STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	67392	A. BUILDING: _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY PRAIRIE CREEK MEMO	4309 W CREEKSIDE CIRCLE SIOUX FALLS, SD 57106

(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 Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted on 3/25/25 through 3/26/25. Good Samaritan Society Prairie Creek Memory Care was found not in compliance with the following requirements: S173, S201, S215, S296, S331, S352, and S630.	S 000	Initial Comments Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by state law. For the purpose of any allegation the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facilities allegation of compliance in accordance with section 7305 of the State Operations Manual.	
S 173	44:70:02:17(8-9) Occupant Protection The facility shall: (8) Ensure that any clothes dryer must have a galvanized metal transition duct for exhaust or flexible transition duct listed and labeled in accordance with UL 2158A; and (9) Ensure that the storage and transfilling of oxygen cylinders or containers meet the requirements of the NFPA 99 Health Care Facilities, 2012 Edition, chapter 11. A resident may store in the resident's room a maximum of three E-cylinders or seventy-two cubic feet, or 2.040 cubic meters of oxygen on an as-needed basis, in addition to oxygen in use by the resident. If a facility admits or retains a resident not capable of self-preservation, the facility must meet NFPA 101 Life Safety Code, 2012 edition, health care occupancy standards in chapter 18 or 19, or equip the facility with complete automatic sprinkler protection. This Administrative Rule of South Dakota is not met as evidenced by:	S 173	S 173 1. Galvanized metal ducts were installed on personal laundry room dryers on west and east units on 3/28/2025. 2. Assisted living center will ensure residential dryers will meet regulation by ensuring galvanized metal transition ducts for exhaust or flexible transition ducts in accordance with UL2158A. 3. Assisted living manager, or designee, will audit residential dryers weekly to ensure dryer duct requirements met per facility maintenance policy. Assisted living manager will report to QAPI committee of findings. QAPI committee will determine the need for further monitoring or auditing.	3/28/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelsey Nicola
TITLE: Facility Manager
(X6) DATE: April 12, 2025

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S 173	Continued From page 1 Based on observation and interview, the provider failed to install galvanized metal exhaust ductwork for two of two residential dryer locations (east and west and assisted living residential laundry). Findings include: 1. Observation on 3/26/25 at 10:40 p.m. revealed the personal laundry room for the west unit had a residential style dryer. That dryer had foil paper exhaust ducting installed. Interview with maintenance manager F at that same time confirmed that condition. 2. Observation on 3/26/25 at 1:13 p.m. revealed the personal laundry room for the east unit had a residential style dryer. That dryer had foil paper exhaust ducting installed. Interview with maintenance manager F at the time of the above observations confirmed those conditions. Further interview with maintenance manager F at the time of the above observations revealed he was aware of the requirement for galvanized metal vent pipes for dryer exhaust. He further stated those dryers had been replaced since the last time he had personally inspected them. He went on to state the installing contractor likely installed the foil paper exhaust ducting as those units had the galvanized metal duct exhaust previously.	S 173		
S 201	44:70:03:02 General Fire Safety Each facility must be constructed, arranged, equipped, maintained, and operated to avoid undue danger to the lives and safety of occupants	S 201		

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S 201	Continued From page 2 from fire, smoke, fumes, or resulting panic during the period of time reasonably necessary for escape from the structure in case of fire or other emergency. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, the facility must conduct monthly drills to provide training for all personnel. This Administrative Rule of South Dakota is not met as evidenced by: A. Based on observation and interview, the provider failed to maintain two separate hazardous areas (north and south storage rooms for the west unit) as required. Findings include: 1. Observation on 3/26/25 at 10:05 a.m. revealed the north storage room in the resident wing was over 100 square feet and had large amounts of combustibles stored in it. Testing of the fire-rated door to that room revealed it would not close and latch into the doorframe under the power of the closer. That door needs to close and latch to maintain the required fire rating of that room. 2. Observation on 3/26/25 at 10:18 a.m. revealed the supply room in the resident wing was over 100 square feet and had large amounts of combustibles stored in it. Testing of the fire-rated door to that room revealed it would not close and latch into the doorframe under the power of the closer. That door needs to close and latch to maintain the required fire rating of that room. Interview with maintenance manager F at the time of the above observations confirmed those conditions. B. Based on observation and interview, the provider failed to provide sprinkler protection	S 201	S201 1. Fire rated doors were adjusted on 4/1/2025. 2. Assisted living center will ensure all fire-rated doors will close and latch under the power of the closer. 3. Assisted living manager, or designee, will audit fire-rated doors weekly x4 then monthly x3. Assisted living manager will report to QAPI committee of findings. QAPI committee will determine the need for further monitoring or auditing.	4/10/2025

