:<br><br>*Cook H used the same gloved hands to touch the refrigerator handle, cheese packaging, remove ready-to-eat cheese, and retrieve bread from a bag.<br><br>*DDS G did not respond when asked if that observation demonstrated safe food handling practices, nor did he address those observations with cook H at that time.<br><br>Observations and interview on 9/4/25 at 3:08 p.m. with | F0812 | | |

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| F0812 SS=F | Continued from page 51<br>DDS G in the kitchen revealed he:<br><br>*Agreed the oven was dirty with charred food and built-up grease on the sides, bottom, inside the door, on top of the door, and on the door handle.<br><br>*Agreed that the Robo Coupe food processor had built up food grime on the rim, base, and cord.<br><br>*Agreed that the top edge and sides of an ingredient cart holding clean cups had food and dirty handprints on it.<br><br>*Agreed that the clean plate rack had many different food particles on the bottom where the plates rested.<br><br>*Agreed that the speed rack (tray rack) had built-up food and a sticky substance on the tray rails.<br><br>*Agreed that the prep table, the shelf above it, and the shelf below it were soiled with food particles and debris.<br><br>*Agreed that the plate shelf below the steam table was soiled with food spills.<br><br>*Agreed that the steam table knobs had areas of sticky foods and built-up grease.<br><br>*During the walk-through, he used his bare hands to pick at and touch many of the unclean surfaces, and then responded to a staff request for a glass of soda for a resident by putting a glove on his left hand and picking up a glass with that gloved hand. He then used his right unwashed bare hand and removed the ice scoop from the holding bin and scooped from the ice well into the glass. He then handed the glass of soda to the staff member.<br><br>*He did not wash his hands before putting the glove on his left hand or before handling the ice scoop with his other bare hand.<br><br>*When asked if he should have washed his hands before donning the glove and serving the soda, he did not respond.<br><br>*He stated there were no steam table temperature logs as staff did not monitor the temperatures of the steam table or food once placed in the steam table.<br><br>*He confirmed that the kitchen staff were responsible for stocking and cleaning the serving counter in the dining room, which tea bags, creamer packets, sugar | F0812 | | |

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| F0812 SS = F | Continued from page 52<br>packets, hand sanitizer packets, and brown sugar for oatmeal.<br><br>Observation on 9/4/25 at 3:30 p.m. of the serving counter in the main dining room revealed:<br><br>*A jar of brown sugar had a screw-on lid and a single spoon inside of it.<br><br>*A bowl of hand sanitizing wipes that had a black dried liquid inside the bowl on the counter.<br><br>*Cook H carried several bunches of bananas from the storeroom to the kitchen while holding them between his shirt and bare arms.<br><br>Observation and testing on 9/5/25 at 8:12 a.m. of a sample breakfast tray from the kitchen revealed:<br><br>*The menu for the day included biscuits and gravy, scrambled eggs, oatmeal, and a banana.<br><br>*The meal tray had scrambled eggs, a biscuit with thin tan gravy and several bits of sausage, a banana, a glass of milk, and a cup of coffee on it. Oatmeal was not included.<br><br>*The food plate had a cover on it, and food temperatures were taken within two minutes of the meal tray being prepared by the kitchen staff.<br><br>*Recorded food temperatures were:<br><br>-Scrambled eggs: 103 degrees Fahrenheit (F).<br><br>-Gravy in pool on plate: 103 degrees F.<br><br>-Gravy on top of biscuit: 100 degrees F.<br><br>-Milk: 47 degrees F.<br><br>-Coffee: 146 degrees F.<br><br>Observation on 9/5/25 at 11:00 a.m. of the dining room and kitchen revealed that all the unclean surfaces previously observed and noted on 9/2/25, 9/3/25, and 9/4/25 remained uncleaned.<br><br>2. Observation on 9/2/25 at 2:56 p.m. in the rehab unit dining room revealed: | F0812 | | |

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| F0812 SS=F | Continued from page 53<br><br>*There was food on the table in at least two place settings, and a circular, ring-shaped sticky spot in three areas.<br><br>*What appeared to be diced carrots and other unidentified food crumbs were scattered on the floor under three tables.<br><br>*There were small pieces of white paper and plastic wrappers on the floor near the serving window and in several places throughout the dining room.<br><br>*A cabinet with a coffee maker on the counter had a significant amount of coffee spills on the top of the counter, in the drawer of that cabinet, down the front of the cabinet, and on the carpet around that cabinet.<br><br>Observation and interview on 9/2/25 at 5:32 p.m. in the rehab unit dining room revealed:<br><br>*Those same tables observed above had the same food items and sticky spots on them, but now also had utensils, wrapped in napkins, and a cup at each place setting.<br><br>*The food, paper, and plastic remained on the floor.<br><br>*The cabinet and the counter with the coffee maker remained dirty.<br><br>*Resident 95 stated that the spot where she and resident 94 were seated had food on it and pointed to two other spots on the table that were dirty.<br><br>*Resident 94 stated that the table where she was seated to eat her dinner was sticky and that it had been that way at lunchtime.<br><br>Observation and interview on 9/2/25 at 5:46 p.m. with CNA R in the rehab unit dining room revealed:<br><br>*Resident 95 stated that the tables were dirty, and she began to clean those tables.<br><br>*CNA R thought that it was the kitchen staff's responsibility to clean the kitchenette and the tables between resident mealtimes. She thought that housekeeping cleaned the floors in the dining room between resident mealtimes.<br><br>*She expected that the tables would have been cleaned | F0812 | | |

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| F0812 SS = F | Continued from page 54<br>before the kitchen had set the table for the next meal.<br><br>Observation and interview on 9/2/25 at 5:49 p.m. with cook H in the rehab unit dining room revealed:<br><br>*He arrived with an insulated cart that contained the residents' meals. He had a beard and a mustache. He wore a black cap but was not wearing a beard net.<br><br>*He placed the tin pans that contained sandwiches and broccoli slaw into the steam table, which contained an orangish colored water and food particles, including particles of corn.<br><br>*He washed his hands, then tried to put on a pair of gloves. He stated that he needed large gloves, but that there were none. He wore those gloves partway up his hand, with the fingers of the gloves dangling. With those partially gloved hands, he:<br><br>-Took a can of pop from the fridge.<br><br>-Used his gloved hand to pick up a sandwich and place it on a plate, then he scooped salad onto the plate and placed the plate on the counter above the steam table.<br><br>-He repeated that process for each plate of food. While completing that task, he:<br><br>--Touched a butter packet on the counter, wiped his right hand on his shirt, and touched his cheek.<br><br>--Picked up a box of gloves and handed them to CNA R.<br><br>--Repeatedly used his right hand to adjust his left glove.<br><br>--Opened the refrigerator and took out the mustard and mayonnaise.<br><br>*Cook H stated that he tried to use one hand when he touched the sandwiches and the other hand when he touched other things in the kitchenette.<br><br>*At 5:58 p.m., cook H removed his gloves and washed his hands. While washing his hands, he splashed water on the walls and the counter around the sink. He then put on another pair of gloves, opened the food cart, removed the dessert cups, placed them on the counter, and then quickly left the kitchenette.<br><br>Observation on 9/3/25 at 8:35 a.m. in the rehab unit | F0812 | | |

