STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY CANISTOTA	700 WEST MAIN ST , CANISTOTA, South Dakota, 57012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/17/26 through 3/19/26, and from 3/23/26 through 3/24/26. Good Samaritan Society Canistota was found not in compliance with the following requirements: F578, F641, F645, F684, F689, F812, F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/17/26 through 3/19/26, and from 3/23/26 through 3/24/26. Areas surveyed included quality of care, quality of life and potential abuse and neglect related to resident personal hygiene and residents rights. Good Samaritan Society Canistota was found not in compliance with the following requirements: F689 and F880.	F0000	The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law.	
F0578 SS = E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F0578	1. Resident 46's code status has been verified with the resident and/or POA and updated to reflect full code (CPR) status. Residents 1, 3, 5, 6, 9, 23, 26, 40, 42, 44, 46, 51, and 58 will have CPR wishes reviewed with them and/or POA by SSD and using a signature form. SSD/Designee will scan the signed form into their EMR stating resident wishes regarding code status. 2. All other current residents will be reviewed by SSD/designee to ensure code status wishes are accurate and scanned into their EMR. 3. An Advanced Directive form will be implemented by SSD/designee on admission and with any change in CPR wishes, with resident and/or responsible party signature. This form will be added to the admission packet by ADM/SSD designee. Code status discussion will occur at time of admission and documented in the EMR progress note. Code status will be consistent across physician orders, care plan, and EMR banner. Any discrepancies will be reconciled immediately. ADM will educate SSD and all department leaders on new process.	4-24-26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amy Evenson	Administrator	4-20-26

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F0578 SS = E	Continued from page 1 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider failed to ensure the code status (emergent treatment a person wishes to receive if their heart or breathing would stop) for thirteen of sixteen sampled residents (1, 3, 5, 6, 9, 23, 26, 40,42, 44, 46, 51, and 58) wishes were determined and accurately documented in the residents' electronic medical records (EMR) at the time of their admission to the facility and one of one sampled resident (46) with discrepancies in his documented code status. Findings include: 1. Review of resident 46's EMR revealed that he was admitted to the facility on 2/3/26. His 2/3/26 Brief Interview for Mental Status (BIMS) assessment score was 3, which indicated his cognition was severely impaired. A banner displayed in his EMR indicated that he wanted to receive (cardiopulmonary resuscitation), an emergency procedure to provide chest compressions and often rescue breathing to preserve brain function and maintain blood circulation (CPR), if his heart or breathing stopped. His care plan had a 2/4/26 initiated code status focus area that indicated "I have a DNR [do not resuscitate] order." A 2/3/26 physician's order indicated he had a DNR code status.	F0578	4. ADM or designee will complete audits on new admissions to ensure code status form is completed and properly identified in their EMR, weekly for 4 weeks, every other week for 2 weeks, and 1 x monthly for 2 months with all audits taken to QAPI meeting until the facility demonstrates sustained compliance as determined by the committee. 5. Substantial compliance to be achieved by 4/24/26.	

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F0578 SS = E	Continued from page 2 There was no documentation in resident 46's EMR that indicated his code status wishes were for CPR. 2. Review of resident 1, 3, 5, 6, 9, 23, 26, 40, 42, 44, 46, 51, and 58's electronic medical records (EMR) revealed: -Resident 5 was admitted to the facility on 11/22/24. No documentation in the resident's EMR indicated his code status wishes. -Resident 23 was admitted to the facility on 2/22/24. No documentation in the resident's EMR indicated her code status wishes. -Resident 26 was admitted to the facility on 7/7/20. No documentation in the resident's EMR indicated her code status wishes. -Resident 51 was admitted to the facility on 6/13/24. No documentation in the resident's EMR indicated his code status wishes -Resident 3 was admitted to the facility on 12/14/20. No documentation in the resident's EMR indicated his code status wishes. -Resident 9 was admitted to the facility on 1/23/26. No documentation in the resident's EMR indicated her code status wishes. -Resident 42 was admitted to the facility on 10/30/25. No documentation in the resident's EMR indicated his code status wishes. -Resident 46 was admitted to the facility on 2/03/26. No documentation in the resident's EMR indicated his code status wishes. -Resident 58 was admitted to the facility on 3/12/26. No documentation in the resident's EMR indicated his code status wishes. -Resident 1 was admitted to the facility on 8/19/25. No documentation in the resident's EMR indicated his code status wishes. -Resident 6 was admitted to the facility on 11/17/25. No documentation in the resident's EMR indicated her code status wishes. -Resident 40 was admitted to the facility on 6/25/24.	F0578		

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F0578 SS = E	Continued from page 3 No documentation in the resident's EMR indicated her code status wishes. -Resident 44 was admitted to the facility on 5/20/22. No documentation in the resident's EMR indicated her code status wishes. 3. Interview on 3/18/26 at 10:42 a.m. with administrator A regarding resident's code status revealed the provider did not have a form for the residents or their representatives to sign to indicate the resident's code status wishes. She provided a form that included a signed physician admission standing order with a DNR code status that was used if the resident did not have a formal advanced directive. 4. Interview on 03/19/26 at 4:16 p.m., with social worker (SW) D, regarding the facility's admission process for obtaining and documenting a residents' code status wishes revealed that the facility reviews their residents' advance directives with the residents during their admission to the facility. She stated the facility did not review the resident's code status wishes with residents when they were admitted to the facility. The facility does not utilize a form for the residents or their representatives to document those wishes. SW D indicated that she would ask residents to verbally state their preferences for their code status at the time of admission. For residents who were admitted from a hospital, their code status was determined based on their hospital discharge documentation. The facility did not have documentation to indicate a resident's code status preference at the time of their admission to the facility. SW D stated the facility followed standing orders from the medical director regarding code status at the time of a resident's admission to the facility. She documented the resident's or their family's preference regarding code status in an admission progress note in the resident's EMR and communicated that information to the nursing staff. The nursing staff would then document that preference in the resident's EMR. 5. Centers for Medicaid and Medicare Services (CMS) State Operations Manual Appendix PP (Guidance to Surveyors for Long Term Care Facilities) definition of	F0578		

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F0578 SS = E	Continued from page 4 code status "Do Not Resuscitate (DNR) Order" refers to a medical order issued by a physician or other authorized non-physician practitioner that directs healthcare providers not to administer CPR in the event of cardiac or respiratory arrest. The existence of an advance directive does not imply that a resident has a DNR order. The medical record should show evidence of documented discussions leading to a DNR order."	F0578		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review,	F0641	1. MDS modification will be entered by MDS Nurse to correct resident 42 and 46's coding related to PASRR level. 2. All current residents most recent MDS will be reviewed by HIM/designee to ensure proper coding related to PASRR level. Any concerns will be corrected by MDS nurse by submitting MDS modifications. 3. SSD will review all PASRR Level 1 screens for accuracy prior to admission and with new diagnosis- any diagnosis of mental illness, psychosis, TBI, or behavioral disturbance will trigger Level 2 review- Level 2 requests will be submitted by SSD/designee prior to admission with documentation in the EMR. IDT will review new admission PASRR's and new diagnosis PASRR changes during daily clinical meeting. MDS nurse will review all MDS assessments pertaining to PASRR level to ensure that the coding matches the PASRR prior to signing the assessment. All necessary parties that perform some part of MDS will be educated on these changes and requirements by our clinical learning and development specialist by the compliance date. Any others that are unable to attend meeting will have 1:1 education with the appropriate parties. 4. DNS or designee will complete audits on new assessments to ensure correct Level for PASRR is obtained, weekly for 4 weeks, every other week for 2 weeks, and 1 x monthly for 2 months with all audits taken to QAPI meeting until the facility demonstrates sustained compliance as determined by the committee. 5. Substantial compliance to be achieved by 4/24/26.	4-24-26