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S 201	Continued From page 3 through the facility as required for one randomly observed location (behind the commercial dryer). Findings include: 1. Observation on 3/26/25 at 1:32 p.m. revealed the enclosed space behind the commercial gas dryer was not covered by the buildings automatic fire sprinkler system. Interview at that same time with the maintenance manager F revealed he was unaware of that condition. He stated that condition had existed since the building was built.	S 201	S201 1. Sprinkler head was added to area behind commercial dryer on 4/10/2025. 2. Assisted living manager, or designee, will audit sprinkler head with other building sprinkler heads conducted yearly.	4/10/2025
S 215	44:70:03:03 Fire Extinguisher Equipment Fire extinguisher equipment shall be installed and maintained to the following standards: (1) Portable fire extinguishers must have a minimum rating of 2-A:10-B:C; (2) Fire extinguisher equipment must be inspected monthly and maintained yearly; and (3) Approved fire extinguisher cabinets must be provided throughout the building with one cabinet for each 3,000 square feet or 278.7 square meters of floor space or fraction thereof. The fire resistance rating of corridor walls must be maintained at recessed fire extinguisher cabinets. The glazing in doors of fire extinguisher cabinets must be wire glass or other safety glazing material. Fire extinguisher cabinets must be identified with a sign mounted perpendicular to the wall surface above the cabinet. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider	S 215	S215 1. Fire extinguishers were checked on 4/2/2025. 2. Assisted living center will ensure all fire extinguishers will be checked monthly and maintained yearly. 3. Assisted living manger, or designee, will audit to ensure fire extinguishers are inspected monthly x3. Assisted living manager will report findings to QAPI committee of findings. QAPI committee will determine the need for further monitoring or auditing.	4/2/2025

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S 215	Continued From page 4 failed to inspect all fire extinguishers monthly as required for one randomly observed location (boiler room by the kitchen). Findings include: 1. Observation on 3/26/25 at 11:35 p.m. revealed the fire extinguisher in the boiler room by the kitchen did not have any of its monthly inspections performed since the annual inspection in November of 2024. Interview at that same time with the maintenance manager revealed he was unaware of that condition. He stated the guy who he has performing the monthly fire extinguisher inspections must have forgotten that extinguisher was in that location.	S 215		
S 296	44:70:04:04(1-11) Personnel Training These programs must be completed within thirty days of hire for all healthcare personnel and must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness, including responding to resident emergencies and information regarding advanced directives; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Resident rights; (6) Confidentiality of resident information; (7) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (8) Nutritional risks and hydration needs of residents; (9) Abuse and neglect; (10) Problem solving and communication techniques related to individuals with cognitive impairment or challenging behaviors if admitted	S 296	S296 1. Missing training, Nutrition and Hydration Basics, was assigned via online learning to all staff on 3/27/2025 and will be covered at staff meeting on 4/15/2025. 2. Assisted living center will ensure all staff will have all required training upon hire and annually. 3. Assisted living manager, or designee, will audit employee files monthly x3 to ensure all required trainings are completed. Assisted living manager will report to QAPI committee of findings. QAPI committee will determine the need for further monitoring or auditing.	5/10/2025

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S 296	Continued From page 5 and retained in the facility; and (11) Any additional healthcare personnel education necessary based on the individualized resident care needs provided by the healthcare personnel to the residents who are accepted and retained in the facility. Any personnel whom the facility determines will have no contact with residents are exempt from the training required by subdivision (8). This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure annual training for nutritional risks and hydration needs of residents was completed for two of five reviewed employees (E and F). Findings include: 1. Review of Employee E's file revealed: *She had been hired on 4/12/23. *She had completed the nutritional risks and hydration needs of residents training on 4/14/23. *There was no record of her completing nutritional risks and hydration needs of residents training in 2024. 2. Review of Employee F's file revealed: *She had been hired on 6/4/24. *There was no record of her ever-completing nutritional risks and hydration needs of residents training. 3. Interview on 3/26/25 at 1:00 p.m. with administrator A revealed:	S 296		

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S 296	Continued From page 6 *She confirmed employees E and F had not completed nutritional risks and hydration needs of residents training in 2024. *She had learned the nutritional risks and hydration needs of residents training had not been deployed by human resource information system (employee training system) in 2024. *She was not aware the training system had not deployed that training in 2024. *She agreed that training should have been completed annually and on initial hire.	S 296		
S 331	44:70:04:10(1) Tuberculin Screening... Requirements Tuberculin screening requirements for healthcare personnel and residents are as follows: (1) Each healthcare personnel or resident shall receive an initial individual TB risk assessment that is documented and the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within twenty-one days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of admission or employment are considered two-step. A TB blood assay test completed within a twelve-month period prior to the date of admission or employment is an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare personnel or resident transfers from one licensed healthcare facility to another licensed healthcare facility within this state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin or blood assay TB testing having been completed within the prior twelve months. Skin	S 331	S331 1. TB test for resident missing started. First step was started on 3/26/2025 and read on 3/28/2025. Second step will be completed within 21 days of first step. All other current resident charts audited to ensure TB testing met requirements. 2. Assisted living center will ensure that residents have TB testing completed within 21 days of move in per Screening Residents for Tuberculosis policy. Assisted living nurse will put calendar reminders for TB shots and reading. 3. Assisted living manager, or designee, will audit new resident charts to ensure TB testing is done within 21 days of move in. Audit will be completed monthly x3. Assisted living manager will report to QAPI committee of findings. QAPI committee will determine the need for further monitoring or auditing.	5/10/2025