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| F0812 SS = F | Continued from page 55<br>dining room with DDS G revealed:<br><br>*He brought the breakfast cart to the dining room from the main kitchen and got set up to serve breakfast.<br><br>*He sanitized a thermometer to check the temperatures of the food items in the steam table and recorded them in the food temperature logbook.<br><br>*He put on a pair of gloves, took four pieces of bread out of the bag, and put them in the toaster.<br><br>*With those same gloved hands, he went to the steam table, picked up a plastic container, and moved it to the counter.<br><br>*He went back to the toaster and with those same gloved hands, he picked up the slices of toast and put them in the steam table.<br><br>*He then put four more pieces of bread in the toaster.<br><br>*At 8:45 a.m., with those same gloved hands, he began to plate the breakfast food for the six residents in the dining room.<br><br>*He removed his gloves and put on a new pair of gloves, but did not first wash his hands.<br><br>*He picked up the lids from the steam table and put them on the counter.<br><br>*With those same gloved hands, he plated seven room trays using tongs for the eggs but used his gloved hand to pick up the toast and put it on the plates.<br><br>*He then removed his gloves and threw them away, and again did not wash his hands.<br><br>*When asked about glove use and hand washing, he stated he would wash his hands before putting gloves on, and after her removed his gloves.<br><br>Observation on 9/4/25 at 7:55 a.m. with DDS G in the rehabilitation dining room kitchenette revealed he:<br><br>*Placed the pans into the steam table and washed his hands.<br><br>*Got his cell phone out of his pocket and appeared to type a text.<br><br>*Got a key out of his pocket and attempted to open the | F0812 | | |

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| F0812 SS = F | Continued from page 56<br>suggestion box that was mounted on the wall in the dining room.<br><br>*Went back into the kitchenette and got his phone out of his pocket, and appeared to have typed another text message.<br><br>*Put on a pair of gloves and started plating the residents' food.<br><br>*Plated eleven residents' room meal trays.<br><br>*Removed his gloves, put the pans from the steam table back in the cart, and wheeled it back to the main dining room.<br><br>*Did not wash his hands.<br><br>Review of the provider's September Rehab Temperature Log Book in the dining room revealed:<br><br>*The breakfast food temperatures were the only meal temperatures recorded on 9/1/25.<br><br>*No food temperatures were recorded for 9/2/25.<br><br>*DDS G had recorded the breakfast food temperatures for 9/3/25<br><br>Review of the provider's June, July, and August Rehab Temperature Log books for 2025 revealed:<br><br>*June was missing 24 of 90 food temperature documentations.<br><br>*July was missing 12 of 93 food temperature documentations.<br><br>*August was missing 41 of 93 food temperature documentations.<br><br>Interview on 9/4/25 at 2:32 p.m. with DDS G regarding food temperatures, glove use, and hand hygiene in the rehab unit kitchenette revealed:<br><br>*The kitchen staff takes the food temperatures in the main kitchen, and then they take them again when they get to the rehab unit kitchenette to ensure proper temperatures are maintained.<br><br>*He expected the staff to document the food | F0812 | | |

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| F0812 SS = F | Continued from page 57<br>temperatures for all meals.<br><br>*He agreed that it was not being completed for all meals.<br><br>*He expected the staff to:<br><br>-Wash their hands before they put on their gloves.<br><br>-Take the trays out of the cart and put them in the steam table.<br><br>-Remove the gloves and wash their hands.<br><br>-Put on new gloves and plate the food for the resident's meal.<br><br>-Remove gloves and wash their hands.<br><br>-Put on new gloves.<br><br>-Put the pans back in the cart.<br><br>-Clean the countertops, steam table, and common area of the kitchenette.<br><br>-Remove the gloves, wash their hands, and return the cart to the main kitchen.<br><br>3. Interview on 9/2/25 at 4:31 p.m. with DDS G revealed:<br><br>*He expected the kitchen staff to wear gloves "at all times".<br><br>*He thought the chef beanie provided adequate for hair coverage.<br><br>Interview on 9/3/25 at 4:00 p.m. with DDS G about complaints made by residents to surveyors about meal substitutions or omissions revealed:<br><br>*There was ham on the breakfast menu for Monday, but sausage patties were served.<br><br>*There was bacon on the breakfast menu for Wednesday, but sausage patties were served.<br><br>*He stated that the kitchen lacked the equipment to prepare ham or bacon in quantities sufficient for all residents.<br><br>*He explained that the sausage patties were easier to | F0812 | | |

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| F0812 SS = F | Continued from page 58<br>cook and hold at temperature.<br><br>*He agreed that the food served to the residents did not match the menu.<br><br>*Substitutions did not require approval if they were considered "like items," such as substituting one meat for another or toast for a muffin.<br><br>*Residents were not notified of substitutions of "like items".<br><br>Interview on 9/4/25 at 9:05 a.m. with infection prevention specialist (IPS) I revealed she:<br><br>*Expected the kitchen staff to follow hand washing and glove use practices according to their facility's policy and food safety training.<br><br>*Had limited oversight of the kitchen as food service was provided by a contracted company, with DDS G responsible for kitchen operations.<br><br>*Had discussed clean versus unclean practices with DDS G, including touching clothing and the face.<br><br>*Expressed uncertainty regarding the effectiveness of those conversations.<br><br>Interview on 9/4/25 at 1:00 p.m. with DDS G revealed:<br><br>*The steam tables in the kitchen and rehab unit kitchenette were to be drained and cleaned every night.<br><br>*DDS G agreed that the rehab unit kitchenette steam table was not clean and had dirty water and kernels of corn in the water from a meal served five days earlier.<br><br>*The kitchen staff were responsible for cleaning the tables in the rehab unit dining room.<br><br>*He agreed that kitchen staff should not have set the tables for supper without wiping them down after lunch, especially while food debris remained.<br><br>*He was unaware that the rehab unit kitchen counters were soiled with food debris and were not cleaned after lunch.<br><br>*He was unaware that the food temperature log in the rehab unit kitchenette had not been completed. | F0812 | | |

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| F0812 SS = F | Continued from page 59<br>*He had not verified that the cleaning was completed in the kitchen, dining room, or rehab unit dining room.<br><br>*He thought the dirty meal dishes sometimes remained on the tables in the main dining room when activities started because some residents were still eating.<br><br>*Lunch was to be served from 11:45 a.m. to 12:45 p.m.<br><br>*He reported that the kitchen staff had a large onboarding manual to read before their first shift.<br><br>*He did not provide additional kitchen staff training on-site.<br><br>*He agreed that the menu cards, used in the main dining room, listed important information, including diet textures and allergies, which were critical to the residents' safe consumption of meals served.<br><br>*He was unaware that the diet cards used in the rehab unit dining room did not contain that same information.<br><br>*He acknowledged that plate covers are reused multiple times during the meal service, but did not believe this posed a cross-contamination risk.<br><br>*He did not acknowledge or respond when asked whether kitchen staff using gloved hands to touch phones, refrigerator handles, menu cards, reused plate covers, and ready-to-eat foods demonstrated safe food handling.<br><br>*He believed the chef's beanie provided adequate hair coverage.<br><br>*He believed facial hair only needed to be covered when it reached a certain length.<br><br>*When asked if he was aware of the facility policy regarding hair covering, he stated he was not.<br><br>Interview on 9/4/25 at 3:00 p.m. with FSW X revealed he:<br><br>*Had been employed and worked in the kitchen for approximately five months.<br><br>*Had not received training when he started, as he claimed prior kitchen experience.<br><br>*Was unable to describe a process for handwashing or glove-changing. | F0812 | | |