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F0641 SS = D	Continued from page 5 the provider failed to ensure two of two sampled residents'(42 and 46) Minimum Data Set (MDS) (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) assessments were accurately coded regarding Pre-Admission Screening and Resident Reviews (PASRR), used to screen residents for serious mental health, intellectual disabilities, or developmental disabilities to ensure appropriate placement and specialized services, and Level I PASRRs. Findings include: 1. Review of resident 42's electronic medical record (EMR) revealed: *He admitted to the facility on 10/30/25. *His diagnoses included schizoaffective disorder (hallucinations, delusions, disorganized speech), bipolar type (episodes of mania, extreme "highs", and sometimes major depression), traumatic brain injury (TBI), and epilepsy (recurrent, unprovoked seizures). *His 10/28/25 level I (one) PASRR was coded as "Yes" to the questions: *"Does this individual have a confirmed or suspected serious mental illness diagnosis limited to the following?" *"Does the individual have a confirmed or suspected diagnosis of an intellectual disability (ID) that was prior to the age of 22?" *Resident 42 was referred to Maximus for further mental health evaluation and then to the Department of Human Services, Division of Developmental Disabilities (DDD). *His 10/28/25 notice of "PASRR Outcome Explanation", indicated "The facility should mark yes for question A1500 on the Minimum Data Set' Is the resident currently considered by the state level II [two]PASRR process to have a serious mental illness and/or intellectual disability or a related condition?'" *His 11/05/25 comprehensive MDS assessment indicated: *Item A1500 was coded as "No" to the question, "Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition?"	F0641		

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F0641 SS = D	Continued from page 6 *Item A1510 was not coded, which would have indicated that resident 42 had a serious mental illness or intellectual disability. *Item A1550, conditions related to intellectual disability (ID) and developmental disability (DD), was coded as "None of the above" to the question, "If the resident is 22 years of age or older, complete only if A0310A+01." *His 10/30/25 care plan indicated he received an antipsychotic (medications used to manage psychosis, including delusions, hallucinations, and severe agitation) medication related to his schizoaffective disorder, bipolar type, and anticonvulsant (therapeutic agents that stabilize nerve cell membranes, reducing abnormal electrical activity in the brain to prevent seizures) medication related to epilepsy. 2. Review of resident 46's EMR revealed: *He admitted to the facility on 2/3/26. *His diagnoses included anxiety, behavior, psychotic, and mood disturbance. *His 1/29/26 level I PASRR was coded as "No" to the question, "Does this individual have a confirmed or suspected serious mental illness diagnosis limited to the following disorders?" -The question had indicated that if the diagnoses were checked, then mark "Yes." *His 2/9/26 notice of "PASRR Outcome Explanation" indicated, "The facility should mark yes for question A1500 on the Minimum Data Set 'Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition.' *His 2/9/26 comprehensive MDS assessment indicated: *Item A1500 was coded as "No" to the question: "Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition?" *Item A1510 was blank. 3. Interview and record review on 3/16/26 at 4:16 p.m. of resident 46's PASRR level 1 screening when he was	F0641		

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F0641 SS = D	Continued from page 7 admitted to the facility with social worker (SW) D revealed: *She was responsible for completing item A1500 on the comprehensive MDS assessments for all residents. 4. Interview and record review on 3/24/26 at 1:47 p.m. with registered nurse (RN)/ Minimum Data Set (MDS) C, regarding completing residents' comprehensive MDS assessments revealed: * SW D completed the PASRR on the residents' comprehensive MDS assessments, and then RN C signed those assessments to indicate that it was accurate? *She confirmed item A1500 on resident 46's 11/05/25 comprehensive MDS assessment for resident 46 should have been coded as "yes". 5. Review of Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 October 2025 revealed section A, item A1500, "Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD [intellectual disability/developmental disability] or related condition".	F0641		
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services,	F0645	1. Resident 1's Care Plan was updated to reflect the type of trauma that the resident suffers from. Resident 1's level II was submitted and approved on 1/27/26. Level II PASRR was scanned for this resident. Resident 46's level II PASRR review was submitted on 3/23/26 and was not approved. Level I is current. 2. All other current residents will be reviewed by SSD/designee to ensure that PASRR screening is accurate and scanned into their EMR. 3. IDT team to preview PASRR form prior to admission. SSD will review all PASRR Level 1 screens for accuracy prior to admission – Any diagnosis of mental illness, psychosis, TBI or behavioral disturbance will trigger Level 2 review – Level 2 requests will be submitted prior to admission with documentation in the EMR. SSD will be educated of these requirements by compliance date by the Admin.	4-24-26

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F0645 SS = D	Continued from page 8 whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or	F0645	4. ADM or designee will complete audits on new admissions weekly for 4 weeks, every other week for 2 weeks, and 1 x monthly for 2 months with all audits taken to QAPI meeting until the facility demonstrates sustained compliance as determined by the committee. 5. Substantial compliance to be achieved by 4/24/2026.	

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F0645 SS = D	Continued from page 9 is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure two of two sampled residents (1 and 46) with diagnosed anxiety, behaviors, psychosis, and mood disturbances had a Preadmission Screening and Resident Review (PASRR) reviewed for accuracy to ensure the resident were evaluated for mental health care needs. Findings include: Based on record review, interview, and policy review, the provider failed to ensure two of two sampled residents (1 and 46) with diagnosed anxiety, behaviors, psychosis, and mood disturbances had a Preadmission Screening and Resident Review (PASRR) reviewed for accuracy to ensure the resident were evaluated for mental health care needs. Findings include: 1. Review of resident 46's electronic medical record (EMR) revealed: *He admitted to the facility on 2/3/26. *Resident 46's diagnoses included: anxiety, behaviors, psychosis, and mood disturbances. *On 02/03/26, he had a Brief Interview for Mental Status (BIMS) assessment score of 3, which indicated his cognition was severely impaired. *He had a Level I (one) PASRR completed on 01/29/26. - The question, "Does this individual have a confirmed or suspected serious mental illness diagnosis limited to the following disorders?" was marked "No". 2. Review of resident 1's EMR revealed: *He admitted to the facility on 8/19/25. *His 8/20/25 care plan had a focus area that indicated "The resident has a psychosocial well-being deficit reliving trauma." The care plan did not indicate what	F0645		