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S 331	Continued From page 7 testing or TB blood assay tests are not necessary if documentation is provided by the transferring healthcare facility, healthcare personnel, or resident, of a previous positive reaction to either test. Any healthcare personnel or resident who has a newly recognized positive reaction to the skin or TB blood assay test must have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview and policy review the provider failed to ensure one of five sampled residents (1) had a two-step Mantoux tuberculin (TB) skin test (a test used to detect latent TB infections completed upon admission. Findings include: 1.Review of resident 1's electronic medical record (EMR) revealed: *She admitted to facility on 2/8/23. *Immunization documentation listed TB testing had been completed on 7/3/23 and 7/5/23. 2. Interview on 3/26/25 at 10:00 a.m. with registered nurse (RN) C revealed: *Resident 1 had been given the TB skin test late. *She missed that she had not gotten it on her move-in/admission. *She was unsure of the actual dates they were given. *She did not have paper records to verify they were given. *A former licensed practical nurse (LPN) documented them wrong in the electronic record system, point click care (PCC).	S 331		

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S 331	Continued From page 8 Interview on 3/26/25 at 12:38 p.m. with administrator A and manager B revealed: *Their expectation was that TB testing would be completed upon a resident's move-in/admission. *They would complete a resident's two-step TB test unless it was indicated they are unable to have them. 3. Review of provider's revised 3/27/24 Screening residents for tuberculosis policy revealed: *"Purpose: To provide early identification of residents infected with tuberculosis (TB) and minimize potential for exposure to TB as required by state regulations." *2. If the ALC is providing the testing, a blood assay test (Quantiferon TB Gold test) or two-step Mantoux method should be used for tuberculin skin test (TST), unless otherwise directed per state regulations. This involves administering the initial test upon move-in/admission, which is read within 48 to 72 hours by a nurse or physician. If the first TST is negative the second test should be placed one to three weeks after the placement of the first test or per state regulations. The second test is read 48 to 72 hours after administration.	S 331		
S 352	44:70:04:13 Resident Admissions The facility shall evaluate and document each resident's care needs at the time of admission, thirty days after admission, and annually thereafter, to determine if the facility can meet the needs for each resident. This Administrative Rule of South Dakota is not met as evidenced by:	S 352		

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S 352	Continued From page 9 Based on record review, interview, and policy review the provider failed to ensure the required evaluation of resident need assessments had been completed upon admission, 30 day and annually for one of five sampled residents (1). Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed: *She was admitted to the facility on 2/8/23. *She had an admit level of care need assessment completed on 2/7/23. *She had an annual level of care need assessment completed on 2/19/24. *She had a significant change level of care need assessment completed on 11/25/24. *She had an annual level of care need assessment completed on 2/17/25. *She did not have a level of care need assessment completed 30 days after her admission. 2. Interview on 3/26/25 at 10:00 a.m. with registered nurse (RN) C revealed: *She completed the level of care need assessment for all residents. *Level of care need assessments were to be completed at admit, 30 days following admit, significant change of a resident, and annually. *She agreed that resident 1 did not have a level of care need assessment completed 30 days after admitting to the facility. Interview on 3/26/25 at 12:38 p.m. with administrator A and manager B revealed: *Their expectation was that nursing would complete residents' level of care need assessments upon admission, 30 days following admission, mini level of care need assessments are completed every six months, upon a	S 352	S352 1. Resident 1 moved in Feb. 8, 2023. We cannot go back and complete a 30 day evaluation. All other current resident charts reviewed to ensure 30 day evaluations were completed. 2. Assisted living center will ensure residents have 30 day evaluations done 30 days after moving in per the Resident Assessment policy. Assisted living center now waits to open initial evaluation upon move in when resident is physically in the building in PointClickCare. This ensures that the 30 day evaluation is automatically triggered and not missed. Assisted living nurse all will put calendar reminders on work calendar for 30 day evaluation be completed. 3. Assisted living manager, or designee, will audit resident charts to ensure evaluations are done per Resident Assessment Policy. Audit will be completed monthly x3 and assisted living manager will report to QAPI committee of findings. QAPI committee will determine the need for further monitoring or auditing.	3/28/2025

