STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/07/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 10/7/26. Good Samaritan Society Sioux Falls Center was found in compliance.	E0000		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	11/2/2026

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10679	A. BUILDING: _____ B. WING _____	10/08/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 10/6/26 through 10/8/26. Good Samaritan Society Sioux Falls Center was found not in compliance with the following requirement: S296.	S 000	The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law.	
S 296	44:73:07:11 Director of Dietetic Services A facility shall have a full-time dietary manager who is responsible to the administrator and who shall direct the dietetic services. The dietary manager must: (1) Be a certified dietary manager; (2) Be a certified food service manager; (3) Have a similar national certification for food service management and safety from a national certifying body; or (4) Have an associate's or higher degree in food service management or hospitality from an accredited institution of higher learning that has a course of study in food service or restaurant management. Any dietary manager who does not must enroll, within ninety days of the dietary manager's hire date, in programming necessary to achieve one of the qualifications, and achieve the qualifications within eighteen months of hire. The dietary manager and at least one cook shall possess a current certificate from a ServSafe Manager Food Protection Program offered by various retailers, the Certified Food Protection Professional's Sanitation Course offered by the Association of Nutrition and Foodservice Professionals, or an equivalent training program as determined by the department. Individuals	S 296	On October 8, 2026, the Morrison Living General Manager reviewed qualification requirements for the individual responsible for dietetic services. The Dining Services Director was enrolled in the Food Service Manager (FSM) examination on October 9, 2026, and is scheduled to test on November 3, 2026. The Morrison Living General Manager is scheduled to complete the Certified Dietary Manager (CDM) examination on November 2, 2026. Documentation of the qualification review, examination enrollment, and scheduled testing has been obtained and maintained. A review of individuals assigned responsibility for dietetic services was completed to verify qualifications and supporting documentation. All identified gaps were addressed through the corrective actions previously described.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 10/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10679	A. BUILDING: _____ B. WING _____	10/08/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 296	Continued From page 1 seeking ServSafe recertification are only required to take the national examination. The dietary manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each resident are met. If the dietary manager is not a dietitian, the facility must schedule dietitian consultations onsite at least monthly. The dietitian shall approve each menu, assess the nutritional status of each resident with problems identified in the assessment, and review and revise dietetic policies and procedures during scheduled visits. The facility shall have sufficient personnel to meet the dietetic needs of the residents and provide dietetic services for a minimum of twelve hours each day. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and record review, the provider failed to ensure one of one dietary manager (DM) (H) was certified according to the requirements. Findings include: 1. Interview on 10/6/26 at 8:37 a.m. with DM H revealed she had worked at the facility for a year as the dietary manager. She was not a certified dietary manager (CDM) and did not know certification was required. She had not taken a dietary manager course in the past. She and the entire dietary team were employed by a staffing supplier for the provider. 2. Interview on 10/7/26 at 2:28 p.m. with administrator A revealed he did not know DM H should be certified. He thought the provider was	S 296	A credential verification process has been implemented. Qualifications, or required coursework and examination scheduling, will be verified before an individual is assigned responsibility for dietetic services. Certification, examination, and supporting records will be maintained. Morrison Living General Manager will track certification status, renewal/expiration dates, and required CEUs. Once certification is obtained, credential compliance will be reviewed quarterly and prior to renewal. Results will be reported through the facility QAPI process, and documentation of each review will be maintained. The Director of Nutrition and Wellness or designee will audit compliance annually as part of the mock survey process. Substantial compliance will be achieved by 11/8/2026.	11/8/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10679	A. BUILDING: _____ B. WING _____	10/08/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 296	Continued From page 2 exempt from the CDM requirement because registered dietitians (RD) I and J worked at a local sister facility, oversaw the provider's menu, and performed nutrition assessments for the provider's residents.	S 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 10/07/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 10/7/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Good Samaritan Society Sioux Falls Center (building 01) was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K300, K321, and K781 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000	The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law. On 10/19/2026, the 2-hour fire rated separation wall between building 01 and 02 were repaired by maintenance director to meet NFPA requirements.	
K0300 SS = D Bldg. 01	Protection - Other CFR(s): NFPA 101 Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to maintain the fire-resistive design for one randomly observed two-hour fire-rated building separation walls (between Building 01 and Building 02). Findings include: 1. Observation on 10/7/26 at 11:28 a.m. revealed the two-hour fire-rated separation wall (between Building 01 and Building 02) adjacent to room 242 had an unsealed 2 inch by 2 inch opening in the gypsum board of the wall above the ceiling over the east door leaf. Interview with the maintenance supervisor at the	K0300	By 10/30/2026, all fire barriers will be assessed by maintenance director or designee to ensure they meet the NFPA requirements. Any fire barriers that do not meet the NFPA requirements will be addressed and repaired immediately at time of assessment. By 11/6/2026, clinical lead development specialist or designee will provide education to maintenance staff on the NFPA requirements for fire barriers. Maintenance staff who do not complete education by 11/6/2026 will be educated by clinical lead development specialist or designee prior to their next scheduled shift. Fire barriers audits will be completed by the maintenance director or designee weekly x 4, monthly x2. Maintenance director or designee will report audit findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring. Substantial completion will be achieved by 11/6/2026.	11/6/2026

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	10/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 10/07/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0300 SS = D Bldg. 01	Continued from page 1 time of the observation confirmed that finding. He stated he was unaware of that condition and believed the communications company installing new internet connections had recently caused it.	K0300		
K0321 SS = D Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation, testing, and interview, the provider failed to maintain one separate hazardous	K0321	On 10/19/2026, maintenance director repaired the activities storage room door to operate within NFPA requirements. By 10/30/2026, all hazardous areas will be assessed by maintenance director or designee to ensure there are no doorstops being used and all door hardware is working properly. Any door hardware that is identified as being deficient at time of assessment will be immediately fixed by maintenance director or designee. By 11/6/2026, clinical lead development specialist or designee will educate all staff on the NFPA requirements for hazardous areas. All staff who do not complete education by 11/6/2026 will be educated by clinical lead development specialist or designee prior to their next scheduled shift. Audits of hazardous areas will be completed by the Administrator or designee weekly x 4, monthly x2. Maintenance director or designee will report audit findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring. Substantial completion will be achieved by 11/6/2026.	11/6/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING **01 - MAIN BUILD...** B. WING	**10/07/2026**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0321 SS = D Bldg. 01	Continued from page 2 area (activities storage room) as required. 1. Observation and testing on 10/7/26 at 11:58 a.m. revealed the activities storage room was over 100 square feet and contained combustible items creating a hazardous area. The door to that room had a wooden-door-wedge holding it open. That door-wedge created a condition where the door would not close and latch with the operation of the closer as required. Further observation at that same time revealed that the door was provided with a magnetic door holding device which was tied into the buildings fire alarm system. However, the metal portion affixed to the door had fallen off, rendering the hold-open inoperable. Interview with the maintenance supervisor at that time confirmed that finding. He stated he was unaware of that condition. He added, had he known of that condition he would have had it fixed immediately. He believed the activities staff had placed the wooden-door-wedge out of convenience.	K0321	On 10/8/2026 the space heater in resident room 44 was removed by administrator. By 10/30/2026, maintenance director or designee will assess all resident rooms, offices and common areas to ensure there are no portable heaters. If any portable heaters are identified during full facility assessment, they will be removed immediately by maintenance director or designee. By 11/6/2026, clinical lead development specialist or designee will provide education to all staff on the NFPA requirements for portable heating devices. All staff who do not complete education by 11/6/2026 will be educated by clinical lead development specialist or designee prior to their next scheduled shift. Audits of resident rooms, offices and common areas searching for portable space heaters will be completed by the Administrator or designee weekly x 4, monthly x2. Maintenance director or designee will report audit findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring. Substantial completion will be achieved by 11/6/2026.	11/6/2026
K0781 SS = D Bldg. 01	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to ensure portable space heating devices were prohibited as required in one randomly observed location (resident room 246). 1. Observation on 10/7/26 at 2:17 p.m. revealed a portable space heater was in use in resident room 246. Interview with resident 44 at the same time as the observation revealed he had brought that item into the facility himself. He further stated he had brought it in "over a year ago", and that, "the CNAs (certified nursing assistants) and housekeeping staff know I have it"	K0781		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 10/07/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0781 SS = D Bldg. 01	Continued from page 3 Interview with the administrator directly following that observation confirmed that finding. He stated he believed the claims made by resident 44 were untrue, as he was certain his staff would notify him had they noticed any space heater in use in any resident room.	K0781		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING **02 - BUILDING 0...** B. WING	**10/07/2026**