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F0645 SS = D	Continued from page 10 the trauma was. *He had a 2/27/26 BIMS assessment score of 15, which indicated his cognition was intact. *His admission diagnoses included: other signs and symptoms involving cognitive functions and awareness; psychosis; traumatic brain injury; personal history of mental and behavioral disorders; major depressive disorder, and anxiety. 3. Interview and record review on 3/16/26 at 4:16 p.m. with social worker (SW) D regarding resident 46's Level I PASARR when he was admitted to the facility revealed: *She reviewed resident 46's Level I PASRR and acknowledged that it had been completed it incorrectly. *She acknowledged that a Level II (two) PASARR request should have been submitted for resident 46. 4. Interview and review on 3/19/26 at 4:01 p.m. of resident 1's Level 1 PASRR with SW D revealed: *When a resident admitted to the facility, from a hospital, with a Level I PASRR already completed by the hospital, she was responsible for reviewing that PASRR for accuracy and submitting a Level II PASRR to the State Mental Health Agency (SMHA) for additional review when the Level I PASRR was "positive (the Level I PASRR has identified a suspected or confirmed serious mental illness (SMI), intellectual disability (ID), or developmental disability (DD)." *Resident 1 admitted to the facility from the hospital with a Level I PASRR that was completed by the hospital social worker on 8/15/25. *The Level I PASRR indicated a categorical outcome (an expediated determination made during a Level II evaluation) was being requested and was marked as yes, and the area of "IF YES, WHICH ONE?" had no areas marked. *SW D reviewed resident 1's 8/15/25 Level I PASRR and did not notice that his mental health diagnoses were not included on that PASRR. *She submitted resident 1's 8/15/25 Level I PASRR to the SMHA on 1/27/26 for Level II PASRR determination. *She indicated a Level II request for resident 1 should	F0645		

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F0645 SS = D	Continued from page 11 have been submitted to the SMHA after he was admitted to the facility on 8/19/26. *She did not indicate on Level 1 his additional mental health diagnoses, nor did she complete a new, accurate, Level 1 screen. 5. Interview and record review on 3/24/26 at 1:47 p.m. with registered nurse (RN)/ Minimum Data Set (MDS) C revealed: *She expected each resident's Level I PASRR to be completed and accurate. *She indicated that SW D completed the PASRR on the residents' comprehensive MDS assessments, and then RN/MDS C signed the assessments to indicate that they were completed accurately. *She agreed that resident 46's PASRR on his comprehensive MDS assessment was coded incorrectly and should have been coded as "yes". 6. Review of the provider's 5/14/25 Preadmission Screening and Resident Review (PASRR) policy revealed: *"The Preadmission Screening and Resident Review (PASRR) is a federal requirement to ensure [the] nursing facility residents with serious mental illness (MI) or intellectual and developmental disability (ID/DD) are: -Identified and evaluated; -Placed in the most appropriate and least restrictive setting available; -Transitioned to an appropriate community setting when they no longer meet criteria for nursing facility placement; -Provided with the MI/ID/DD services they need, including specialized services." *"A negative Level I screen permits admission to proceed and ends the pre-screening process unless possible serious mental disorder or intellectual disability arises later. A positive Level I screen necessitates an in-depth evaluation of the individual, by the state-designated authority, known as Level II PASRR, which must be conducted prior to admission to the facility".	F0645		

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F0645 SS = D	Continued from page 12 *"Failure to pre-screen residents prior to admission to the facility may result in the failure to identify residents who have or may have MD, ID, or a related condition. A record of the prescreening should be retained in the resident's medical record". *"Individuals who have or are suspected to have MD, ID, or a related condition (as indicated by a positive Level I screen) may not be admitted to a Medicaid-certified nursing facility unless approved based on Level II PASRR evaluation and determination. Exemptions to this requirement are specified in §483.20 (k)(2) and may be exercised at the discretion of the State, as specified in the State's PASRR process".	F0645		
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (7) with risk for developing skin wounds caused by prolonged pressure and expressed discomfort in areas of irritated skin around her suprapubic catheter (a flexible tubing surgically placed through the abdomen into the bladder to drain urine) insertion site and in her abdominal fold was assessed for irritation and her physician was notified of those skin conditions to determine and order treatment to promote healing and prevent those areas from worsening or developing into pressure wounds. Findings include: 1. Observation and interview on 03/17/26 at 11:04 a.m. with resident 7 revealed she was in her room, seated in her wheelchair. There was catheter tubing that extended from her shorts, connected to the catheter bag (a device used to collect urine), and was clipped to her wheelchair. She stated that she had problems with her catheter and that "it bleeds every day." She indicated,	F0684	1. Resident 7 was seen by MD Director on 3/25/26. MD Director ordered split gauze to S/P catheter site BID and to place interdry to abdominal fold every 5 days. 2. Any other residents with S/P catheters or braden scale cores at less than 18 will be identified and assessed. 3. Director of Nursing or designee will provide necessary education to nursing staff related to proper catheter and peri-care, skin integrity and moisture associated skin damage, skin assessments, and provider notification guidelines for skin breakdown and wounds. A clinical trigger will be created to review any new skin breakdown, drainage, redness or pain will require nurse assessment within the same shift and provider notification. Any skin concerns will be immediately reported to a licensed nurse. Licensed nurse will assess and document within same shift. All ordered treatments will be initiated and documented each shift. Care plan will be updated to reflect current skin treatments and interventions on all residents as needed. Care Plans will be reviewed for accuracy and updated appropriately for all residents.	4-24-26

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F0684 SS = G	Continued from page 13 "It is bad down here (pointed to her groin area)." 2. Review of resident 7's electronic medical record (EMR) revealed her admission to the facility was on 11/8/21. Her 2/19/26 Brief Interview of Mental Status assessment score was a 15, which indicated her cognition was intact. Her diagnoses included: neuromuscular dysfunction of the bladder (caused by nerve damage that interrupts signals between the brain and bladder, leading to poor bladder control); Type 2 diabetes with chronic kidney disease; Cystostomy status (a surgical opening into the bladder to allow for urinary drainage); retention of urine, (inability to fully empty the bladder); dermatitis (skin inflammation); and morbid obesity (excessive weight that significantly impacts health and well-being). Her 1/6/26 skin observation assessment indicated she had a "moist/pink" abdominal fold, and her groin area was "pink and moist". The treatment indicated for those areas was "Nystatin External Powder" and was last documented as administered on "12/31/25." Her skin observation assessments indicated that on 1/13/26, her skin observation assessment indicated her groin was "pink [and] moist". On 1/20/26, abdomen had "s/p [status post] pink area" and "scattered bruising [due to] insulin injections." On 1/27/26, her abdomen had "pink skin under abdominal fold" and her groin was "pink [and] moist skin." On 2/3/26, her abdomen had "pink and moist under abdominal folds" and her groin was "pink moist". On 2/17/26, her abdomen had "irritation under abdominal fold", and the listed treatment of Nystatin External Powder was last documented as administered on "12/31/25." On 2/24/26, her abdomen was "pink, moist under abdominal folds [and] scattered bruising from insulin administration". On 3/3/26, the assessment indicated her "Skin check was completed – no skin conditions observed/skin condition resolved" and "no new skin issues noted". There were no medications or treatments listed. Resident 7's skin observation assessments completed on 1/13/26, 1/20/26, 1/27/26, 2/3/26, and 2/24/26, indicated there were no treatments "that will or are being done on the skin conditions". Resident 7's 3/17/26 skin assessment indicated she had an abdominal fold with intermittent serous drainage, pink in color, and the only intervention identified was to clean the area. Her 3/24/26 nurse's progress note indicated her skin	F0684	4. Director of Nursing or designee will complete direct observation and documentation audits to ensure compliance with assessment, treatment, and physician notification requirements related to skin conditions. Director of Nursing or designee will complete direct observation audits of residents identified with skin concerns including MASD, catheter sites, and skin folds) to verify that skin assessments are completed timely and accurately, appropriate interventions/treatments are in place and being followed & changes in condition are identified and addressed. Documentation audits of EMR to include skin assessments reflect current condition and include measurable/descriptive details, physician notification occurs with any new or worsening skin condition, orders are obtained, implemented, and documented & care plans are updated to reflect current needs and interventions. These audits will occur weekly for 4 weeks, every other week for 2 weeks, and 1 x monthly for 2 months with all audits taken to QAPI meeting until the facility demonstrates sustained compliance as determined by the committee. 5. Substantial compliance to be achieved by 4/24/26.	