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| F0812 SS = F | Continued from page 60<br>*Acknowledged he had touched his phone with gloved hands while preparing residents' food and admitted that this likely occurred frequently.<br><br>*Asked whether his gloves could be washed after touching contaminated surfaces.<br><br>*Had not been instructed to cover his facial hair.<br><br>Interview on 9/4/25 at 3:05 p.m. with DDS G revealed:<br><br>*He agreed that kitchen staff should ensure dining trays and meals served reflected correct resident preferences, diets, and adaptive equipment.<br><br>*He was solely responsible for adding diet orders to menu cards.<br><br>*He thought CNAs were responsible for managing resident preferences.<br><br>*He was the only kitchen staff member with ServSafe for Food Manager's training.<br><br>*There were no plans in place to have another current employee complete the ServSafe training.<br><br>Interview on 9/5/25 at 8:30 a.m. with dietitian BB revealed:<br><br>*She was the dietitian for the contracted food service responsible for preparing lunch and supper meals at the central kitchen.<br><br>*She approved all menus for meals prepared at the central kitchen and served at the facility.<br><br>*The oversight of the facility dining service was designated as the responsibility of DDS G.<br><br>*Breakfast was to be prepared based on the menus she approved.<br><br>*The substitution of "like items", such as a meat for a meat or toast for a muffin, did not require her approval, but she expected the menu to be followed as closely as possible.<br><br>*She agreed that the documented temperatures of the scrambled eggs, biscuit and gravy, or milk on the sample tray were not within safe food serving ranges. | F0812 | | |

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| F0812 SS = F | Continued from page 61<br><br>Interview on 9/5/25 at 9:40 a.m. with DDS G regarding breakfast tray temperatures revealed:<br><br>*He did respond when asked if the temperatures were within safe food serving guidelines.<br><br>*When questioned about the unsafe temperatures on the sample breakfast tray, he said "the biscuit was still okay".<br><br>*He confirmed that food temperatures were not checked during or after meal services.<br><br>Interview on 9/5/25 at 9:50 a.m. with administrator A regarding glove use, hand washing, and food temperatures revealed:<br><br>*He expected that the kitchen staff would follow the facility's policy for hand washing and glove use.<br><br>*His expectations for food temperature documentation were that the staff would follow the policy and document temperatures for each meal.<br><br>*He agreed that it was not being done.<br><br>Interview on 9/5/25 at 10:00 a.m. with FSW Y revealed:<br><br>*She had been employed at the facility for approximately two and a half weeks.<br><br>*Her onboarding training primarily consisted of extensive reading.<br><br>*She reported difficulty retaining the information due to the volume of content.<br><br>*She was unable to describe the proper procedure for handwashing and glove use.<br><br>*She stated she followed the practices of her coworkers.<br><br>*She had not received on-site training on kitchen processes and procedures beyond the initial onboarding reading.<br><br>Interview on 9/5/25 at 10:15 a.m. with administrator A revealed: | F0812 | | |

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| F0812 SS = F | Continued from page 62<br>*He expected kitchen staff to:<br><br>-Adhere to facility policies regarding hair and facial hair coverings, hand washing and glove use, kitchen cleaning, food temperature monitoring, and hygiene.<br><br>-Follow physician diet orders, address allergies, accommodate assistive device needs, and honor food preferences.<br><br>-Be responsive to food council suggestions and resident choices to the extent possible.<br><br>*He expected DDS G and all kitchen staff to comply with food safety guidelines.<br><br>*He agreed that the breakfast sample tray items did not meet safe food serving temperature standards.<br><br>*He was aware of complaints about hot food being served cold and the frequent serving of cold food items such as sandwiches.<br><br>*He stated the process for gathering feedback on food choices was through the resident food council, and conducting informal audits of five residents at a time about food taste, food temperature, and choice.<br><br>Interview on 9/5/25 at 11:20 a.m. with administrator A revealed he:<br><br>*Thought that contract dietitian FF or DDS G met with residents when they were admitted to the facility to discuss resident choices.<br><br>*Was not aware that contract dietitian FF was not meeting with residents about preferences.<br><br>4. Review of the provider's 12/16/24 revised Food Temperature Monitoring policy revealed:<br><br>*"Food is cooked, reheated or cooled to ensure proper holding temperatures before each meal service."<br><br>*"Food temperatures are taken and recorded before each meal service."<br><br>Review of provider's hand washing and glove use – food nutrition services policy dated 6/6/25 revealed:<br><br>*The purpose was to provide guidelines regarding hand | F0812 | | |

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| F0812 SS = F | Continued from page 63<br>hygiene and glove use to reduce the risk of cross-contamination when serving highly susceptible populations.<br><br>*Highly susceptible populations were defined as persons who are more likely than other people in the general population to experience foodborne disease, including:<br><br>-Older adults.<br><br>-Obtaining food at a nursing home.<br><br>*Acceptable food barriers were defined as utensils, deli papers, and appropriately used disposable gloves (single task, uncontaminated). "Hand washing and hand sanitizer are not acceptable barriers."<br><br>*"Employees do not touch any food with bare hands – ready-to-eat or otherwise. Proper utensils such as tissue, spatula, tongs, and single-use gloves should be used for food handling to reduce cross-contamination."<br><br>*" Employees must wash hands before handling food, after handling raw meat, when switching tasks, and after performing any activity that could contaminate hands."<br><br>*"Hands are washed in designated hand washing sinks that are easily identified and stocked with soap and paper towels."<br><br>*"Employees involved in food preparation, distribution and serving must consistently utilize good hygienic practices and techniques."<br><br>*When to wash hands included:<br><br>-When reporting to work and when to kitchen after a break.<br><br>-After touching any contaminated object (face, hair, body, clothing, garbage, dirty utensils, dirty dishes, phone).<br><br>-Before and after using gloves.<br><br>-Between dirty and clean dish handling.<br><br>-Anytime contamination is suspected.<br><br>*Proper use of gloves included:<br><br>*Hands are washed thoroughly before putting on gloves and after taking gloves off. | F0812 | | |