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S 352	Continued From page 10 significant change in a resident's condition, and annually. *They were aware the revised 5/29/24 Resident assessment policy did not include wording to complete that assessment 30 days following a resident's admission to the facility. *The policy included wording that some states may require additional periodic evaluations; refer to state specific regulations. 3. Review of provider's revised 5/29/24 Resident Assessment Policy revealed: *"Purpose: To define the assessment process for assisted living residents to determine health concerns and needs." *"A. The Level of Care Evaluation-AL or Nursing Assessment and Level of Care Evaluation-AL (PCC/EMR)-will be completed by a licensed nurse (LPN or RN as required by state assisted living and board of nursing regulations) for each resident prior to or upon admission, annually, and upon significant change in condition. Some states may require additional periodic evaluations; refer to state specific regulations."	S 352		
S 630	44:70:07:04 Storage And Labeling Of Medications All medications must be stored in a well illuminated, locked storage area that is well ventilated, maintained at a temperature appropriate for medication storage, and inaccessible to residents and visitors at all times. Medications suitable for storage at room temperature must be maintained between fifty-nine and eighty-six degrees Fahrenheit, or between fifteen and thirty degrees centigrade. Medications that require refrigeration must be maintained between thirty-six and forty-six degrees Fahrenheit, or between two and eight	S 630		

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S 630	Continued From page 11 degrees centigrade. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview and policy review the provider failed to ensure two of two medication refrigerators were temperature checked and documented at least daily by staff. Findings include: 1. Observation on 3/26/25 at 9:08 a.m. of the evergreen unit medication refrigerator revealed: *The temperature in the refrigerator was 36 degrees Fahrenheit. *The evergreen unit medication refrigerator log had several missed temperature checks. -No temperature checks had been documented from 3/1/25 through 3/5/25 an from 3/13/25 through 3/18/25. -Only one pm (p.m.) temperature check had been documented on 3/6/25 and 3/20/25. -Only one am (a.m.) temperature check had been documented on 3/12/25, 3/19/25, and from 3/24/25 through 3/26/25. 2. Observation on 3/26/25 at 9:25 a.m. of the willow unit medication refrigerator log revealed: *No temperature checks had been documented from 3/10/25 through 3/11/25 nd from 3/22/25 through 3/23/25. *Only one pm (p.m.) temperature check had been documented on 3/14/25, 3/17/25 through 3/21/25, and 3/24/25 through 3/25/25. 3. Interview on 3/26/25 at 9:25 a.m. with certified medication aide (CMA) D revealed: *Temperatures should be documented twice daily, once on the day shift and once on the night shift. *Staff who had the keys were to complete the	S 630	S630 1. Staff education will be completed by Assisted living manager at staff meeting on 4/15/2025. Assisted living manager will review the Medication Acquisition, Receiving, Packing and Storage policy ensuring that all staff know that refrigeration temperatures need to be recorded daily on temperature log and that the refrigerator temperature range needs to be between 36 degrees Fahrenheit and 46 degrees Fahrenheit. Education will be given on procedure if temperature is not within acceptable temperature range. 2. Assisted living manager, or designee, will complete audits of refrigeration temperature log weekly x4 and then monthly x3. Assisted living manager will report to QAPI committee of findings. QAPI committee will determine the need for further monitoring or auditing. 3. Education will be covered in staff meeting on 4/15/2025.	5/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	67392	A. BUILDING: _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY PRAIRIE CREEK MEMO	4309 W CREEKSIDE CIRCLE SIOUX FALLS, SD 57106

(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 630	Continued From page 12 temperature logs. 4. Interview on 3/26/25 at 10:10 a.m. with registered nurse (RN) C revealed: *CMAs were to document the refrigerator temperatures in the log. *She was unsure how often this is completed. *Manager B was to keep those logs and follow up on that task. 5. Interview on 3/26/25 at 10:16 a.m. with manager B revealed: *AM shift staff with the keys were to document the temperatures on the medication refrigerator log. *She monitored that they are being completed. *She looked at them throughout the month. *The logs were turned in to her at the end of the month. *She had worked on the willow unit in the beginning of March 2025. *She had not seen the logs recently. 6. Review of the provider's revised 9/23/24 Medication acquisition, receiving, packaging and storage Policy revealed: *"Purpose to define the assisted living community's (ALC) process regarding ordering, receiving, packaging and storage of medications." *11. Refrigerators holding medications (such as insulin, etc.) will have temperatures maintained between 36 degrees F (Fahrenheit) and 46 degrees F. Medication room temperatures will maintain between 59 degrees F and 86 degrees F. Refrigerator temperatures will be checked daily, adjusted as necessary and documented on the Refrigerator/Freezer Temperature Log.	S 630		