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F0684 SS = G	Continued from page 14 was warm, dry, and the color was within normal limits. There was a skin condition labeled "001" located on her perineum (the skin between the genitals and anus) that had not been evaluated, was classified as moisture-associated skin damage (MASD), and was acquired in the facility. She had a second skin condition that the staff were monitoring, labeled "002" located on her abdomen, classified as MASD, and was acquired in the facility. There were no measurements for these skin conditions documented. Resident 7's physician was notified of these skin conditions. Her physician's orders included a 6/8/24 order for "catheter care BID [twice a day]", and a 5/28/25 order to change her suprapubic sponge each day. The physician order to change her suprapubic sponge each day was discontinued in October 2025. Her physician's orders included an order on 4/30/25 for InterDry to be applied to the affected area as needed for MASD. On 9/17/26, this order was put on hold, resumed on 9/29/25, put on hold on 2/7/26 as she was admitted to the hospital, and was resumed again on 2/10/26. She had a 1/5/26, physician's order to "Change catheter every month and PRN [as needed] if dislodged or plugged and unable to clear with irrigation." 3. Observation and interview on 3/23/26 at 3:56 p.m. with resident 7 revealed she had a nighttime catheter bag clipped onto her bed frame that held a moderate amount of clear yellow urine. She indicated she had a suprapubic catheter, that the insertion site was "sore" and "sometimes had blood". Resident 7 stated the staff did not use a sponge or ointment when they cleaned that site and wished they would use a sponge. Resident 7 pulled up her shirt and separated her abdominal fold where her suprapubic catheter site was, which revealed a pink, shiny area that appeared moist, without a split sponge (pre-cut sterile dressing designed to fit snugly around catheters, used to absorb drainage). She stated the staff would clean the insertion site by wiping it in the morning and at night with a wet wipe. 4. Interview on 3/23/26 at 4:05 p.m. with medication assistant (MA) G revealed that resident 7 had her catheter flushed twice a day. The nurse would cleanse the catheter insertion site, and the certified nursing assistants (CNAs) and medication aides MAs would also cleanse the insertion site if they were providing resident care and saw drainage from the site. She was	F0684		

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F0684 SS = G	Continued from page 15 not aware of any gauze or creams being applied to resident 7's catheter insertion site. 5. Interview on 3/23/26 at 4:10 p.m. with CNA/environmental services supervisor (ESS) J, who was scheduled to work the evening of 3/23/26 as a CNA, revealed she was not aware of any blood in resident 7's urine or bleeding at her catheter insertion site. 6. Observation and interview on 3/23/26 at 4:15 p.m. with registered nurse (RN) F regarding resident 7's suprapubic catheter revealed there was no known history of blood in her urine. Sometimes there was serous (clear watery fluid) drainage at her suprapubic insertion site, which was in an abdominal fold, and she believed it was related to friction and from being "tugged" on. RN F often would see resident 7 in the morning when resident 7 woke up. RN F would flush her catheter at that time; otherwise, she did not see the serous drainage. When CNAs completed catheter care for resident 7, they would wipe the drainage at the catheter insertion site and cleanse the area each morning and night, as needed. RN F stated there were no physician-ordered creams for resident 7, as the abdominal fold area was open. She would apply a split sponge, as needed, if she had one. She indicated she had none with her that morning (3/23/26) and was not able to get back to resident 7's room to apply one to her abdominal fold. She confirmed there was no physician order for a split sponge. RN F examined resident 7's abdominal fold, which had a split in the skin and granulation (new, connective tissue and microscopic blood vessels that form on the surfaces of a wound during the healing process) tissue with a small opening. RN F stated the doctor was aware of the site and skin issue. She indicated that resident 7 reported pain when she was asked about it. She indicated that the CNAs and bath aides reported residents' skin concerns to the nurses. She stated that the residents' skin assessments were completed for residents with a Braden Scale (a tool used to assess the risk for developing skin ulcers caused by prolonged pressure) score greater than 18, and resident 7 had a physician order for nurse skin assessments. 7. Observation and interview on 3/24/26 at 10:18 a.m. with resident 7 revealed that her right-side abdominal fold was pink with a reddened area. The catheter insertion site was red, the skin was granulating (developing new connective tissue and microscopic blood	F0684		

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F0684 SS = G	Continued from page 16 vessels) on each side of the catheter tube at the insertion site, and the area appeared moist. There was no gauze, dressing, or split sponge at the supra-pubic catheter site. Resident 7 reported that it hurt, and she felt pain across her abdomen in the fold. She stated when gauze was placed in the fold, "they [staff members] didn't change it, and it [the gauze] was yellow and green." She had, in the past, refused the powder to be placed in the abdominal fold and stated she did not like it. She explained the powder as "an irritation too." Resident 7 stated she told various staff members and CNAs that she wanted gauze placed in her abdominal fold, and they said they had to talk to the nurse about that. 8. Interview on 3/24/26 at 10:29 a.m. with CNA N regarding resident 7 revealed she cleansed around the suprapubic catheter insertion site, that sometimes had "leakage there with blood," and she used a wipe and cleaner to cleanse the area. CNA N indicated resident 7's skin was "a little bit red," and that the resident complained that her skin was irritated and itched. CNA N applied a barrier cream to resident 7's skin every time she assisted resident 7 with her catheter care. She stated the area in resident 7's abdominal fold was "moist a lot," she had bladder spasms, and CNA N stated she "feels urine is leaking into the abdominal fold". Resident 7 did not ask for gauze, and "just asks for the cream to be applied" in her abdominal fold. CNA N had not seen a split gauze or any other dressing in resident 7's abdominal fold. She indicated the nurse completed the suprapubic catheter insertion site treatment. 9. Interview and review of resident 7's EMR on 3/24/26 at 10:47 a.m. with RN E, revealed resident 7's suprapubic catheter care included flushing the catheter twice a day, cleansing the area around her catheter insertion site, and in her abdominal fold with a "wipe". When she completed the treatment in the morning, there was extra moisture and serous drainage at the suprapubic catheter insertion site. She indicated she only saw the bloody drainage in the mornings. RN E indicated that resident 7 had bladder spasms and urine leakage at the suprapubic catheter insertion site. She offered to resident 7 to get a physician's order for powder to keep the area dry, but resident 7 refused. Resident 7 had not asked her for gauze to be placed in the abdominal fold or to have a split sponge at the catheter insertion site. Resident 7's suprapubic catheter care treatment order	F0684		