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| F0812 SS = F | Continued from page 64<br><br>*The use of gloves does not eliminate the need for proper hand washing or good hygiene.<br><br>*Utensils and single-service deli papers may be used instead of gloves when touching any food, ready-to-eat or otherwise.<br><br>*Proper use of gloves included:<br><br>-Gloves are worn when the employee is handling ready-to-eat foods and completing a single task.<br><br>-Gloves are changed before handling ready-to-eat foods.<br><br>-When coming in contact with something that may be contaminated, such as handling pots/pans/tray/utensils.<br><br>-Whenever an employee changes an activity, the type of food being worked with, or whenever he or she leaves the workstation.<br><br>-Any time contamination is suspected.<br><br>-Ensure that gloves fit.<br><br>Review of provider's cleaning schedule – food and nutrition services dated 11/21/24 revealed:<br><br>*The purpose was to promote a system that identifies cleaning tasks to be completed and to provide guidelines to employees for the proper cleaning of kitchen equipment.<br><br>*The policy/procedure for the cleaning schedule revealed:<br><br>-The director of food and nutrition services is to post daily, weekly, and monthly cleaning assignments.<br><br>-The director is responsible for monitoring employees to ensure that cleaning duties are completed in a satisfactory and timely manner.<br><br>*The guidelines for kitchen and equipment cleaning included:<br><br>-Check each equipment item in kitchen for cleanliness and that it is in good repair.<br><br>-Sanitize surfaces when they come in contact with food.<br><br>-Check daily for cobwebs, dust, and dirt so it cannot | F0812 | | |

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| F0812 SS = F | Continued from page 65<br>~~fall from the ceiling.~~<br><br>-Clean and sanitize cabinets, drawers, and countertops at the end of the day.<br><br>-Empty and clean drawers weekly.<br><br>-Clean and sanitize dining room tables before the breakfast meal and after each meal service.<br><br>Review of provider's food temperature monitoring – food and nutrition services policy dated 12/16/24 revealed:<br><br>*The purpose was to reinforce Hazard Analysis Critical Control Point (HACCP) guidelines and state and federal regulations regarding food temperatures.<br><br>*Definitions included:<br><br>-Time/temperature control for safety (TCS) food – A food that requires time/temperature control to limit pathogenic microorganism growth or toxin formation.<br><br>-Proper holding temperature – Temperature required for food safety (cold food < 41 degrees F and hot food >125 degrees F).<br><br>-Proper serving temperatures – A temperature that is both appetizing to the resident and minimizes the risk for scalding and burns; this is the temperature when the food reaches the resident.<br><br>*The policy stated:<br><br>-Food is cooked, reheated, or cooled to ensure proper holding temperatures before each meal service.<br><br>-Food temperatures are taken and recorded before each meal services. Periodically, temperatures are taken at other times during or at the end of meal service to ensure temperatures are held within acceptable ranges.<br><br>-Food is served at proper serving temperatures.<br><br>*The procedure process stated:<br><br>-Before meal service, the cook/designee takes the "cook-to " and "serve" temperatures of all TCS menu items and records them on the weekly food temperature record.<br><br>*The location monitors TCS foods throughout meal service: | F0812 | | |

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| F0812 SS = F | Continued from page 66<br><br>-By temperature: Retake temperatures periodically throughout meal service to ensure TCS foods are held below 41 degrees F for cold foods or above 135 degrees F for hot foods.<br><br>-By time: TCS foods can be held for service without additional temperature monitoring if the following parameters are met: the TCS food is held for service a total of four hours, including transport and service. If reheated at any point, the maximum holding time is reduced to two hours, and the food can only be reheated once.<br><br>*TCS hot foods should be served at 135 degrees F or higher.<br><br>*TCS cold foods will be held at or lower than 41 degrees F and served promptly after being removed from the refrigerator. This includes snack items.<br><br>*Temperatures are periodically taken during or at the end of meal service to ensure that holding temperatures are adequate.<br><br>*Test tray monitoring occurs as part of quality assurance monitoring to ensure temperatures are acceptable when the location uses room trays or satellite dining rooms.<br><br>-Temperatures for test trays are based on proper serving temperature.<br><br>-Test tray is checked after all residents have been served.<br><br>*The person in charge oversees the monitoring and documentation of food temperatures.<br><br>Review of the provider's hygiene and dress code – food and nutrition services policy revealed:<br><br>*The purpose was to promote a professional appearance, safety, and sanitation.<br><br>*The hygiene and dress code policy are enforced.<br><br>*Employees are informed during orientation of expectations for personal appearance, hygiene, and dress code.<br><br>*Hairnets or hair restraints and beard nets or beard restraints are used: | F0812 | | |

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| F0812 SS = F | Continued from page 67<br>-When cooking, preparing, or assembling food or ingredients. This includes dish rooms and storage areas. Hair is to be covered completely. | F0812 | | |
| F0880 SS = E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br>§483.80 Infection Control<br>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.<br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br>§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;<br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or<br>infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending | F0880 | All residents who utilize lift slings have potential to be impacted by this deficient practice.<br>Sit-to-stand lift with substance build-up has been cleaned according to manufacturer and facility policy by 9/8/2025.<br>All lift slings found on or touching the floor were removed from use and re-laundered before reuse by 9/8/2025.<br>Sling hooks were raised to prevent any touching the floor by 10/3/2025.<br>Kromer Plumbing contacted on 9/25/2025 to fix the pipe that is leading in the storage closet. Kromer Plumbing came to the facility on 10/1/2025 to fix piping and fill hole in the ceiling.<br><br>A full review of all mechanical lifts and sling storage will be completed throughout the facility completed by the DON, administrator and maintenance director by 10/14/2025 to check for:<br>Cleanliness of lift equipment<br>Proper sling storage and identification of slings that may have touched the floor.<br>A facility-wide environmental infection control inspection will be conducted by the DON and maintenance director to identify and address any evidence of leaks, mold, or unsanitary conditions.<br><br>All staff received mandatory retraining on:<br>Infection prevention.<br>Proper sling storage.<br>Education was completed by the administrator by 10/3/2025. | |

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| F0880 SS = E | Continued from page 68<br>upon the infectious agent or organism involved, and<br><br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(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<br><br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br><br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br><br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, and policy review, the provider failed to ensure proper infection control practices were followed by allowing clean resident lift slings to lay on the floor, failing to properly clean resident lifting devices, and allowing water to leak from ceiling in a storage closet.<br><br>Findings include:<br><br>1. Observation on 9/2/25 at 4:45 p.m., of a sit to stand lift (a mechanical lift used to assist from a seated to a standing position) had an unknown substance build-up where residents would place their hands while being lifted.<br><br>2. Observations on 9/3/25 at 1:30 p.m., 9/4/25 at 8:50 a.m., and again on 9/5/25 at 11:20 a.m. in the clean storage room on the second floor revealed: | F0880 | To monitor compliance, DON/designee will audit sling storage to ensure slings are not touching the floor. DON/Designee will audit 5 occurrences where mechanical lifts are used to ensure lifts are properly disinfected after use. Administrator/designee will audit sling storage and storage rooms to ensure lift slings are not touching the floor and no water is leaking through the ceiling. Sling storage areas include the central sling storage on the second floor and the pantry storage room on the first floor. Audits will occur weekly x 4 weeks, every other week x 4 weeks, and monthly x2 months. Administrator/designee will report to the QAPI Committee monthly. The QAPI Committee will determine on-going interventions and monitoring.<br><br>Substantial compliance will be achieved on 10/14/2025. | 10/14/2025 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 09/05/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER | 401 WEST SECOND STREET , SIOUX FALLS, South Dakota, 57104 |