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

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K0000 Bldg. 02	INITIAL COMMENTS A recertification survey was conducted on 10/7/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Good Samaritan Society Sioux Falls Center (building 02) was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K300, and K355 in conjunction with the provider's commitment to continued compliance with the fire safety standards	K0000	On 10/7/2026, maintenance director removed medication carts from areas identified to ensure doors were unobstructed and could close and latch to maintain the ninety-minute fire rating and the 2-hour rating of the fire-wall assembly. By 10/30/2026, all fire rated doors will be assessed by maintenance director or designee to ensure they meet the NFPA requirements and are able to close and latch unencumbered. Any fire doors that do not meet the NFPA requirements will be addressed and corrected immediately at time of assessment. By 11/6/2026, clinical lead development specialist or designee will provide education to maintenance staff, all nurses, medication aids and nurse leaders on the NFPA requirements for fire doors. Any required staff who do not complete education by 11/6/2026 will be educated by clinical lead development specialist or designee prior to their next scheduled shift. On 10/27/2026, maintenance director placed a tape reminder on the wall located near the fire doors identified as a visual cue to ensure medication aids and nurses do not place their medication carts in an area that will not adhere to NFPA requirements related to fire doors.	
K0300 SS = E Bldg. 02	Protection - Other CFR(s): NFPA 101 Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This STANDARD is NOT MET as evidenced by: Based on observation, testing, and interview, the provider failed to maintain the fire-resistive rating for two randomly observed ninety-minute rated fire doors (by the activities office and near the physician's office). Findings include: 1. Observation and testing on 10/7/26 at 11:55 a.m. revealed the ninety-minute door in the fire wall separating the east corridor from the activities area would not close and latch into the frame when released from the magnetic door hold-open That door had a medication cart in the way preventing it from closing. That door leaf must close and latch to maintain the ninety-minute fire-rating and the 2-hour rating of the fire-wall assembly.	K0300		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 10/07/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0300 SS = E Bldg. 02	Continued from page 1 Interview with the maintenance supervisor at the time of the observation confirmed that finding. He stated he was unaware that condition existed. He further stated he had spoken with the nursing staff several times about ensuring the medication carts were not placed where they can impede that door from closing. 2. Observation and testing on 10/7/26 at 12:20 p.m. revealed the north leaf of the ninety-minute double doors in the fire wall separating the east corridor from the dining room (near the physician's office) would not close and latch into the frame when released from the magnetic door hold-open. That door had a medication cart in the way preventing it from closing. That door leaf must close and latch to maintain the ninety-minute fire-rating and the 2-hour rating of the fire-wall assembly. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He stated he was unaware that condition existed. He further stated he had spoken with the nursing staff several times about ensuring the medication carts were not placed where they can impede that door from closing.	K0300	Fire door audits will be completed by the maintenance director or designee weekly x 4, monthly x2. Maintenance director or designee will report audit findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring. Substantial completion will be achieved by 11/6/2026.	11/6/2026
K0355 SS = E Bldg. 02	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to perform monthly checks of fire extinguishers in accordance with NFPA 10 on three randomly checked fire extinguishers (maintenance office, kitchen, and staff coordinator's office) since the annual inspection. Findings include: 1. Observation on 10/7/26 at 10:42 a.m. revealed the	K0355	On 10/7/2026, the fire extinguishers identified during survey as not having monthly checks were assessed by maintenance director or designee. By 10/30/2026, all fire extinguishers will be assessed by maintenance director or designee to ensure monthly inspections are completed and documented. Any fire extinguisher not assessed in accordance with NFPA 10 requirements will be immediately addressed by maintenance director or designee at time of review. By 11/6/2026, clinical lead development specialist or designee will provide education to maintenance staff on the NFPA 10 requirements for fire extinguishers. Maintenance staff who do not complete education by 11/6/2026 will be educated by clinical lead development specialist or designee prior to their next scheduled shift.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING **02 - BUILDING 0...** B. WING	**10/07/2026**

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

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K0355 SS = E Bldg. 02	Continued from page 2 fire extinguisher in the maintenance office was missing the monthly maintenance checks since the annual recertification of the fire extinguisher by the fire extinguisher provider (Heiman Fire Equipment) on 6/15/2026. Interview with the maintenance supervisor at the time of the observation revealed he was unaware of that condition. 2. Observation on 10/7/26 at 11:33 a.m. revealed the K-Type fire extinguisher in the kitchen was missing the monthly maintenance checks since the annual recertification of the fire extinguisher by the fire extinguisher provider (Heiman Fire Equipment) on 6/15/2026. Interview with the maintenance supervisor at the time of the observation revealed he was unaware of that condition. 3. Observation on 10/7/26 at 11:49 a.m. revealed the fire extinguisher in the staff coordinator's office was missing its monthly maintenance checks for the month of July in 2026. Interview with the maintenance supervisor at the time of the observation revealed he was unaware of that condition. He went on to state the facility had a fire extinguisher map his workers were supposed to consult to ensure all fire extinguishers were checked monthly.	K0355	Fire extinguisher audits will be completed by the maintenance director or designee weekly x 4, monthly x2. Maintenance director or designee will report audit findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring. Substantial completion will be achieved by 11/6/2026.	11/6/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING B. WING	10/08/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 10/6/26 through 10/8/26. Good Samaritan Society Sioux Falls Center was found not in compliance with the following requirements: F552, F578, F584, and F657.	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. (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	F0578	On 10/7/2026, DNS updated resident 7's electronic medical record to reflect 'full code', which accurately reflects the resident's most recent code status form that was completed on 9/9/2026. On 10/27/2026, DNS reviewed code statuses with residents 2, 5, 7, and 9 or their representatives to ensure code status was accurate and up to date. New code status forms were signed and completed for residents 2, 5, 7, and 9 on 10/27/2026. On 10/27/2026, DNS verified the advanced directive documentation against the resident electronic medical record to ensure consistency and accuracy. Any discrepancies identified were immediately corrected, and documentation was completed to reflect the resident's informed choices.	