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F0684 SS = G	Continued from page 17 did not include catheter insertion site care or to apply a split sponge. There was a 5/28/25 order from her urologist that included an order for a split sponge. RN E confirmed the split sponge was discontinued in October 2025. RN E confirmed resident 7 had bladder spasms and that her urine back flowed at the suprapubic catheter insertion site, into the abdominal fold, and on to her skin. She reported that resident 7 had not reported or complained to her about her skin being irritated or pain in her abdominal fold. RN E described the skin in resident 7's abdominal fold as being intact, light pink, and moist. She confirmed this description was documented on the 3/17/26 nurse skin assessment and that the resident's weekly skin assessment was due today (3/24/26), but she had not completed it. RN E would clean the skin in the abdominal fold with wipes; resident 7 refused powders, and the CNAs applied barrier cream to her abdominal fold. 10. Observation and interview on 3/24/26 at 11:10 a.m. of RN E completing resident 7's weekly skin assessment revealed that resident 7 grimaced and voiced "ouch" throughout RN E cleansing the area with wipes. She stated "ouch" and touched her right abdominal area with her hand. Her abdominal fold had a white ointment in it and was observed as being moist. Resident 7 stated the white ointment was not helping her skin heal. The skin in resident 7's abdominal fold was reddened and excoriated (worn off). There was an approximately 6-inch-long by 0.25-inch-wide red streak on the right side of her abdomen in the abdominal fold. There was an approximately one centimeter (cm) area on each side of the supra pubic catheter insertion site that was red, excoriated, and appeared to have new granulation of the skin. The catheter tubing had serous drainage on it, which RN E wiped off with a wipe. RN E spent approximately five minutes using four or more wipes to cleanse resident 7's abdominal fold and the suprapubic site and tubing. Resident 7 continued to wince and voice "ouch" throughout RN E's cleansing of the area. RN E stated to resident 7 that she was trying to clean her up. RN E then stated she would remove the two tubes of DynaShield skin protectant cream from the bedside so the CNAs would not use it on her abdominal fold. RN E removed her gloves, performed hand hygiene (wash or sanitize hands), and stated she was going to the medication room to get supplies and would be back. She returned to resident 7's room approximately 5 minutes	F0684		

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F0684 SS = G	Continued from page 18 later with wound cleanser spray, a split drain sponge, gauze, and InterDry sheets (specialized, antimicrobial, moisture-wicking textiles designed to manage skin folds and skin-to-skin contact areas). She cleansed the suprapubic catheter insertion site wound with the spray and gauze, placed a split drain sponge around the suprapubic catheter insertion site, and laid the InterDry sheets into the abdominal fold. RN E stated she had not seen the resident's red, newly granulated area around the supra pubic insertion site, and the red excoriated skin in the abdominal fold there before. She stated there was a PRN (as needed) order for the InterDry sheets. She did not use them before but was aware that other nurses had used them for under resident 7's breasts in the summer. She was not certain when the the CNAs started applying the cream in resident 7's abdominal fold and indicated no CNAs had reported to her resident 7's current skin conditions that she first saw during today's (3/24/26) skin assessment. 11. Interview and record review on 3/24/26 at 2:20 p.m. with RN F, director of nursing (DON) B, and RN/Minimum Data Set (MDS) nurse C revealed resident 7 had her suprapubic catheter surgically placed on 4/23/25. In October 2025, at the request of the nurses, her provider discontinued the order for the split drain sponge at the suprapubic catheter insertion site because that area was healed. They were aware that resident 7's abdominal fold was moist but were not aware that the suprapubic catheter insertion site was red, appeared excoriated, and had new granulation tissue present. DON B stated the nurses did not use a split sponge at the insertion site, as the physician had discontinued it. Resident 7's physician had ordered InterDry sheets PRN, on 4/30/25 to reduce the moisture in her skin folds. DON B would expect the nurses to use the InterDry sheets in resident 7's abdominal folds to reduce the moisture and to prevent excoriation. Nurse skin assessments were done weekly, and there was no expectation for the nurses to measure the pink area in her folds. 12. Review of the provider's 12/8/25 Skin Assessment Pressure Ulcer Prevention and Documentation Requirements policy revealed "Assessment and Documentation of Bruises/Contusions/Skin Tears/Abrasions[.]" "An abrasion is a wound caused by superficial damage to the skin, no deeper than the epidermis. If a bruise/contusion/skin tear/abrasion is observed on a resident, this should be reported to the nurse immediately. The bruise/contusion/skin	F0684		

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F0684 SS = G	Continued from page 19 tear/abrasion should be monitored weekly and any changes and/or progress toward healing should be documented on the Skin Observation UDA [user defined assessment] and on the resident's care plan." 13. Review of the provider's 3/2/26 Catheter: Care, Insertion and Removal, Drainage Bags, Irrigation, Specimen policy revealed, "It is important to keep the dressing dry and cleanse the suprapubic skin insertions site using clean technique every day and as necessary." "Catheter Care – Indwelling Catheter "Catheter care will be completed with morning and bedtime cares and as needed… Observe meatus and surrounding tissue for inflammation, encrustations, swelling, or discharge, ask the resident if burning or discomfort is present."	F0684		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review the provider failed to ensure the safe use of devices by two of two certified nursing assistants (CNA) (H and K) observed transferring a resident to and from her wheelchair and her mattress without a gait belt (a waist strap gripped as support for safe mobility and transfers) for one of one sampled resident (11) with Huntington's disease (a progressive genetic disorder that causes the breakdown of nerve cells in the brain and involuntary movements) who needed to be transferred with the assistance of two staff members and the use of a gait belt. That failure put the resident at risk for falling and injury. 1. Observation and Interview on 3/17/26 at 3:33 p.m. with CNAs K and CNA H while assisting resident 11 to stand up from her wheelchair in her room revealed the CNAs were positioned on each side of resident 11 and they had one hand under each of the resident's arms	F0689	1. CNA H and K educated on proper safe resident handling to ensure safety for resident 11. 2. All residents that require transfer assist with the use of a gait belt could be at risk for this tag. 3. Staff education will occur to ensure that staff are aware of all transfer methods for each resident. All falls will trigger an immediate nurse assessment and appropriate interventions put into place. Staff education will occur by the compliance date by clinical learning development specialist or DNS. Staff that does not attend training will have 1:1 visits with necessary individuals by compliance date. 4. Director of Nursing or designee will complete audits while resident transfers occur and throughout all shifts weekly for 4 weeks, every other week for 2 weeks, and 1 x monthly for 2 months with all audits taken to QAPI meeting until the facility demonstrates sustained compliance as determined by the committee. 5. Substantial compliance to be achieved by 4/24/2026.	4-24-26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY CANISTOTA	700 WEST MAIN ST , CANISTOTA, South Dakota, 57012