| (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 |
|---|---|---|---|---|
| F0880 SS = E | Continued from page 69<br>*Several lift slings were lying on the floor, and multiple slings that had been hanging on three of the four walls had been touching the floor.<br><br>*Inside the storage room where the lift slings were stored, a sign was posted above the slings that had a red stop sign it and stated "ALL STAFF PLEASE MAKE SURE SLINGS ARE NOT TOUCHING THE GROUND THANK YOU!"<br><br>3. Interview on 9/4/25 at 9:00 a.m. with certified nursing aide (CNA) J revealed:<br><br>*CNAs would hang the lift slings up when they were received from laundry.<br><br>*She was aware that slings should not have been lying on or touching the floor.<br><br>*She reported that slings were touching the floor "all the time."<br><br>*She stated "It's kind of gross" regarding using lift slings after they had been on the floor.<br><br>4. Interview on 9/4/25 at 10:20 am with certified medication aide (CMA) JJ revealed:<br><br>*He reported that lift slings were hung up by the laundry staff members after they had been cleaned.<br><br>*He did not believe that the clean slings should have been touching the floor.<br><br>*He stated that lift slings were still used to assist the residents even if they were touching the floor.<br><br>5. Interview on 9/5/25 at 10:50 a.m. with infection prevention specialist I revealed:<br><br>*After lift slings had been washed, they were brought to the storage closet by the laundry staff members and put away by the CNAs.<br><br>*She reported that she had not noticed the slings touching the floor.<br><br>*She reported it was an infection control problem for them to be used after lying on the floor.<br><br>*She acknowledged that the slings laying on the floor were considered dirty and should not have been used. | F0880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 09/05/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER | 401 WEST SECOND STREET , SIOUX FALLS, South Dakota, 57104 |

| (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 |
|---|---|---|---|---|
| F0880 SS = E | Continued from page 70<br><br>6. Observations on 9/4/25 at 3:00 p.m. and 9/5/25 at 11:25 a.m. in the main level clean storage room next to the conference room revealed a hole in the ceiling with an unknown black speckled substance around it where water was dripping into a plastic bin.<br><br>7. Interview with infection prevention specialist I revealed she was aware of the hole in the ceiling and reported that it had been there since around May of 2025.<br><br>*She reported that maintenance staff had attempted to repair the hole and the leaking water, but was unsuccessful.<br><br>*She acknowledged that the leaking hole in the ceiling was an infection control concern and needed to be fixed.<br><br>8. Review of the provider's 12/2024 Infection Prevention and Control Program policy revealed:<br><br>*"Purpose, To 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." | F0880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING | (X3) DATE SURVEY COMPLETED 09/03/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER | 401 WEST SECOND STREET , SIOUX FALLS, South Dakota, 57104 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K0000 | INITIAL COMMENTS<br><br>A recertification survey was conducted on 9/3/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Good Samaritan Society Sioux Falls Center (Building 01) was found not in compliance.<br><br>The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K353 and K923 in conjunction with the provider's commitment to continued compliance with the fire safety standards. | K0000 | Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. | |
| K0353<br>SS = D | Sprinkler System - Maintenance and Testing<br><br>CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing<br><br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br><br>a) Date sprinkler system last checked<br>_____<br><br>b) Who provided system test<br>_____<br><br>c) Water system supply source<br>_____<br><br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br><br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on observation, measurement, and interview, the provider failed to maintain at least 18 inches of unobstructed space under one randomly observed sprinkler deflector required for one randomly observed | K0353 | On 9/3/2025, the items stored within 18 inches of the sprinkler head were adjusted to meet NFPA requirements.<br><br>By 10/1/2025, all sprinkler heads will be inspected to make sure the NFPA required 18 inches of separation requirement is met. The TELS platform for the building was audited to ensure the sprinkler inspection task was available on 9-29-25.<br><br>By 10/2/2025, all staff will be trained in the importance of keeping items at least 18 inches away from sprinkler heads. If staff are not present for all staff education, they will be educated prior to their next shift. | |

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 |
|---|---|---|
| [signature] | Administrator | 10/2/2025 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING | (X3) DATE SURVEY COMPLETED 09/03/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER | 401 WEST SECOND STREET , SIOUX FALLS, South Dakota, 57104 |

| (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 |
|---|---|---|---|---|
| K0353 SS = D | Continued from page 1<br>location (Pantry).<br><br>Findings include:<br><br>1. Observation on 9/3/25 at 11:17 a.m. revealed a sprinkler head in the storage closet in the corridor next to the lower-level room marked "Pantry" was obstructed by cases of N-95 face masks on a storage shelf. Those face masks were approximately only 10 inches below the bottom of the sprinkler head deflector. That shelf and those items would interrupt the proper discharge and operation of the sprinkler head.<br><br>Interview with the maintenance director at the time of the observation revealed he was not aware of the obstructed sprinkler head. He agreed the storage of was those items did not meet the required 18-inch clearance and would interrupt the proper discharge and operation of the sprinkler head. | K0353 | The Administrator or designee will complete audits weekly x 4, monthly x 2 and quarterly x 2 to ensure items are not stored within 18 inches of the sprinkler head. Administrator/designee will report to the QAPI Committee monthly. The QAPI Committee will determine on-going interventions and monitoring.<br><br>Substantial completion will be obtained by 10/14/2025. | 10/14/2025 |
| K0923 SS = D<br><br>Bldg. 01 | Gas Equipment - Cylinder and Container Storag<br><br>CFR(s): NFPA 101<br><br>Gas Equipment - Cylinder and Container Storage<br><br>Greater than or equal to 3,000 cubic feet<br><br>Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.<br><br>>300 but <3,000 cubic feet<br><br>Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.<br><br>Less than or equal to 300 cubic feet<br><br>In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.<br><br>A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign | K0923 | By 9/3/2025, the o2-container storage will be adjusted to adjusted to meet NFPA requirements.<br><br>By 10/1/2025, all o2 storage tanks will be audited to make sure they are being stored within NFPA requirements.<br><br>By 10/2/2025, all staff will be trained in the importance keeping 02 storage tanks stored and moved safely. If staff are not present for all staff education, they will be educated prior to their next shift.<br><br>The Administrator or designee will complete audits of o2 storage tanks weekly x 4, monthly x 2 and quarterly x 2 to ensure items are not stored within 18 inches of the sprinkler head. Administrator/designee will report to the QAPI Committee monthly. The QAPI Committee will determine on-going interventions and monitoring.<br><br>Substantial completion will be obtained by 10/14/2025. | 10/14/2025 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046 | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 01 - MAIN BUILDING 0... B. WING | 09/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER | 401 WEST SECOND STREET , SIOUX FALLS, South Dakota, 57104 |