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	11/2/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

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F0578 SS = E	Continued from page 1 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, interview, and policy review, the provider failed to the resident's rights to choose advance directive (a document that expresses a person's health care wishes if they become unable to speak for themselves) code status (specifies the type of emergent treatment a person wishes to receive if their heart or breathing would stop) for one of five sampled residents (7) reviewed, whose wishes were not accurately identified in the residents' electronic medical record (EMR) and to ensure that the resident or the resident's representative participated in the determination of advance directives related to the resident's code status wishes for four of five sampled residents (2, 5, 7, and 9) reviewed for accurately documented code statuses. Findings include: 1. Review of resident 7's electronic medical record (EMR) on 10/7/26 at 8:08 a.m. revealed he admitted to the facility on 2/18/26. The EMR banner below the resident's picture indicated "ADVANCE DIRECTIVE: Do Resuscitate (CPR), Do Hospitalize, Use Antibiotics." An 11/20/25 Advanced Care Plan Short Form signed by resident 7 indicated "I give the following instructions about my health care (my values and beliefs, what I do and do not want, use about specific medical treatments or situations, including whether or not I wish to receive artificial Nutrition and hydration): DNR." His 8/20/26 Brief Interview of Mental Status (BIMS) assessment score was 12, which indicated his cognition was moderately impaired. An 9/9/26 physician's order indicated, "ADVANCE DIRECTIVE: Do Resuscitate (CPR), Do Hospitalize, Use Antibiotics." 2. Review of resident 7's EMR on 10/8/26 at 3:40 p.m. revealed a 10/7/26 physician's order which indicated, "ADVANCE DIRECTIVE: Do Not Resuscitate (DNR)."	F0578	All residents residing in the facility have the potential to be affected by this deficient practice. The DNS, Social Services Director, and/or designee completed a 100% audit of all current residents to verify the code status documented in the electronic medical record matches the most current signed advance directive or physician order, advance directive documents are present in the medical record, and documentation reflects participation of the resident and/or resident representative in advance directive and code status decisions. Any discrepancies between advance directive forms, physician orders, and EMR documentation are identified and corrected immediately. Any identified concerns were addressed at the time of audit. The Clinical Lead Development Specialist or designee will educate all licensed nurses, social services staff, MDS staff, and nurse leaders regarding facility advanced directives policy including the resident's right to formulate advance directives and make treatment decisions along with requirements for resident/resident representative participation in code status determinations. Education will be completed by 11/6/2026. Any employee who has not completed the required education by that date will receive education prior to working their next scheduled shift. A prompt will be added to the clinical review meeting stand up sheet to ensure IDT team review and oversight for resident advanced directives upon admission, upon readmission, following any significant change in condition or upon resident or representative request for a change in code status.	

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F0578 SS = E	Continued from page 2 3. Interview on 10/7/26 at 4:40 p.m. with certified nursing assistant (CNA) R and registered nurse (RN) G revealed the resident's current code status wishes could be found in the resident's EMR below the resident's picture and in the physician's orders. In the event of an emergency that may require a determination of whether a resident required CPR or had a DNR code status, CNA R would alert the nurse, who would make that determination, and CNA R would get the crash cart (a cart that stores medication and equipment for use during a medical emergency). CNA R was unable to log into the EMR system, and RN G offered to help answer the surveyor's questions. 4. Interview, EMR review, and document review on 10/7/26 at 4:57 p.m. with RN G revealed that she confirmed that the banner in resident 7's EMR below the resident's picture indicated that he had a DNR code status. He had a 10/7/26 physician's order which indicated, "ADVANCE DIRECTIVE: Do Not Resuscitate (DNR)." She stated that the resident 7's code status could also be found in a binder that was kept on the crash cart. The provider's 10/7/26 Advanced Directives Order Listing report located inside that binder indicated that at 2:10 p.m., resident 7's code status was listed as "ADVANCE DIRECTIVE: Do Not Resuscitate (DNR)." 5. Review of resident 2's EMR revealed she admitted to the facility on 8/15/25. Her 7/15/26 BIMS assessment score was 13, which indicated her cognition was intact. A 3/26/26 physician's order indicated, "ADVANCE DIRECTIVE: Resuscitate (CPR)." Her 4/22/26 Advanced Care Plan Short Form section "I give the following instructions about my health care (my values and beliefs, what I do and do not want, use about specific medical treatments or situations, including whether or not I wish to receive artificial Nutrition and hydration):" was crossed out with a large "X" and did not include her code status wishes. A 6/3/26 physician's order indicated, "ADVANCE DIRECTIVE: Do Not Resuscitate (DNR)." Her 6/3/26 Interagency Transfer Orders from the hospital indicated "Do not resuscitate." There was no documentation that resident 2 participated in a discussion about her advance directives or code status wishes. 6. Review of resident 5's EMR revealed he admitted to the facility on 2/27/25. His 2/22/23 "Wishes for Health Care: Short Form Advance [Healthcare]	F0578	DNS or designee will audit 10 resident records to ensure advance directives are present and current, EMR code status accurately reflects the resident's documented wishes, documentation supports resident and/or representative participation in decision-making, and required physician orders are present and consistent with advanced directive documentation. Audits will be completed weekly x4, every other week x2 and monthly x2 by DNS or designee to ensure risk versus benefits and education related to alternate treatment options are present and facility remains in compliance. DNS or designee will report audit findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring. Substantial compliance will be achieved by 11/6/2026.	11/6/2026

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F0578 SS = E	Continued from page 3 Directives" form section "I give the following instructions about my health care (my values and beliefs, what I do and do not want, use about specific medical treatments or situations, including whether or not I wish to receive artificial Nutrition and hydration):" was crossed out with a large "/" and did not include his code status wishes. A 2/27/25 physician's order indicated, "ADVANCE DIRECTIVE: Do Not Resuscitate (DNR)." A 3/24/25 "SNF [skilled nursing facility] 30-day visit" summary indicated, "Advanced Care Planning DNR." His 9/1/26 BIMS assessment score was 15, which indicated his cognition was intact. A 9/17/26 care conference progress note indicated, "Advanced Directive addressed and confirmed," but did not identify his advance directive or code-status wishes or if he was involved in a discussion of such during the care conference. There was no documentation in the resident's EMR that resident 5 participated in a discussion about his advance directives or code status wishes. 7. Review of resident 9's EMR revealed he admitted to the facility on 2/25/25. A 2/25/25 Telephone Encounter Communication form indicated that on 2/25/25 resident 9 had a code status of "Full Code," and the provider's policy required a "do resuscitate or do not resuscitate" order status. That form indicated "Do cpr [CPR]." An 8/21/26 physician's order indicated, "ADVANCE DIRECTIVE: Do Not Resuscitate (DNR)." His 9/9/26 BIMS assessment score was 15, which indicated his cognition was intact. There was no documentation in the resident's EMR that resident 9 participated in a discussion about his advance directives or code status wishes. 8. Interview and record review on 10/7/26 at 1:52 p.m. with administrator A revealed that the "X" on resident 2's 4/22/26 Advanced Care Plan Short Form indicated that it was her wish to have a DNR code status, and that the "/" on resident 5's 2/22/23 Wishes for Health Care: Short Form Advance [Healthcare] Directives form indicated that it was his wish to have a DNR code status. Administrator A stated that he spoke with resident 2 and resident 5 that day to confirm their code-status wishes but did not document those conversations. He then stated that he thought RN G discussed resident 2 and resident 5's code-status wishes with them at their last care conferences and that both residents indicated they wished to have a DNR code	F0578		

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F0578 SS = E	Continued from page 4 status. He acknowledged that crossing out a section of the form did not clearly identify their code status wishes on those forms. 9. Interview and record review on 10/8/26 at 12:29 p.m. with director of nursing (DON) B and RN G revealed that the provider's palliative care (a specialized medical approach that focuses on relieving the symptoms, pain, and stress of serious illnesses to improve quality of life) provider used the Advanced Care Plan Short Form and confirmed that resident 2's 4/22/26 Advanced Care Plan Short Form did not indicate that resident 2 participated in a discussion about her advance directives or code status wishes. RN G thought that form may have been used to change resident 2's healthcare agent (a person you legally choose to make medical decisions for you if you become incapacitated and cannot speak or decide for yourself) not to indicate code status wishes. RN G acknowledged that she did not know resident 2's advance directives or code status wishes when she looked at that form. DON B expected the palliative care provider to fully complete the Advanced Care Plan Short Form to indicate that resident 2 participated in a discussion about her advance directives or code status wishes. DON B confirmed there was no documentation in the EMR that resident 2 participated in a discussion about her advance directives or code status wishes. DON B confirmed that resident 5's 2/22/23 Wishes for Health Care: Short Form Advance [Healthcare] Directives form did not indicate that resident 5 had participated in a discussion about his advance directives or code status wishes but she knew he wanted a DNR code status because it was discussed at his care conference. She confirmed that the care conference documentation indicated they discussed his advance directives but did not specify what those advance directives were or what his code status was. DON B confirmed there was no documentation in the EMR that resident 5 participated in a discussion about his advance directives or code-status wishes. DON B stated that resident 9's code status changed when he was in the hospital between 8/10/26 and 8/21/26 from wanting to receive CPR to DNR. She thought the hospital staff had a conversation with resident 9 about his code status before he had surgery. Resident 9 returned to the nursing home on 8/21/26 with a DNR code status order. There was no documentation that resident 9 participated in a discussion about his advance directives or code	F0578		