(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
F0689 SS = D	Continued from page 20 while their other hands held the waistband of the resident's pants. each of her arms and held the back of her pants. The CNA's prompted resident 11 to step forward onto her mattress, and turn, and then the CNAs lowered her to a lying position on her mattress. The CNA's changed her incontinence brief (absorbent, protective garments designed to manage bladder or bowel leakage), then prompted her to stand. Resident 11 pulled herself up to a standing position by holding the CNA's hands while the CNAs held on to the back of her pants. Resident 11 was then prompted to turn and sit down on her wheelchair. CNA K stated that resident 11 could not use a mechanical lift (a device used to safely transfer individuals with limited mobility between beds, chairs, and bathrooms) because she had previously thrown herself out of the lift. 2. Review of resident 11's electronic medical record (EMR) revealed her care plan indicated she was able to transfer to and from her mattress on the floor and her wheelchair with hand-held assistance from two CNAs and the use of a gait belt. The resident could hold the hands of CNAs for transfers. 3. Interview on 3/24/26 at 11:39 with CNA K revealed she was not concerned regarding resident 11's transfers because she held onto the resident's pants. She acknowledged she did not use a gait belt to transfer resident 11 on 3/17/26 and stated that she "probably should have". 4. Interview on 3/23/26 at 12:06 p.m. with registered nurse (RN) F revealed that resident 11 was not safe to be transferred with a mechanical lift due to her uncontrolled movements. She expected the CNAs to use a gait belt when transferring resident 11. 5. Interview on 3/24/26 at 8:54 a.m. with director of nursing (DON) B revealed that the CNAs would refer to the residents' care plan (personalized plan that addresses a resident's care needs, goals, and interventions), daily report (information shared between CNAs at a shift change regarding the care of residents) to know how to care for the residents. She expected the CNAs to use a gait belt when they transferred resident 11.	F0689		

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F0689 SS = D	Continued from page 21 6. Review of the provider's 12/1/25 Care Plan policy revealed," Residents will receive and be provided with the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment." The policy did not address the implementation of interventions. 7. Review of the provider's 12/12/25 "Safe Resident Handling Program" policy revealed," Good Samaritan's goal is to maintain a safe living and working environment for residents and employees."	F0689		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure the staff followed standard food safety and sanitation practices in the kitchen and food storage areas where residents' food was stored, prepared, and served. Findings include: 1. Observation on 3/17/26 at 8:20 a.m. of the	F0812	1. All dented cans have been discarded appropriately. The top of the dishwasher and fan blades have been cleaned properly. Staff education was provided to FSA M regarding proper hand hygiene and the proper way to carry supplies/product throughout the facility. 2. All residents could be impacted by this tag. 3. Staff education will occur for all dietary staff to ensure compliance with food safety and sanitizing policies. Cans will be checked at time of delivery for any dents or cracks and will be placed in a separate area with a note stating do not use. These products will be returned to the manufacturer. Staff education will occur by the CDM by compliance date. If staff are unable to attend training, they will have 1:1 training with CDM to ensure compliance. 4. CDM or designee will complete audits for hand hygiene, kitchen cleanliness, and dented cans across all shifts weekly for 4 weeks, every other week for 2 weeks, and 1 x monthly for 2 months with all audits taken to QAPI meeting until the facility demonstrates sustained compliance as determined by the committee. 5. Substantial compliance to be achieved by 4/24/26	4-24-26

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F0812 SS = E	Continued from page 22 provider's dry food storage room, canned goods rack, revealed a # (number) 10 can (holds 12-13 cups) of applesauce and a #10 can of dill pickles that both had severe dents at the sealed seam that could cause cracks and entry of bacteria. On the ceiling, a yellow conduit tube had what appeared to be a dust-like substance on it. That substance was approximately two inches long and hanging from various areas of the conduit tube. 2. Observation on 3/17/26 at 8:46 a.m. of the dishwashing area revealed a tan-colored residue that covered the top of the dishwasher, and by the far edge, the residue was one-half inch thick. That same residue was on the wall next to the dishwasher. Behind the dishwasher was what appeared to be yellow insulation wrapped around a pipe with a silver covering that was peeling off the yellow insulation. One area of the silver covering was peeled back and measured approximately 2 feet by 5 inches. A second area of peeling was approximately 8 inches long. There was an oscillating table-top fan attached to the wall between the cupboard and the dishwasher that had dust build-up on the fan blades and the front grille. That fan was turned slightly upward and was blowing air into the clean dishwashing area where clean dishes were present. 3. Observation at 11:58 a.m. of food service assistant (FSA) M revealed she held a clean Cambro (plastic food storage container) against her apron. After putting the Cambro container in the cupboard, she went to the freezer and took out eight single-serve containers of frozen dessert. She used both of her hands to hold the desserts against her apron, entered the dining room, and served those desserts to various residents. 4. Observation on 3/17/26 at 12:19 p.m. of FSA M, in the kitchen, revealed she performed hand hygiene (wash or sanitize hands) at the hand-washing sink, dried her hands on a paper towel, then used one of her clean hands to open the lid of the trash can, and placed the paper towel she dried her hands with in the trash can. That trash can had a step-on pedal to open the lid without touching it. 5. Interview on 3/24/26 at 5:25 p.m. with certified dietary manager (CDM) L and administrator A regarding dietary processes revealed, that CDM L was not aware there were dented cans in the dry storage room, and stated they should not be available for use. She was not aware of the accumulated dust on the yellow conduit	F0812		

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F0812 SS = E	Continued from page 23 tube in the storage room, or that the oscillating fan was blowing into the clean dishwashing area while it had dust on the blades and grille. CDM L expected FSA M not to carry clean dishes or food products against her apron and should have used a cart to transport the products. CDM L confirmed there was a foot pedal to open the trash can, and FSA M should not have used her hand to open the trash can. Administrator A acknowledged the above deficient practices and stated, "They [dietary staff] have had training [by CDM L)." 6. Observation and interview on 3/24/26 at 5:35 p.m. with CDM L in the kitchen revealed she was aware of the tan-colored residue that covered the top of the dishwasher and on the wall next to the dishwasher. She stated that it was cleaned after each meal service. She agreed the amount of "food particle" residue on the dishwasher could not have accumulated after one missed cleaning. CDM L stated the silver covering over the yellow insulation around the pipe behind the dishwasher was for protection and that it was that way "for a while," and should have been replaced. 7. Review of the provider's 3/13/26 Food Supply Storage policy revealed there was no guidance regarding the storage of canned goods. 8. Review of the provider's 2/1/3/26 Warewashing (the cleaning and sanitizing of utensils and food-contact surfaces of equipment) Mechanical and Manual policy revealed that the warewashing machine was to be cleaned before use, and at a frequency to prevent recontamination of equipment and utensils to ensure that the equipment performed its intended function. 9. Review of the provider's 12/3/25 Cleaning Schedule-Food and Nutrition Services policy revealed, "Keep fans/grills in unit clean", "Ceilings: Check daily for cobwebs, dust and dirt or condensation so it cannot fall from the ceiling", and "Fans: clean weekly or as needed". 10. Review of the provider's 6/27/25 General Sanitation – Food and Nutrition policy revealed, "The location stores, prepares, distributes and serves food under sanitary conditions at all times." and "The location's food preparation, kitchen, serving areas and dry storage are cleaned and sanitized on a regular basis to limit contamination and prevent food-borne illness."	F0812		