| (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 |
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| K0923<br>SS = D<br><br>Bldg. 01 | Continued from page 2<br>includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."<br><br>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.<br><br>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on observation and interview, the facility failed to protect medical gas storage as required. Combustible items were stored within five feet of the oxygen cylinders and those cylinders were not clearly marked full or empty in one randomly observed location (lower-level med room).<br><br>Findings include:<br><br>1. Observation on 9/3/25 at 11:21 a.m. revealed combustible materials had been stored adjacent to and within five feet of oxygen cylinders in the lower-level med room. Eight E sized oxygen cylinders were found stored in single cylinder rolling carts. Those cylinders were stored directly next to a partially full trash can. Additionally, those cylinders were not clearly identified as "full" or "empty". Both the oxygen storage requirements for being clearly marked and the minimum five feet of separation from combustibles were not maintained as required in that area.<br><br>Interview with the maintenance director at that same time confirmed that finding. He stated he was unaware those oxygen cylinders were stored in that manner in that location. He further stated he believed nursing staff likely stored those cylinders there out of convenience due the oxygen storage room being located on the level above that med room.<br><br>The deficiency had the potential to affect all occupants of the smoke compartment. | K0923 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 - 1... B. WING | (X3) DATE SURVEY COMPLETED 09/03/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER | 401 WEST SECOND STREET , SIOUX FALLS, South Dakota, 57104 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K0000 | INITIAL COMMENTS | K0000 | | |
| | A recertification survey was conducted on 9/3/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Good Samaritan Society Sioux Falls Center (Building 02) was found not in compliance.<br><br>The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K211 in conjunction with the provider's commitment to continued compliance with the fire safety standards. | | | |
| K0211<br>SS = D<br><br>Bldg. 02 | Means of Egress - General<br><br>CFR(s): NFPA 101<br><br>Means of Egress - General<br><br>Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.<br><br>18.2.1, 19.2.1, 7.1.10.1<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on observation and interview, the provider failed to maintain egress paths free of hazards for one randomly observed exits (West Dock Exit).<br><br>Findings include:<br><br>1. Observation on 9/3/25 at 2:42 p.m. revealed the path of egress for the north end of the west dock exit had spalling concrete that created abrupt level changes of greater than one-quarter of an inch within the path of egress. LSC 7.1.6.2<br><br>Interview with the maintenance director at the time of the observation confirmed that condition. He stated they had tried to patch those areas previously, but the patches did not hold and they had come up during snow removal during the previous winter. | K0211 | By 10/1/2025, the concrete of the west dock exit will be adjusted or fixed to meet NFPA requirements.<br><br>By 10/2/2025, all means of egress areas will be audited to ensure a safe means of egress can be achieved. The TELS platform for the facility will be audited to ensure the means of egress task is available.<br><br>By 10/2/2025, all staff will be trained on the importance of keeping corridors and walkway free of obstructions. If staff are not present for all staff education, they will be educated prior to their next shift.<br><br>Audits of the egress corridors and walkways will be completed weekly x 4, monthly x 2 and quarterly x 2. Administrator/designee will report to the QAPI Committee monthly. The QAPI Committee will determine on-going interventions and monitoring.<br><br>Substantial completion will be obtained by 10/14/2025. | 10/14/2025 |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 - 1... B. WING | (X3) DATE SURVEY COMPLETED 09/03/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER | 401 WEST SECOND STREET , SIOUX FALLS, South Dakota, 57104 |

| (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 |
|---|---|---|---|---|
| K0211<br>SS = D<br>Bldg. 02 | | K0211 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 09/03/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER | 401 WEST SECOND STREET , SIOUX FALLS, South Dakota, 57104 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E0000 | Initial Comments<br><br>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 9/3/25. Good Samaritan Society Sioux Falls Center 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 |
|---|---|---|
| [signature] | Administrator | 10/2/2025 |

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 |
|---|---|---|---|
| | 10679 | A. BUILDING: _____ B. WING _____ | 09/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER | 401 W 2ND ST SIOUX FALLS, SD 57104 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| S 000 | Compliance/Noncompliance Statement<br><br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 9/2/25 through 9/5/25. Good Samaritan Society Sioux Falls Center was found in compliance. | S 000 | The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law. | |
| S 000 | Compliance/noncompliance Statement<br><br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 9/2/25 through 9/5/25. Good Samaritan Society Sioux Falls Center was found not in compliance with the following requirements: S206, S210, S236, 290, and S301. | S 000 | | |
| S 206 | 44:73:04:05 Personnel Training<br><br>The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. All healthcare personnel must complete the orientation program within thirty days of hire and the ongoing education program annually thereafter.<br><br>The orientation program and ongoing education program must include the following subjects:<br>(1) Fire prevention and response;<br>(2) Emergency procedures and preparedness;<br>(3) Infection control and prevention;<br>(4) Accident prevention and safety procedures;<br>(5) Proper use of restraints;<br>(6) Resident rights;<br>(7) Confidentiality of resident information;<br>(8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms;<br>(9) Care of residents with unique needs; | S 206 | Maintenance Technician C will complete training by 10/14/2025 on:<br>Proper restraint use.<br>Resident Rights.<br>Care of Residents with Unique Needs.<br>Dining Assistance/Nutrition.<br>Risks/Hydration Needs.<br>Administrator will ensure Maintenance Technician C's training has been completed.<br><br>Food Service D's orientation required training record has been corrected to reflect completion of all required orientation topics. Documentation was verified and will be filed appropriately.<br><br>No residents were found to have been harmed as a result of the deficient practice. | |

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

TITLE: Administrator

(X6) DATE: 12/5/2025

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 |
|---|---|---|---|
| | 10679 | A. BUILDING: _____ B. WING _____ | 09/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER | 401 W 2ND ST SIOUX FALLS, SD 57104 |

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| S 206 | Continued From page 1<br>(10) Dining assistance, nutritional risks, and hydration needs of residents;<br>(11) Abuse and neglect; and<br>(12) Advanced directives.<br><br>Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section.<br><br>The facility shall provide additional personnel education based on the facility's identified needs.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on record review and interview, the provider failed to ensure the required new hire training was completed within 30 days of hire for two of five employees (maintenance technician C and food service worker D) reviewed.<br><br>Findings include:<br><br>1. Review of the provider's employee personnel training record for maintenance technician C revealed:<br>*He was hired on 5/15/25.<br>*He had not completed training as of 9/5/25 for the required topics of:<br>-Proper restraint use.<br>-Resident rights.<br>-Care of residents with unique needs.<br>-Dining assistance/nutrition risks/hydration required training.<br><br>2. Review of the provider's employee personnel training record for food service worker (FSW) D revealed:<br>*He was hired on 2/3/25. | S 206 | A facility-wide review of all employee training records will be completed by the Administrator/designee to ensure compliance with orientation requirements. Facility-wide review showed all employees were up to date on required training with no concerns identified.<br><br>New hires will be scheduled to complete required training modules within the first two weeks of hire to allow time for follow-up before the 30-day requirement. Morrison HR Specialist will ensure all new hire training and dietary training are completed within 30 days of hire.<br>Administrator provided education to dietary manager and Morrison HR specialist regarding the completion of orientation and on-going education and corrective actions required to ensure compliance.<br><br>Dietary Staff:<br>All new staff members will attend required trainings before beginning work going forward. Training will be provided, and all staff have to demonstrate competency by passing exam with more than 80%. If 80% is not met, staff will be reeducated until able to demonstrate competency.<br><br>All new team members will complete required trainings before being allowed on the floor.<br><br>HR files for all dietary employees required trainings will be audited weekly x4, monthly x2, quarterly x2 by HR specialist to ensure compliance.<br><br>Dietary manager or designee will report dietary staff education review findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring.<br><br>Substantial compliance will be achieved on 10/14/2025. | 10/14/2025 |