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F0578 SS = E	Continued from page 5 status wishes when he returned to the nursing home on 8/21/26. DON B acknowledged that she changed resident 7's code status order on 10/7/26 from CPR to DNR after reviewing resident 7's 11/20/25 Advanced Care Plan Short Form, which indicated his wishes were DNR. RN G then provided DON B with the 9/9/26 physician's order that indicated resident 7 wanted to be a "FULL CODE," and DON B changed the order back to "CPR" in the EMR system. DON B confirmed there was no documentation in the EMR that resident 7 participated in a discussion about his advance directives or code-status wishes. The Advanced Directives Order Listing report, located in the binder on the provider's crash cart, was printed each day at midnight or whenever a resident's code status changed. DON B stated that she printed a new report when she changed resident 7's code status from CPR to DNR and back to CPR. DON B indicated that the provider used the form, "FAX Communication To Physician For Code Status Update," which included the resident's code status and the resident's or their representative's signature to indicate the resident participated in a discussion about their advance directives or code status wishes. She expected that when a resident was admitted to the facility, readmitted to the facility, or had a change in their advance directive code status wishes, the FAX Communication To Physician For Code Status Update form would be completed by the nurse who completed the resident's admission or readmission assessment or received the information about a resident's change in advance directive code status wishes. DON B expected the nurse to send the completed form to the resident's physician for signature and then to update the order in the EMR. 10. Review of the provider's 3/2/26 Advance Directive including Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator (AED) policy, revealed its purpose was to "provide each resident with the opportunity to make decisions related to medical care and select a proxy [healthcare agent]," and "to define a process to make the resident decisions known." "Advance directive: A written instruction..." "At the time of admission or re-admission, social services or designated staff member asks the resident/healthcare decision-maker whether the resident has prepared an advance directive such as	F0578		

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F0578 SS = E	Continued from page 6 a living will [a legal document that tells doctors and family members what medical treatments you want or do not want if you become unable to communicate your wishes], durable power-of-attorney [someone designated on a legal document to act on behalf of a resident] for healthcare decisions, guardianship [a court-established legal relationship where a judge appoints a person or entity make personal, medical, or financial decisions for someone else], portable and enduring order form etc. The designated staff member will meet with the resident/healthcare decision-maker to answer questions and determine if the resident/healthcare decision-maker wishes to develop or amend advance directives. If an advance directive has been formulated, a copy will be scanned into [the provider's EMR]." "The verbal declination of CPR by a resident, or, if applicable, a resident's representative, should be witnessed by two staff members. Follow individual state specific requirements."	F0578	On 10/16/2026, Sertraline was discontinued for resident 9. On 10/23/2026, DNS reviewed resident 9's medical record and identified that resident remains on amitriptyline and fluoxetine. Fluoxetine consent form was completed along with education provided to the resident/representative on 10/19/2026. On 10/27/2026, DNS received signed consent form for amitriptyline and provided education to the resident/representative on risks versus benefits of medications or of alternative treatments. All residents currently receiving psychotropic medications have the potential to be affected. The Director of Nursing or designee completed an audit of all residents receiving psychotropic medications to verify documentation of the indication for use, documentation that risks, benefits, and alternatives were discussed with the resident and/or representative, signed informed consent forms were present, and consent was obtained prior to medication administration whenever required. Any identified missing documentation or consents were addressed immediately through resident/representative education and completion of informed consent documentation.	
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure the staff educated the resident or resident's representative on the specific condition to be treated, the symptoms that the medication was intended to help,	F0552		

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F0552 SS = D	Continued from page 7 the risks versus benefits of medications, or of alternative treatments that were attempted, to make an informed decision for consent for the use of psychotropic medications (a drug that affects brain activities associated with mental processes and behavior) before they were given for one of four sampled residents (9) who were administered psychotropic medications. Findings include: 1. Review of resident 9's electronic medical record (EMR) revealed he admitted to the facility on 2/25/25. His 9/9/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact. His diagnoses included anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), panic disorder (a type of anxiety disorder characterized by recurrent, unexpected periods of intense fear or discomfort), personality disorder (a long-standing, inflexible pattern of thinking, feeling, and behaving that differs significantly from cultural expectations and causes ongoing distress or problems in daily life), and major depressive disorder with psychotic symptoms (a serious, common mood disorder characterized by at least two weeks of persistent, severe low mood, loss of interest, and low energy that disrupts daily life). His 6/16/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) had a 6/16/26 focus area that indicated the resident was on medications with Food and Drug Administration (FDA) "Boxed Warnings or warnings of adverse consequences R/T [related to] Anxiety Disorder, Major Depressive Disorder, Personality disorder as E/B [evidenced by] use of medications [that] include Amitriptyline [a psychotropic medication used to treat major depressive disorder], Clonazepam [a medication used to treat panic disorder], Lisinopril [a medication used to lower blood pressure], [and] Sertraline [a psychotropic medication used to treat anxiety and depression]." The goal for that area was that "The resident will be free from discomfort or preventable adverse reactions related to medication use through the review date." Interventions included to "Monitor resident [9's] condition on clinical practice guidelines or clinical standards of practice r/t use of medications," and to "refer to boxed warnings in the orders or eMAR [electronic medication administration record] reference of choice."	F0552	Clinical lead development specialist or designee will educate all nurse leaders, RNs, LPNs and social workers on F552 requirements related to informed consent and resident rights. Education will include specific diagnosis or symptom being treated, risks and benefits of psychotropic medications, alternative treatments and non-pharmacological interventions, resident/resident representative choice, required documentation standards, and obtaining consent prior to administration of newly ordered psychotropic medications. Education will be completed by 11/6/2026. Any employee who does not receive the required training by 11/6/2026 will be educated by clinical lead development specialist or designee prior to their next shift. New psychotropic medication orders will be reviewed during clinical review meetings to ensure informed consent is completed before administration whenever applicable. A prompt will be added to the clinical review meeting stand up sheet to ensure IDT team review and oversight. Psychotropic medication documentation, education and consents for all residents with new psychotropic medication orders will be audited by the DNS or designee weekly x4, every other week x2 and monthly x2 by DNS or designee to ensure risk versus benefits and education related to alternate treatment options are present and facility remains in compliance. DNS or designee will report audit findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring. Substantial compliance will be achieved by 11/6/2026.	11/6/2026