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F0812 F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F0812 F0880	1. Resident 6 & 44's rooms have been cleaned to ensure proper cleanliness. CNA I has been educated on the proper way to clean and disinfect whirlpool tub. All other resident rooms to be audited to ensure they are cleaned properly. 2. All other residents could be at risk for this tag. 3. Staff education will occur to re-educate staff on proper cleaning and infection prevention processes. EVS to maintain cleaning logs of resident rooms to ensure that they are being properly cleaned. Room cleanliness to be added to nursing department shift checklist to assist with day-to-day cleaning. Whirlpool cleaning will occur after each bath session. A cleaning log will be created for whirlpool for individuals giving baths. Staff education will occur by the clinical learning development specialist or designee by compliance date. Staff unable to meet with clinical learning development specialist will work with appropriate supervisor to ensure compliance is reached by compliance date. 4. Director of Nursing, EVS, or designee will complete room cleanliness audits and whirlpool audits while staffing are cleaning tub across all necessary shifts weekly for 4 weeks, every other week for 2 weeks, and 1 x monthly for 2 months with all audits taken to QAPI meeting until the facility demonstrates sustained compliance as determined by the committee. 5. Substantial compliance to be achieved by 4/24/26.	4-24-26

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F0880 SS = E	Continued from page 25 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, and policy review, the provider failed to ensure the staff followed infection prevention practices regarding the disinfection of one of one whirlpool by one of one observed certified nursing assistant (CNA) (I), and the prompt cleaning of two of two sampled residents' (6 and 44) bedroom floors observed with bowel movement (BM) on them. Findings include: 1. Observation, interview, and review of whirlpool cleaning instructions on 3/17/26 at 3:22 p.m. with CNA I cleaning the whirlpool revealed he filled the whirlpool with water and disinfectant to "a couple of inches" up from the bottom of the whirlpool, he used a scrub brush and thoroughly scrubbed all interior surfaces with the disinfectant solution in the bottom of the tub. He then indicated he would let the disinfectant solution sit for ten minutes, drain the tub, and then rinse the tub's interior. He was not sure how to flush the disinfectant from the whirlpool jets. After reviewing the instructions for cleaning and disinfecting the whirlpool, he stated he did not know where the flush button for the whirlpool jets was.	F0880		

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F0880 SS = E	Continued from page 26 2. Observation on 3/19/26 at 10:38 a.m. of the whirlpool revealed the whirlpool door located on the end of the tub was open, with one-fourth inch of water in the bottom of the tub, and suds in the area between the bottom of the tub's edge and where the door closes. Water was filling the reservoir of the tub, and hair on the drain plug, and wrapped around the chain that attached the drain plug to the tub. There was a dry scrub brush lying on the top of the whirlpool. There was no other scrub brush available in the whirlpool room. 3. Observation on 3/17/26 at 10:54 a.m. of resident 6's room revealed two areas of a dark brown substance, both approximately one and one-half inches round in size, dried onto the floor. 4. Observation on 3/18/26 at 8:45 a.m. of resident 6's room revealed a staff member on her knees, scrubbing the dark substance on the floor that was identified on 3/17/26, with a washcloth. 5. Observation on 3/18/26 at 8:49 a.m. of resident 44's room revealed she was not in her room. There was a small brown stain on her pillow, a brown streak located on the sheet on the edge of her bed, a two-inch round formed piece of BM on the floor, additional bedding, and a pair of shorts with an incontinent (involuntary urine or bowel leakage) brief inside of them with BM smeared throughout. 6. Observation on 3/18/26 at 9:32 a.m., of resident 44's room revealed the same conditions as observed above, and at 11:00 a.m., those areas were clean. 7. Interview on 3/24/26 at 1:50 p.m. with director of nursing (DON) B, registered nurse (RN) Minimum Data Set (MDS) C nurse, and environmental services supervisor (ESS) J revealed ESS J stated that resident rooms were to be swept and mopped daily. There were no housekeepers to be scheduled on the weekends, so no sweeping or mopping was completed then. EES J had discovered urine on the floor in resident 44's room, but no BM. DON B stated that anytime there was urine or BM on the floor, someone from the nursing department was to clean that up. She then stated resident 44 would take herself to the bathroom, "but is not very good at it", and required staff assistance with cleaning and dressing herself. She expected fluids to be cleaned up immediately and the bed linens to be changed when soiled.	F0880		

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F0880 SS = E	Continued from page 27 DON B stated two CNAs were scheduled to work as bath aides Monday through Friday. DON B indicated she did not complete audits for cleaning the whirlpool. She expected the whirlpool to be cleaned and disinfected after each resident's use. She was not aware that CNA I did not know how to clean the whirlpool jets. 8. Review of the provider's undated Whirlpool System Cleaning instructions for rinsing the whirlpool jets revealed "Press and hold the Disinfectant Button located on the left side of the tub. As the button is held down, the properly mixed cleaning solutions is running through the air injection system and out all of the air jets. Release the button after you see solution coming out of all the air jets and you have 1 to 1 ½ [one and a half] gallons of disinfectant solution [disinfectant and water combined] in the foot well of the tub." "Using the long handled brush, …thoroughly scrub all interior surfaces of the tub with the solution that remains in the foot well of the tub. Let disinfectant stay on surface for 10 minutes …" "Remove the plug from the drain." "Rinse the tub's interior surfaces thoroughly with the shower sprayer." "Press and hold the Rinse button located on the left side of the control panel until clear water runs from all the air jets. Then release the Rinse button." 9. Review of the provider's Cleaning Blood and Body Fluid Spill policy revealed the staff were to "contain the spill. Block off the area until cleanup and disinfection/sanitization is completed." For hard surfaces body fluids are to be wiped up using a dry cloth or paper towels, then "use [a] wet cloth or wipes to remove all visible soil/organic material."	F0880		

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E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 3/17/26. Good Samaritan Society Canistota was found not in compliance with the following requirements: E004 and E039.	E0000	The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law.	
E0004 SS = D	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at	E0004	1. By completion date, an emergency plan will be put in place including the emergency plan, emergency agreements, communication plan, and HVA. 2. There emergency plan will be reviewed on an annual basis to ensure compliance with CMS requirements. 3. All staff will be instructed on the polices and procedures in the Emergency Plan. 4. Audits will be completed of the Emergency plan documentation weekly x 4, monthly x 2. Audits will be reviewed by the QAPI committee. 5. Substantial completion will be achieved by 4/24/26.	4-24-26

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amy Evenson	Administrator	4-20-26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY CANISTOTA	700 WEST MAIN ST , CANISTOTA, South Dakota, 57012

(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
E0004 SS = D	Continued from page 1 least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider failed to update the emergency preparedness plan agreements (housing and water supply agreements) annually. 1. Record review on 3/17/26 at 12:48 p.m. revealed no documentation that the provider's current emergency preparedness plan memorandums of understanding/agreements were updated annually. For example, both the temporary housing agreement and the water supply agreement was not updated annually since 2016. Interview with the administrator during the exit conference confirmed those findings. She stated they did not have more current agreements.	E0004		
E0039 SS = D	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or	E0039	1. The administrator or designee will develop, implement, and coordinate emergency preparedness drills to participate in a full-scale community-based exercises, a facility-based exercise if a community-based exercise is not available and an annual tabletop exercise. An After-Action Review (AAR) will be conducted and documented after each exercise. Documentation will be completed of all drills to include attendance, scenario, and corrective actions. 2. The administrator or designee will update the facilities Emergencies Preparedness plan to include Emergency Preparedness Testing and the implementation of best practices. 3. The Administrator and Ancillary service manager will be trained on the testing requirements for Emergency Preparedness. 4. Audits of the EMP binder will be conducted weekly x4, monthly x 2. Audits will be reviewed by the QAPI committee. 5. Substantial completion will be achieved by 4/24/26.	4-24-26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY CANISTOTA	700 WEST MAIN ST , CANISTOTA, South Dakota, 57012