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| S 206 | Continued From page 2<br>*He had completed all the required training as of 5/25/25.<br>*His training on those topics had not been completed within his first 30 days of hire.<br><br>3. Interview on 9/5/25 at 10:30 a.m. with administrator A revealed:<br>*He agreed that the above listed employees had not completed the above required education within 30 days of hire. | S 206 | Food Service Worker D and Food Service Worker E both completed health evaluations by a licensed healthcare professional on 8/4/25. Their records have been updated to reflect compliance.<br><br>Both employees were reviewed and cleared of communicable diseases prior to continuing work.<br><br>No residents were found to be harmed by the delay in health evaluations. | |
| S 210 | 44:73:04:06 Personnel Health Program<br><br>The facility shall have a personnel health program for the protection of the residents. Before assignment to duties or within fourteen days after employment, a licensed health professional must evaluate all personnel to ensure no personnel is infected with any reportable communicable disease that poses a threat to others. The evaluation must include an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease that may endanger the health of residents, and fellow personnel may not return to duty until the personnel is determined by a physician, physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on employee records review, and interview, the provider failed to ensure the | S 210 | A department wide review of all dietary employee health files will be completed by Morrison HR specialist by 10/2/2025 to verify that each staff member has a current health evaluation on file. Any missing or outdated evaluations will be scheduled and completed. No missing our outdated evaluations were identified during the review completed by the Morrison HR specialist.<br><br>As of September 10, 2025, a new process has been established to ensure compliance with onboarding health requirements. Current policy was utilized in conjuncture to align with new facility process. The Dining Talent Acquisition Manager will coordinate directly with the Infection Specialist to confirm a start date that allows for the TB test and Health Review to be completed on the first day of Orientation.<br>Administrator provided education to dietary manager and Morrison HR specialist regarding the completion of employee health evaluations process requirements and corrective actions required to ensure compliance.<br>Dining Talent Acquisition Manager will ensure that all new employees are fully compliant in TB and Health Review training before the first day of scheduled work. | |

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| S 210 | Continued From page 3<br>completion of a health evaluation by a licensed healthcare professional for two of five randomly reviewed employees (food service worker D and E) within 14 days of their hire.<br><br>Findings include:<br><br>1.Review of food service worker (FSW) D's employee record revealed:<br>*He was hired on 2/3/25.<br>*His health evaluation was completed on 8/4/25.<br>*It had not been completed within 14 days of hire.<br><br>2. Review of FSW E's employee record revealed:<br>*She was hired on 4/19/24.<br>*Her health evaluation was completed on 8/4/25.<br>*It had not been completed within 14 days of hire.<br><br>3. Interview on 9/5/25 at 10:30 a.m. with administrator A revealed:<br>*The provider had taken over the completion of the health evaluations for the food service staff in July 2025.<br>*He agreed the health evaluations for FSW D and E had not been completed within 14 days of hire. | S 210 | Dining Talent Acquisition Manager will complete employee file audits on all dietary employees weekly x4, monthly x2, quarterly x2 to verify that 100% of employees are compliant with the completion of employee health evaluations and all required training and onboarding.<br><br>Onboarding checklist that includes the TB test and Health Review to be completed and signed off prior to first day of work. Audits will be completed for all dietary employees by the Morrison HR specialist weekly x4, monthly x2, quarterly x2.<br><br>Dietary manager or designee will report findings of all dietary employees to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring.<br><br>Substantial compliance will be achieved on 10/14/2025. | 10/14/2025 |
| S 236 | 44:73:04:12(1) Tuberculin Screening Requirements<br><br>Tuberculin screening requirements for healthcare personnel or residents are as follows:<br>(1) Each new healthcare personnel or resident shall receive an initial individual TB risk assessment and the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within twenty-one days of employment or admission to a facility. The qualified personnel must record the assessment and the test in the employee's record or the | S 236 | Food Service Worker D and Food Service Worker E both completed health evaluations, including the TB risk assessment and the two-step tuberculin skin test or TB blood assay test, by a licensed healthcare professional on 8/4/25. Their records have been updated to reflect compliance.<br><br>Both employees were reviewed and cleared of communicable diseases prior to continuing work.<br><br>No residents were found to be harmed by the delay in health evaluations. | |

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| S 236 | Continued From page 4<br><br>resident's medical record. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of admission or employment is considered a two-step test. A TB blood assay test completed within a twelve-month period prior to the date of admission or employment is an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare personnel or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin testing having been completed within the prior twelve months. Skin testing or a TB blood assay test is not necessary if documentation is provided by the transferring healthcare facility, healthcare personnel, or resident, of a previous positive reaction to either test. Any new healthcare personnel or resident who has a newly recognized positive reaction to the skin test or TB blood assay test must have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on employee record review and interview, the provider failed to ensure two of five employees (food service worker D and E) reviewed had received the two-step tuberculin (TB) skin test within twenty-one days of their employment.<br><br>Findings include:<br><br>1.Review of food service worker (FSW) D's employee record revealed:<br>*He was hired on 2/3/25. | S 236 | A department wide review of all dietary employee health files will be completed to verify that each staff member has a current health evaluation, a TB risk assessment and the two-step method of tuberculin skin test or TB blood assay test on file. Any missing or outdated evaluations will be scheduled and completed.<br><br>As of September 10, 2025, a new process has been established to ensure compliance with onboarding health requirements. The Dining Talent Acquisition Manager will coordinate directly with the Infection Specialist to confirm a start date that allows for the TB test and Health Review to be completed on the first day of Orientation. Administrator educated dietary manager and Morrison HR specialist on facility process to ensure compliance with TB risk assessments and the completion of the two-step method of tuberculin skin test or TB blood assay test.<br><br>Dining Talent Acquisition Manager will ensure that all new employees are fully compliant in TB and Health Review training before the first day of scheduled work<br><br>Dining Talent Acquisition Manager will complete employee file audits to ensure the completion of the TB risk assessment, two-step method of tuberculin skin test or TB blood assay test weekly x4, monthly x2, quarterly x2 to verify that 100% of employees are compliant with all required training and onboarding.<br><br>Onboarding checklist that includes the TB test and Health Review to be completed and signed off prior to first day of work. Audits will be completed weekly x4, monthly x2, quarterly x2. | |