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F0552 SS = D	Continued from page 8 A 9/14/26 focus area on his current care plan indicated "The resident [9] has P/F [present/fluctuating] altered mood R/T [his] dx [diagnosis] of anxiety, depression & [and] personality disorder; recent health issues and need for SNF [skilled nursing facility] stay E/B expressed sadness, frustration [and a] score of 7 pts [points] on PHQ-9 [Patient Health Questionnaire-9, a short, 9-item self-report tool used by healthcare providers to screen for, diagnose, monitor, and measure the severity of depression]." Interventions included "Consult with pharmacy, healthcare provider, etc. [et cetera] to consider medication dosage reduction... PASRR [Preadmission Screening and Resident Review (a program designed to prevent the inappropriate placement or long-term stay of individuals with a serious mental illness (SMI), intellectual disability (ID), or developmental disability (DD/I/DD) in Medicaid-certified nursing facilities)] recommendations: Management/monitoring of psychiatric medications – PCP [primary care physician] manages these meds [medications]." A 2/25/25 focus area on his current care plan indicated he used "psychopharmacological (also known as psychotropic) medications R/T Anxiety Disorder, [and] Major Depressive Disorder." Interventions included "Discuss with health care provider, [and] family re [regarding] ongoing need for use of medication." His 1/26/26 Permission for Use of Psychotropic Medications form indicated that he took "Sertraline 50 mg PO at HS [bedtime]". That form did not indicate the specific condition to be treated, the symptoms that he was experiencing that the medication was intended to help, or the non-pharmacological alternatives that were attempted. His 4/1/26 Permission for Use of Psychotropic Medications form indicated that he took "Sertraline 25 mg @ [at] bedtime." That form did not indicate the specific condition to be treated, the symptoms that he was experiencing that the medication was intended to help, or the non-pharmacological alternatives that were attempted. He had a 6/10/25 physician's order for Amitriptyline HCl 5 mg (milligrams) to be administered once daily at bedtime. He had a 6/12/26 physician's order for clonazepam 0.5 mg, 1mg to be administered once a day as needed for anxiety.	F0552		

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

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F0552 SS = D	Continued from page 9 His 6/19/26 Permission for Use of Psychotropic Medications indicated that he took "Clonazepam 1 mg PO [by mouth] Q24 hrs [every 24 hours] PRN [as needed]," and "Sertraline 25 mg PO daily." That form did not indicate the symptoms that he was experiencing that the medications were intended to help, or the non-pharmacological alternatives that were attempted. He had an 8/21/26 physician's order for Sertraline HCl 50 mg, one half tablet, to be administered once daily at bedtime. His 8/25/26 Permission for Use of Psychotropic Medications form indicated that he took "Sertraline 25 mg QD [each day]." That form did not indicate the specific condition being treated, the symptoms he was experiencing that the medication was intended to treat, or the non-pharmacological alternatives that were attempted. There was no documentation in the EMR that resident 9 completed a Permission for Use of Psychotropic Medications form for his use of Amitriptyline, that included the proposed course of the medication, the specific condition to be treated, what symptoms he was experiencing that the medication was intended to help, the risks versus benefits of that medication, or alternative treatments that were attempted. 2. Interview on 10/08/26 at 2:03 p.m. with director of nursing (DON) B revealed that Minimum Data Set (MDS) coordinator C, Medicare coordinator L, registered nurse (RN) G, and RN M were responsible for completing the Permission for Use of Psychotropic Medications form when a resident admitted to the facility with a physician's orders to continue receiving a psychotropic medication, when orders were received to start taking a new psychotropic medication, or when the dose of that type of medication changed. She confirmed that Amitriptyline, Clonazepam, and Sertraline were psychotropic medications. She expected resident 9's 1/26/26, 4/1/26, 6/19/26, and 8/25/26 Permission for Use of Psychotropic Medications forms to be filled out completely and confirmed that those forms contained blank areas. She expected the staff members to indicate which symptoms the resident was experiencing that the medication was intended to help, and which non-pharmacological alternatives were attempted on those forms when they completed them. There was no documentation that a Permission for	F0552		

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F0552 SS = D	Continued from page 10 Use of Psychotropic Medications form was completed with resident 9 that indicated he took Amitriptyline, the specific condition to be treated by that medication, what symptoms he was experiencing that the medication was intended to help, the risks versus benefits of that medication, or alternative treatments to that medication that were attempted. 3. Review of the provider's 12/9/25 Psychotropic Medications policy revealed its purpose was to "evaluate behavior interventions and alternatives before using psychotropic medications... to eliminate unnecessary psychotropic medications." "Based on a comprehensive assessment of a resident, the location must ensure that: Residents who use psychotropic drugs receive... behavioral interventions..." "If the physician prescribes an antipsychotic [medication] for the resident... a consent form must be signed... the Permission for Use of Psychotropic Medications [form] will be used to obtain consent." "If a resident is admitted on psychotropic medication or returns from hospitalization on new psychotropic medications, the following must be completed... the Permission for Use of Psychotropic Medications." "With a dose change of psychotropic medication ... the Permission for Use of Psychotropic Medications [form] must be completed."	F0552		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F0584	Residents #5 and #44 were immediately assessed for safety risks related to clutter and room sanitation concerns. The interdisciplinary team met with each resident to discuss resident rights, infection control concerns, fall risks, and the importance of maintaining a safe living environment. With each resident's consent, staff removed excess clutter, cleaned the resident rooms, and addressed any identified sanitation and safety concerns. The care plans were reviewed and updated as appropriate to reflect resident preferences, interventions, and approaches for maintaining a safe and sanitary room environment while honoring resident choice.	

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F0584 SS = D	Continued from page 11 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the staff provided a safe, clean, and comfortable environment was for two of fourteen sampled residents (5 and 44) observed with cluttered and unclean rooms, who did not allow staff members to routinely clean their rooms to maintain them in a condition that was sanitary and did not pose a safety risk to themselves or other residents. Findings include: 1. Observation and interview on 10/6/26 at 10:13 a.m. with resident 44 in his room revealed he was seated in his wheelchair eating. His room was cluttered with items piled on the floor, his bedside tables, the chair, on top of plastic bins that were stored on the floor, on top of the microwave, and top of the refrigerator. Some piles were more than three feet deep, and the clutter extended several feet from the right wall of his room and in front of the window.	F0584	All residents residing in the facility have the potential to be affected by the deficient practice. An audit of all resident rooms was conducted the administrator or designee to identify clutter, sanitation concerns, fire hazards, infection control concerns, or other environmental safety issues. Any identified concerns were immediately addressed. Clinical Lead Development Specialist or designee will educate all nursing staff, housekeeping staff, maintenance staff and department leaders regarding resident rights and resident choice, along with staff responsibility to provide and maintain a safe, clean, comfortable, and homelike environment. Education for all required staff will be completed by 11/6/2026. Any employee who does not receive the required training by 11/6/2026 will be educated by clinical lead development specialist or designee prior to their next shift. On 11/1/2026, administrator and maintenance director established new documentation process to ensure resident room cleaning is being documented along with resident refusals. Clinical lead development specialist will educate all housekeeping staff on new room cleaning documentation process by 11/6/2026. The Administrator or designee will conduct environmental audits on 10 resident rooms including resident 5 and 44 to ensure rooms remain sanitary and free of safety hazards. Audits will be completed weekly x4, every other week x2 and monthly x2. Administrator or designee will report audit findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring. Substantial compliance will be achieved by 11/6/2026.	11/6/2026