(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
E0039 SS = D	Continued from page 2 (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next	E0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY CANISTOTA	700 WEST MAIN ST , CANISTOTA, South Dakota, 57012

(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
E0039 SS = D	Continued from page 3 required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a	E0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY CANISTOTA	700 WEST MAIN ST , CANISTOTA, South Dakota, 57012

(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
E0039 SS = D	Continued from page 4 set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):]	E0039		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY CANISTOTA	700 WEST MAIN ST , CANISTOTA, South Dakota, 57012

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E0039 SS = D	Continued from page 5 (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or	E0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/17/2026

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E0039 SS = D	Continued from page 6 (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.	E0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/17/2026

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E0039 SS = D	Continued from page 7 (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or	E0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/17/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0039 SS = D	Continued from page 8 (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.	E0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/17/2026

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E0039 SS = D	Continued from page 9 This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider failed to complete a full-scale community based exercise to test their emergency plan. Findings Include: 1. Record review on 3/17/26 at 12:48 p.m. revealed no documentation was present to show that the provider had conducted a full-scale community based exercise to test their emergency plan. The only documentation showed the provider had conducted two tabletop exercises. One exercise was a fire drill, and the other was an elopement drill. Interview with the administrator during the exit conference confirmed those findings. She stated they did not conduct any exercise or had any event other than the two tabletop exercises.	E0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY CANISTOTA	700 WEST MAIN ST , CANISTOTA, South Dakota, 57012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	INITIAL COMMENTS A recertification survey was conducted on 3/17/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Good Samaritan Society Canistota was found not in compliance. Please mark an F in the completion date column for the K241 and K374 deficiencies identified as meeting the FSES.	K0000		
K0241 SS = C	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This STANDARD is NOT MET as evidenced by: Based on observation and record review, the provider failed to maintain at least two conforming exits from each floor of the building. One of two floors (basement) did not have two conforming exits. Findings include: 1. Observation on 3/17/26 at 11:10 a.m. revealed there was only one exit provided from the basement boiler room. The only exit was a stair enclosure that discharged into the vestibule on the main level. Review of previous survey data also identified that condition. The building meets the FSES. Please mark an F in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K0241		F

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
Amy Evenson	Administrator	4-20-2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 03/17/2026

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K0241 SS = C	Continued from page 1 That deficiency would only affect one or two maintenance personnel if in the basement during a fire emergency.	K0241		
K0374 SS = C Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is NOT MET as evidenced by: Based on measurement and document review, the provider failed to maintain at least thirty-two inches of clear width for two of two smoke barrier doors (on the 100 and 200 wings). Findings include: 1. Measurement on 3/17/26 at 2:15 p.m. revealed the cross-corridor doors to the 100-wing measured thirty-one inches of clear width. Further measurement revealed the cross-corridor doors to the 200-wing adjacent to the nurses' station measured thirty inches of clear width. Review of the previous life safety code survey confirmed those findings. The building meets the FSES. Please mark an F in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K0374		F

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
	10603	A. BUILDING: _____ B. WING _____	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY CANISTOTA	700 W MAIN STREET CANISTOTA, SD 57012

(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 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/17/26 through 3/19/26 and from 3/23/26 through 3/24/26. Good Samaritan Society Canistota was found not in compliance with the following requirement: S323.	S 000	The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law.	
S 323	44:73:08:06(1-4) Documentation of Medication Disposal A facility shall ensure that a legend medication not controlled under SDCL chapter 34-20B is destroyed or disposed of by a nurse and another witness. Destruction or disposal of medication controlled under SDCL chapter 34-20B must be witnessed by two persons, both of whom must be a nurse or pharmacist, as designated by facility policy. The following are authorized methods of destruction or disposal: (1) Using a professional waste hauler to take the medications to a permitted medical waste facility or by facility disposal at a permitted municipal solid waste landfill. Prior to disposal all medications must be removed from original containers and made unpalatable by the addition of adulterants and alteration of solid dosage forms by dissolving or combination into a solid mass; (2) Return to the dispensing pharmacy for destruction according to federal and state regulations; (3) Return to an authorized reverse distributor company licensed by the South Dakota Board of Pharmacy; or (4) Release to resident upon discharge after authorization by the resident's prescribing practitioner.	S 323	1. Immediate re-education of the licensed nurse involved regarding state requirements for medication destruction, including the requirement for two authorized witnesses (nurse/nurse or nurse/pharmacist). Audit will be completed of medication destruction records for the past 30 days to identify any additional occurrences of single-signature medication destruction. 2. All residents with current orders for controlled medications could be at risk for this tag. 3. DNS and licensed nursing staff to complete mandatory re-education on medication destruction requirements including state regulations, facility policy , and proper documentation expectations. Medication destruction to be incorporated into routine medication room audits. Medication destruction log has been revised to require two signatures prior to completion. The licensed nurse completing the medication destruction is responsible for ensuring a second authorized witness is present at that time. 4. Director of Nursing or designee will complete audits of medication destruction records to verify presence of two authorized signatures and proper documentation of disposal method weekly for 4 weeks , every other week for 2 weeks, and 1 x monthly for 2 months with all audits taken to QAPI meeting until the facility demonstrates susained compliance as determined by the committee. 5. Substatial compliance to be achieved by 4/24/26.	4-24-26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Amy Evenson | Administrator | 4-20-26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10603	A. BUILDING: _____ B. WING _____	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY CANISTOTA	700 W MAIN STREET CANISTOTA, SD 57012

(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 323	Continued From page 1 This Administrative Rule of South Dakota is not met as evidenced by: Based on closed record review, interview, and policy review, the provider failed to ensure one of one sampled residents' (57) medications were destroyed by two authorized staff members after the resident discharged from the facility. Findings include: 1. Review of resident 57's closed electronic medical record (EMR) revealed he admitted to the facility on 8/8/25 and discharged to a hospice facility on 2/5/26. His medications at the time of his discharge from the facility included: Eliquis, Gemtesa, sertraline, metformin, vitamin D3, pioglitazone, oxybutynin, mirabegron, atorvastatin, metoprolol, donepezil, B-complex vitamins, enalapril, trazodone, nystatin, omeprazole, and glucose chewable tablets. 2. Review of resident 57's medication destruction record indicated the above-listed medications were documented as destroyed with the use of Rx destroyer (a chemical drug destruction product). Licensed practical nurse (LPN) O signed that destruction medication record to indicate he witnessed the destruction of those medications. There was no other witness signature on that form. 3. Interview on 3/24/26 at 5:45 p.m. with director of nursing (DON) B confirmed one person destroyed resident 57's medications, with no other witness present. She was not aware that the state regulations required that the destruction of medications be witnessed by two persons, both who must be a nurse or a nurse and a pharmacist.	S 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10603	A. BUILDING: _____ B. WING _____	03/24/2026

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S 323	Continued From page 2 4. Review of the provider's Medication Disposition (Disposal) policy revealed "Discontinued medications are to be kept in a secure place in the medication room until these can be returned to the pharmacy (if allowed by the state pharmacy regulations) or until destroyed according to state regulation." "Disposal of any medication will be carried out under local, state and federal guidelines or in consultation of the pharmacist in the appropriate disposal procedure."	S 323		