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| S 236 | Continued From page 5<br>*He had received his TB skin tests on 8/20/25 and 8/27/25, both test results were negative.<br>*That testing was outside the twenty-one-day requirement.<br><br>2. Review of FSW E's employee record revealed:<br>*She was hired on 4/19/24.<br>*She had a negative chest x-ray on 9/4/25.<br>*That was outside the twenty-one-day requirement.<br><br>3. Interview on 9/5/25 at 10:30 a.m. with administrator A revealed:<br>*The provider took over the completion of TB testing and health evaluations for the food service workers in the middle of July 2025.<br>*He agreed that FSW D and E did not have their TB skin tests or chest X-rays to confirm they did not have active TB infection completed within twenty-one days of hire. | S 236 | Dietary manager or designee will report findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring.<br><br>Substantial compliance will be achieved on 10/14/2025. | 10/14/2025 |
| S 290 | 44:73:07:05 Food Supply<br><br>The facility shall maintain an on-site supply of perishable and nonperishable foods to meet planned menus for three days. A facility shall maintain an additional supply of nonperishable foods as part of the facility's emergency preparedness plan. A facility may use military meals ready to eat and dried milk in an emergency event according to the facility's emergency response plan.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on observation, interview, menu review, and policy review, the provider failed to maintain an on-site supply of perishable and non-perishable foods as part of their emergency | S 290 | Emergency food supply was provided on site on 9/6/25.<br>A perishable and nonperishable food inventory was created and verified to meet the 3-day requirement for the facility's average daily census of 84 residents.<br><br>A full review of all food storage areas will be completed by Morrison Director of Dining Services and Morrison VP of Operations by 9/7/2025 to verify adequate inventory of both perishable and non-perishable food supply. Inventory levels were compared to the facility census to ensure compliance with state requirements.<br><br>The facility's Emergency Preparedness Plan was revised to include:<br>A written 3-day emergency food menu based on actual on-site supplies.<br>Procedures for ordering and rotating stock to ensure food is always available and not expired. | |

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| S 290 | Continued From page 6<br><br>preparedness plan.<br><br>Findings include:<br><br>1. Observation and interview on 9/4/25 at 1:50 p.m. with the director of dining services (DDS) G revealed:<br>*The facility had a limited supply of canned food in the storage room.<br>*They did not have a 3-day emergency supply on site.<br>*They had ordered a 3-day supply of ready-to-eat meals but had not yet received it.<br><br>2. Interview on 9/5/25 at 10:15 a.m. with administrator A revealed:<br>*He showed an invoice on his phone dated 7/14/25 for the purchase of the ready-to-eat meal supply.<br>*He had been told by the contracted food service vice president that the food had been misdelivered to the central kitchen at a different facility and they would deliver it to the facility on 9/3/25.<br>*They have not received the food by the end of they survey.<br><br>3. Interview on 9/5/25 at 10:55 a.m. with DDS G revealed:<br>*There was no current inventory or menu for emergency food supply available on site.<br>*He had received an email that morning from the company that their 3-day supply was ready to be shipped from California.<br>*The email indicted the facility would be contacted about a delivery date on or about 9/8/25 by the transportation company.<br><br>4. Interview on 9/5/25 at 11:20 a.m. with administrator A revealed: | S 290 | Assignment of the Director of Dining Services (DDS) as the person responsible for maintaining emergency food supplies. Administrator educated Morrison Director of Dining Services and VP of Operations on maintaining emergency food supplies to ensure compliance.<br><br>The Emergency Management binder was updated to include the emergency food supply plan, menus, inventory lists, and ordering procedures.<br><br>Emergency food supplies will now be ordered and stored directly at the facility, rather than relying on central kitchen deliveries, to avoid misrouting or delays.<br><br>Director of Nutrition and Wellness will audit as part of mock survey process annually. Inventory will be verified on 1st of every month.<br><br>Audits will be completed weekly x4, monthly x2, quarterly x2 to ensure the presence of an emergency food supply within the facility. Dietary manager or designee will report findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring.<br><br>Substantial compliance will be achieved on 10/14/2025. | 10/14/2025 |

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| S 290 | Continued From page 7<br>*He was not aware that the food had not been delivered to the central kitchen and was to be shipped from California that day.<br>*The facility averaged a census of 84 residents.<br><br>Review of the invoice quote for the ready-to-eat meals revealed the food ordered was to serve 100 persons per meal per day.<br><br>Review of the provider's current Emergency Management binder revealed:<br>*An index that contained a listing for Food.<br>*There was no corresponding food information in the binder.<br><br>Review of information provided in response to request for 3-day emergency food plan and menu revealed:<br><br>*The facility provided a printout of material from Meals for All that included a menu and emergency and disaster management policy and procedure manual dated February 2024.<br>*The food items referenced in that menu were not on present site. | S 290 | | |
| S 301 | 44:73:07:16 Required Dietary Inservice Training<br><br>The dietary manager or the dietitian shall provide ongoing inservice training for all personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for all dietary or food-handling personnel. The training must include the following subjects:<br>(1) Food safety;<br>(2) Handwashing;<br>(3) Food handling and preparation techniques;<br>(4) Food-borne illnesses; | S 301 | Food Service Worker D completed all required dietary in-service training on 5/20/2025.<br><br>The deficiency was corrected prior to the survey exit.<br><br>No other dietary personnel were past due on training requirements at the time of the review. A full review of all dietary personnel training records will be conducted by Director of Dining Services and Morrison HR Specialist by 10/14/2025 to ensure all staff have completed the required trainings within the correct timeframe. | |

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| S 301 | Continued From page 8<br>(5) Serving and distribution procedures;<br>(6) Leftover food handling policies;<br>(7) Time and temperature controls for food preparation and service;<br>(8) Nutrition and hydration; and<br>(9) Sanitation requirements.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on record review and interview, the provider failed to ensure one of five employees reviewed had completed the required dietary trainings (food safety, handwashing, food handling/prep, foodborne illnesses, serving/distribution, leftovers, time/temp controls, and sanitation) had been completed upon hire for food service worker (FSW) D.<br><br>Findings include:<br><br>1.Review of the provider's employee personnel records for FSW D revealed:<br>*He was hired on 2/3/25.<br>*He had completed the above dietary trainings as of 5/20/25.<br>*The training had not been completed within his first 30 days of hire.<br><br>2. Interview on 9/5/25 at 10:30 a.m. with administrator A revealed he confirmed that FSW D had not completed the required dietary trainings within his first 30 days of hire. | S 301 | Administrator educated Director of Dining Services and VP of Operations the policy related to personnel training records to ensure compliance.<br><br>All new employees will complete the required food safety and hygiene training prior to starting work.<br><br>All Dietary staff will be monitored daily by dietary manager and support staff for food safety and hygiene for the next quarter, and corrective training will be provided for any failures in the observations.<br><br>HR will complete all required training and sign off prior to any employee starts work Director will complete food safety and hygiene audits along with required dietary inservice audits weekly x4, monthly x2, quarterly x2 and provide corrective training for any concerns identified.<br><br>GM will complete weekly audits of Director beginning 10/3/2025 to ensure audits and training are completed within 30 days of hire. Weekly audits will continue for 4 months. GM or designee will report findings to the QAPI committee monthly. The QAPI committee will determine on-going interventions and monitoring to ensure compliance is sustained.<br><br>Dietary manager or designee will report findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring.<br><br>Substantial compliance will be achieved on 10/14/2025. | 10/14/2025 |