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F0584 SS = D	Continued from page 12 The items in the piles included clothing, food boxes, a loaf of bread, dirty dishes, a white plastic basin, and various household cleaning products. There were at least two boxes of cereal on the floor. A can of Raid insect spray was on top of one cereal box. A yellow container of disinfectant wipes was on top of another cereal box. There were multiple surfaces of the microwave that had an unidentified dried orange food substance on them. There was a fork, a knife, multiple pieces of paper, food wrappers, and food crumbs scattered on the floor. On the table near the bathroom door, there was a bowl with unidentified dried food matter on it. There were two medium-sized trash cans near the door of the resident's room. One trash can overflowed with soda bottles and other trash. There were dirty paper towels and a soda bottle on the floor near the door. The baseboard on the wall outside the bathroom door was peeling away from the wall and extended outward approximately five inches from the wall. Resident 44 stated that he used the insect spray to "shoot" the flying insects in his room. His oxygen concentrator (a device that filters room air into purified oxygen) was on, and the oxygen nasal cannula (flexible tubing with prongs that delivers oxygen through the nose) was on the floor near his bed. When asked about his oxygen use, resident 44 threw a fork across the room towards his bed in front of the surveyor. The fork hit the wall and fell onto the floor. The resident stated, "What is your problem," attempted to pick up the oxygen tube from the floor, declined the surveyor's offer to ask a staff member to assist him, and stated, "Just leave." Resident 44 appeared angry, and the surveyor left the room. 2. Review of resident 44's electronic medical record (EMR) revealed he admitted to the facility on 7/2/24. His diagnoses included a history of falling and dependence on renal dialysis (treatment that removes waste products and excess fluid from blood when the kidneys are unable to). His 7/14/26 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact. His current care plan (personalized plan that addresses a resident's care needs, goals, and interventions) included 7/20/26 focus areas that resident 44 had "impaired cognitive function E/B [evidenced by] some issues with judgement, decision	F0584		

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F0584 SS = D	Continued from page 13 making, [and] impulse control," and had "a mood/behavior problem R/T [related to low tolerance for frustration, chronic health issues and ongoing need for SNF [skilled nursing facility] care E/B poor impulse control, quick to anger, verbal aggression," that resident 44 was moved to a private room on 9/24/24 "as he was disruptive, [and] verbally aggressive," and that resident 44 was at risk for falls. Interventions included "Provide resident [44] with necessary cues- stop and return if agitated," and "Redirect/reassure as needed." "[When] Angry: Deescalate [De-escalate resident 44] with calm, unemotional redirection/reassurance." "Resident [44] will maintain a safe environment due to vision loss." "Ensure/provide a safe environment..." There was no documentation in resident 44's behavior tracking task area or progress notes that resident 44 refused to allow the staff to clean his room. 3. Observation and interview on 10/6/26 at 12:40 p.m. with resident 5 in his room revealed that he left the dining room in his power scooter (a powered mobility device used to assist people who had difficulty walking, with handlebars for steering) without eating and was angry that he was not served his food quickly. Resident 5 stated some of the residents were "stupid" and that resident 23 would come into his room because he "doesn't know what he is doing." Resident 5's power scooter seat was ripped, the left side directional light was broken and dangled from it, and the footrest of his scooter was dirty with dried food matter on it. His bed did not have sheets on it, and the pillows and blankets were piled at the head of the bed. The oscillating pedestal fan at the foot of his bed was on, and the front fan guard was on the floor on top of other items that were inside a cardboard box on the floor. There were more than three large cardboard boxes on the floor that contained packages of unopened noodles, cases of soda, clothing, and Lego toys. Next to those boxes near the foot of the bed was a commode (portable toilet). The commode bucket (a removable container that fits directly underneath the seat of a commode) was lined with a plastic bag and was on the floor under the commode approximately one foot from the box of noodle packages. There were Lego pieces and food crumbs scattered on the floor between the resident's bed, commode, dresser, and bathroom. A paper cup that contained a yellow	F0584		

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F0584 SS = D	Continued from page 14 liquid and a fork was on top of the dresser near the television (TV). Resident 5 stated that he moved into that room from another room in the facility a couple of months ago, had not put those items away because he didn't have a place to put them. He knew his fan was broken, said that he would fix it when he had a chance, and thought that his new room was "fine." 4. Review of resident 5's EMR revealed he admitted to the facility on 2/27/25. His 9/1/26 BIMS assessment score was 15, which indicated his cognition was intact. His diagnosis included dependence on renal dialysis, cognitive communication disorder (communication difficulties caused by underlying problems with thinking skills, such as attention, memory, and executive function), and attention deficit hyperactivity disorder (a neurodevelopmental disorder that affects brain development and self-regulation). His care plan included a 9/8/26 focus area that resident 5 had "impaired cognitive function R/T cognitive developmental delay E/B impaired decision making." Interventions included to "present just one thought, idea, question, or command at a time," and that resident 5 "needs assistance on occasion with more complex decision making." A 7/30/26 intervention indicated resident 5 used a "commode for toileting needs," and "needs [staff] assistance with toilet hygiene, but tries to handle [his toilet hygiene] on his own and tends to make a mess with [his] BM [bowel movements]." A 7/31/26 focus area indicated that resident 5 had "impaired psychosocial well-being R/T depression, anxiety, and delayed cognitive development E/B frustration under pressure, a low tolerance for inefficiency, being reactive when facing challenges or setbacks, responding emotionally in difficult conversations, [and] using strong language when upset. Interventions included to observe for "stressors which may be early warning signs of problem behavior," and to make "referrals to appropriate mental health professionals as needed." There was no documentation in resident 5's behavior tracking task or progress notes that resident 5 refused to allow staff to clean his room. 5. Observation and interview on 10/6/26 at 12:44 p.m. with certified nursing assistant (CNA) T revealed that he delivered a lunch meal tray to resident 44 in his room. He stated that resident 44 ate all of his	F0584		

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F0584 SS = D	Continued from page 15 meals in his room, did not allow staff to assist him with care, often became angry with staff when they entered his room, and that resident 44 was "ok" when staff entered his room to drop off his meal tray. He stated that resident 44's room was cluttered and dirty "for a while." CNA T was in the dining room when resident 5 left the dining room without eating lunch, and he would offer resident 5 a lunch meal tray to eat in his room. CNA T thought resident 5 would refuse a lunch meal tray because he often ate the food that his family provided for him, including the packages of noodles. He stated that resident 5 was easily frustrated with other residents and staff. 6. Interview on 10/6/26 at 12:47 p.m. with housekeeper K revealed the boxes on resident 5's floor had been there for a "couple [of] months." She offered to assist resident 5 with putting those items away, but he declined assistance. She thought resident 5 was "protective of his stuff," and he often asked her if she touched his items when he was not in his room. She often picked up his Legos from the floor but was careful not to disturb his items because he would know that she had been in his room. She confirmed that food items were next to the commode and his room was cluttered. She stated that resident 5 often ate in his room and dropped food on the floor near his television. She offered to clean his floor when he was in the room, which sometimes he allowed, and other times he did not. She was afraid to clean resident 44's room because he could be "violent." She stated that the surveyor should be careful if she needed to enter his room because the resident was known to throw forks, knives, or other items at the staff members when they entered his room. She stated that she offered to clean resident 44's room each day when he was present in his room, but resident 44 would get angry, so she tried to clean his room when he was out of the facility for dialysis treatments. She was afraid to touch resident 44's personal items because he became angry when he thought she moved his items, and she did the "best" she could to clean his room without touching his items. She stated it was difficult to clean resident 5 and resident 44's rooms because there was a significant amount of clutter, items on the floor, and because the residents became angry if she touched their items. She did not document when she cleaned	F0584		

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F0584 SS = D	Continued from page 16 residents' rooms because every room was to be cleaned every day. She did not document when a resident refused to have their room cleaned. She told her supervisor that resident 44 refused to let her clean his room and thought that her supervisor had discussed it with administrator A and director of nursing (DON) B, because she was told that those resident rooms were their "home" and that she had to be "respectful" of that. 7. Observation and interview on 10/7/26 at 12:20 p.m. with housekeeper K in the hallway outside resident 5 and resident 44's rooms revealed that resident 23 was wandering around in the hallway. Housekeeper K showed resident 23 where his room was located, which was between resident 5 and resident 44's rooms. At 12:25 p.m., resident 23 left his room and continued to wander around in the hallway. Housekeeper K stated that she was afraid to go into resident 44's room and was waiting for his door to be open, which would have indicated that he was not in his room. Housekeeper K tried to clean resident 5's room earlier that day, but resident 5 got upset with her, so she planned to wait for him to leave his room to attempt to pick up the Legos she had seen on his floor. 8. Interview on 10/7/26 at 2:10 p.m. with administrator A revealed he had not been in resident 44's room in about six months. He was unaware that resident 44 had insect spray in his room, food boxes on the floor, trash that was overflowing, or that staff members were afraid to enter or clean resident 44's room. He knew that resident 44 was protective of his items and frequently returned to the facility with items from the store. Staff members were not allowed to "search" resident 44's bags, and it was difficult to know or account for the items resident 44 purchased and brought back to the facility. Administrator A acknowledged that resident 44's room may have been "a little cluttered." Administrator A thought that it was resident 44's right to live the way he wanted to and that if resident 44 wanted those items in his room and on the floor, then it was resident 44's right to create his own "homelike environment." 9. Observation and interview on 10/7/26 at 2:17 p.m. with administrator A and resident 44 in resident 44's	F0584		

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F0584 SS = D	Continued from page 17 room revealed that administrator A confirmed that resident 44 had insect spray in his room and the room was cluttered. Resident 44 shouted at the surveyor and administrator A when asked about the items in his room. 10. Interview on 10/7/26 at 5:10 p.m. with administrator A revealed that he had a conversation several months ago with the ombudsman (an advocate of residents' overall quality of care and rights) regarding residents' refusals to follow facility protocols and he was told that the resident had the right to choose how they lived and had documented that conversation. 11. Review of the documentation provided that administrator A had discussed concerns related to the condition of resident 5 and resident 44's room with ombudsman S revealed a 10/24/24 progress note for resident 96, who no longer resided at the facility, that indicated administrator A spoke with ombudsman S "regarding resident's [resident 96's] refusal to follow facility protocols. Ombudsman [S] informed administrator [A] that he should notify resident's [96] PO [power of attorney someone designated on a legal document to act on behalf of a resident]." 12. Observation and interview on 10/8/26 at 9:38 a.m. with medication aide (MA) Q revealed resident 5 and resident 44 were independent with their personal care and would ask staff if they needed anything. She did "rounds (checking on residents' status and assistance needs)" every two hours to check on those residents. Resident 44 was very independent, could be aggressive, yelled at staff, did not like to be "bothered," and "does his own thing." She did not go into his room unless he needed help with something and wanted her to enter his room. There were times she would have to bring resident 44 his medication, and he would get very upset and shout at her. She knew that he had thrown items at other staff members, so she was careful not to upset him, and he had never thrown anything at her. She was not in his room on that day (10/8/26), but knew that his room was cluttered and that he was protective of his items. Further interview and observation of resident 5's room with MA Q revealed the resident's room door was open, and the clutter in his room could be seen	F0584		

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F0584 SS = D	Continued from page 18 from the door. MA Q entered resident 5's room and confirmed that there was a bowel movement in resident 5's uncovered commode bucket and package of noodles and a twelve-pack of soda was directly under the left side of the commode. She stated that resident 5 preferred to use the commode. MA Q stated that resident 5 was independent and requested staff assistance when he needed it. Resident 5 would yell at staff and throw items, but she stated that those behaviors were less frequent and less aggressive than resident 44's behaviors. She stated that resident 5 would get angry when other residents wandered into his room. She acknowledged that resident 23 wandered and did not always know where his room was, but that she had not seen resident 23 wander into resident 5's room that day. 13. Observation, interview, and documentation review on 10/8/26 at 9:48 a.m. with director of nursing (DON) B in the hallways outside of resident 5, resident 23, and resident 44's rooms revealed she acknowledged that resident 23 wandered, often did not know where his room or the dining room was and that his room was located directly between resident 5 and resident 44's rooms. She was aware that residents 5 and resident 44's rooms were dirty and cluttered and that those residents did not like housekeeping to clean their rooms. She did not think the housekeepers documented when resident 5 and resident 44 refused to have their rooms cleaned. She expected nursing staff to document when residents refused care, were aggressive, or threw items at staff members, but did not expect nursing staff to document when residents refused to allow housekeepers to clean their rooms. She confirmed that there was no documentation that resident 5 or resident 44 refused to have their rooms cleaned, whether attempts were made to clean those rooms, or what interventions were tried to clean or monitor those rooms for unsafe conditions and trash. DON B did not know the last time she had been in resident 44's room before 10/7/26, when she was made aware of the condition of his room. She acknowledged that the cluttered and unclean conditions of resident 44's room created potential safety risks for resident 44, the staff members, or other residents who might potentially enter that room when resident 44 was not in his room and left his door open.	F0584		

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F0584 SS = D	Continued from page 19 DON B confirmed that there was exposed stool in resident 5's commode bucket and a package of noodles and a twelve-pack of soda was directly under the left side of the commode. She expected that resident 5 and resident 44's rooms would be clean, and that food items would be stored off the floor. She stated that she was not aware of some of the items that resident 5 and resident 44 brought into their rooms because they left the facility independently and could return with items that were potentially unsafe and keep them in their rooms without the staff's awareness. She stated that it was hard to protect resident 5 and resident 44's rights while ensuring that the facility's environment was safe and clean for other residents and staff members. She was unsure whether ombudsman S had been contacted related to resident 5 and resident 44's resistance to allowing housekeeping staff members to clean their rooms. She knew that in the past when residents were not compliant with facility rules, ombudsman S told them there was nothing that the facility could do because of their resident rights. 14. Interview on 10/8/26 at 11:05 a.m. with medical director (MD) F revealed she had not been in resident 5 or resident 44's room recently. She was unaware and was not notified of their behaviors towards staff members or the conditions of their rooms until 10/8/26. There was no discussion with resident 44 or other staff related to those residents' behaviors of shouting at staff, throwing items at people, or being angry with housekeeping at the provider's behavior meeting. There were no interventions in place to manage those behaviors, and they had not discussed potential solutions to those issues until 10/8/26. MD F acknowledged that resident 23 wandered and agreed that the conditions of resident 5 and resident 44's rooms could create a potential safety hazard for resident 23 if the resident wandered into those rooms when those residents were not in their rooms. 15. On 10/7/26 at 4:49 p.m., documentation of resident 5 and resident 44's room cleaning and behaviors related to refusals for room cleaning or aggressive behavior towards staff was requested from administrator A to be received by 3:00 p.m. on 10/8/26 for review and was not provided.	F0584		

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F0584 SS = D	Continued from page 20 16. Review of the provider's undated Standard or Light Cleaning Policy revealed its purpose was to provide "procedures for the proper, daily cleaning of resident rooms. Rehabilitation/ skilled care settings provide care and services to residents who are often vulnerable to infection and the effects of infections due to weakened immune systems. As such, thorough, routine, and high-quality cleaning procedures are necessary to minimize the prevalence of infection." "Standard or Light cleaning should occur on a daily basis in occupied rooms. If standard or light cleaning is not scheduled daily, the schedule should be adjusted for daily cleaning in rooms where…other conditions may require more frequent cleaning." "Address any clutter/trash in the room prior to beginning the cleaning process." "No cleaning supplies… should be stored in the resident rooms." 17. Review of the provider's 12/29/25 Resident Environment- Rehabilitation/Skilled Care & [and] Long Term Care policy revealed its purpose was to ensure an "appropriate resident environment." The policy indicated that the "center will provide a safe, clean, comfortable and homelike environment that allows the resident use of some personal belongings to the extent possible. Resident rooms will be designed and equipped for adequate nursing care, safety, and comfort, as well as the following: Housekeeping and maintenance services…" 18. A review of the provider's undated Procurement and Storage of Equipment, Products and Supplies policy revealed, "Housekeeping equipment, products and supplies should not be stored in resident rooms…" 19. Review of the provider's November 28, 2016 Resident Rights For Skilled Nursing Facilities booklet revealed "The right to retain and use personal possessions, include furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents."	F0584		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F0657	Resident 1's care plan was updated by DNS on 10/7/2026 to ensure the resident's care needs, goals and interventions were addressed and resident specific.	

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F0657 SS = D	Continued from page 21 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review the provider failed to ensure the resident's care plan (a personalized plan addressing a resident's care needs, goals, and interventions) was reviewed and revised to reflect the current care needs for one of four sampled resident (1) who resided in the facility's rehabilitation unit. Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed he admitted to the facility on 9/4/26. He had diagnoses of volvulus (a loop of the intestine twists around itself and its supporting tissue), dysphagia (difficulty or discomfort when swallowing food, liquids, or saliva), and pneumonitis (swelling and irritation of lung tissue) due to inhalation of food and vomit. His 9/9/26 Brief interview for Mental Status (BIMS) assessment score was 14 which indicated his cognition was intact. 2. Observation and interview on 10/6/26 at 8:49 a.m. and 10/7/26 at 1:32 p.m. with resident 1 in his room	F0657	All residents have the potential to be affected by this deficient practice. The Director of Nursing (DON) or designee by 11/4/2026 will complete an audit of all residents residing on the rehabilitation unit to verify that care plans reflected current diagnoses, conditions, and treatment needs. DNS or designee will also review all residents residing on the facility rehabilitation wing to ensure their care plans address recent significant changes in condition, included appropriate goals and interventions, were reviewed and revised following care conferences, therapy updates, or significant clinical changes, and Included evidence of interdisciplinary participation when appropriate. Any care plans identified as incomplete, inaccurate, or not reflective of the resident's current needs were immediately updated. Clinical lead development specialist or designee will educate DNS, all nurse leaders, nurses and social workers on care plan policy related to revisions along with resident care needs, goals and interventions. Education for all required staff will be completed by 11/6/2026. Any employee who does not receive the required training by 11/6/2026 will be educated by clinical lead development specialist or designee prior to their next shift. A prompt will be added to the clinical review meeting stand up sheet to ensure IDT team review and oversight for any care plan changes or necessary updates. The DON, MDS Coordinator, or designee will conduct audits of 10 resident care plans to ensure they accurately reflect current resident conditions, goals, and interventions. Audits will be completed weekly x4, every other week x2 and monthly x2 by DNS or designee to ensure risk versus benefits and education related to alternate treatment options are present and facility remains in compliance.	

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F0657 SS = D	Continued from page 22 revealed that he no longer needed a nasogastric tube (a thin flexible tube passed through the nose, down the throat, and into the stomach to receive liquid nutritional formula). He had an abdominal incision and a colostomy bag (a pouch worn on the outside of the abdomen to collect stool and gas from the body). He did not have a peripherally inserted central catheter (PICC) line (a thin flexible tube inserted into a vein in the upper arm and threaded to a large vein near the heart) that had been removed in the hospital before his admit, a wound vac (a device that uses negative pressure to remove excess fluid and debris from a wound to promote wound healing) which was removed before he was admitted to the facility, a nurse had removed his Jackson-Pratt (JP) drain (a closed-suction device to collect fluid [blood, or serum] from a surgical site) after he came to the facility. 3. Further review of resident 1's EMR revealed he had a 9/23/26 physician's order for a regular diet with regular textures and thin consistency liquids. He had a 9/12/26 physician's order for nutritional supplements 8 ounces, three times a day for weight loss. He did not have current physician's orders for a JP drain. He had a 9/10/26 physician's order to give enteral feed after meal, give if consumes less than 75% (percent) of meal. He did not have physician's orders for a wound vac or to administer his medications through his PICC line. His hospital documentation indicated his wound vac was removed at the hospital on 8/24/26 and his PICC line was removed at the hospital on 9/4/26 at 10:59 a.m. Resident 1's care plan had a focus area initiated on 9/4/26 that indicated the resident required "enhanced barrier precautions (EBP) R/T [reference to] presence of Corpak [feeding tube] requiring tube feeding administration, presence of PICC line, presence of wounds requiring dressing changes and wound vac therapy, presence of surgical incision." 4. Interview on 10/7/26 at 3:45 p.m. with director of nursing (DON) B revealed resident 1's PICC line and wound vac were removed before he admitted to the facility on 9/4/26. 5. Interview on 10/7/26 at 4:15 p.m. with RN G revealed she was responsible for completing the portion of the residents' care plans regarding wounds. She had ordered a wound vac to be used by resident 1, but when he arrived to be admitted to the facility, he did not have a wound vac, or a PICC line. She agreed that his care plan should have been updated when it was known that he did not have a	F0657	DNS or designee will report audit findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring. Substantial compliance will be achieved by 11/6/2026.	11/6/2026

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F0657 SS = D	Continued from page 23 PICC line or a wound vac, she also indicated that DON B was responsible for updating that portion of the resident's care plan for resident 1, but when he arrived at the facility, he had no wound vac, and no PICC line. She would agree that the care plan should have been updated when it was known that he did not have the PICC line or the wound vac on 9/4/26. Resident 1's care plan should have been looked at more closely to be honest as things change quickly and we sometimes do not catch things. If there are changes the care plan should be updated. She stated that resident 1's care plan should have been reviewed more closely when he admitted to the facility and if there were changes his care plan should have been updated. 6. Interview on 10/8/26 at 9:24 a.m. with licensed practical nurse (LPN) E revealed she usually was assigned to work in the facility's rehabilitation unit. Resident 1 had a nasogastric tube and a JP drain when he was admitted to the facility on 9/4/26. He did not have a PICC line or a wound vac when he was admitted to the facility. She did not update the residents' care plans. If changes needed to be made to a resident's care plan, she notified Minimum Data Set (MDS) coordinator C, or Medicare coordinator L on the rehabilitation unit. 7. Interview and EMR review on 10/8/26 at 11:19 a.m. with MDS coordinator C revealed she completed the resident's baseline care plans and revised care plans for the residents who resided in the rehabilitation unit. DON B was responsible for adding infection control information in the resident's care plans. She completed resident 1 admission assessment and indicated in her progress note that he had a JP drain and colostomy, a midline abdominal incision, and a nasogastric tube. Resident care plans were to be reviewed every couple weeks and with any changes in the resident care needs by DON B, RN G, and herself. Changes in the resident's needs were discussed at their morning staff meetings, and whoever oversaw that related area of the residents' care plans, was responsible for updating those residents' care plans. Resident 1 was reassessed by MDS coordinator C on 9/25/26. She said she must have missed those items in the care plan review after completing those assessments. 8. Interview and EMR review on 10/8/26 at 1:16 p.m. with DON B revealed that resident 1 did not have a PICC line or wound vac when he admitted to the facility on 9/4.26. She was responsible for addressing those items, the residents' care needs related to those items and the residents' infection	F0657		

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F0657 SS = D	Continued from page 24 control needs in the residents' care plans. She agreed that resident 1's care plan had not been revised as it should and that she was responsible for making those changes. She expected resident care plans to be updated to reflect changes in physician's orders, and resident care needs as those changes occurred. She expected the residents' care plans to reflect the resident's care needs and care that the resident was receiving. 9. Review of the 12/1/25 provider's 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. Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. Any problems, needs, and concerns identified will be addressed through use of departmental assessments, the Resident Assessment Instrument (RAI) and review of the physician's orders. The comprehensive plan of care will be finalized during an interdisciplinary care team conference no later than seven days after completion of the comprehensive resident assessment. This plan of care will be modified to reflect the care currently required/provided for the resident. The interdisciplinary team will review care plans at least quarterly. Care plans also will be reviewed, evaluated, and updated when there is a significant change in the resident's condition."	F0657		