STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435087	A. BUILDING _____ B. WING _____	12/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 12/2/24 through 12/4/24. Good Samaritan Society Canistota was found not in compliance with the following requirements: F625, F655, and F812.	F 000		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.	F 625	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 the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. F625- Notice of Bed Hold Policy Before/Upon Transfer 1. Corrective action to residents affected: Identified resident 9 and resident 46's missing bed hold policy. Provided resident 9 & 46 with current bed hold policy. 2. Identify other potential Residents affected: All other facility transfers reviewed for the past 3 months to identify any others affected. 3. Measures put into place or systemic changes made to ensure that will not recur: Directed in-services education: Charge Nurses, DON, MDS, and Social Services will be educated on the current bed hold policy and procedure.	01-08-25

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

TITLE: Administrator

(X6) DATE: 12/30/24

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435087	A. BUILDING _____ B. WING _____	12/04/2024

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

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F 625	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review the provider failed to provide bed-hod notices to residents and/or their representatives regarding transfers to the hospital on two of three occasions for two of two sampled residents (9 and 46). Findings include: 1. Interview on 12/3/24 at 8:59 a.m. with resident 9 revealed she: *Had gone to the hospital. *Was there for a long time. *Could not remember why she was in the hospital. Review of resident 9's electronic medical record (EMR) revealed: *She was transported to the emergency department (ED) on 7/23/24 and was admitted to the hospital. *Her power of attorney (POA) was notified by phone of her transfer. *She returned to the facility from the hospital on 7/29/24 with diagnoses of urinary tract infection (UTI) and pneumonia. *Resident 9's POA called the provider on 7/31/24 to inform them he was notified resident 9 was being taken to the ED for an evaluation, but he was not notified she had been admitted. *There was no documentation in her EMR that indicated bed-hold information was given to her or her POA. 2. Interview on 12/3/24 at 9:25 a.m. with resident 46 revealed she did not think she had gone to the hospital recently. Review of resident 46's EMR revealed:	F 625	4.Monitor process for the system change including frequency and person responsible: Administrator or designee will complete audits to ensure bed policy was properly obtained when a resident is transferred to a hospital for 2 x month for 6 months. All audits will be taken to QAPI quarterly until the facility demonstrates sustained compliance as determined by the committee.	

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F 625	Continued From page 2	F 625		

*She was transferred to the hospital on 4/21/24.
-Her POA was notified by phone of her transfer.
-There was no documentation in her EMR that indicated the bed-hold information was given to her or her POA.
*She was transferred to the hospital on 6/7/24.
-Her POA was notified by phone of her transfer.
-A bed-hold was signed by resident 46's POA on 6/10/24.

3. Interview on 12/4/24 at 3:22 p.m. with social worker C regarding the bed-hold notifications revealed:
*She was responsible for issuing the bed-hold notifications.
*The hospitalization for resident 46 happened on a Sunday and it did not get communicated to her.
*She thought it was the nurse's responsibility to issue a bed-hold notification if it was at night or on a weekend.
*She would have issued a bed-hold notice on Monday morning.
*She agreed the bed-hold notifications were not given to the above residents or their POA.

4. Interview with administrator A at 4:02 p.m. regarding bed-hold notifications revealed:
*She knew a resident/responsible party must be notified of the bed-hold when residents transferred to the hospital.
*They had a checklist that staff were to follow for transfers.
*Her expectation was the social worker would issue the bed-hold notifications during normal business hours and the charge nurse would issue it during nights and weekends.
*She agreed bed-hold notifications were not being issued appropriately.

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F 625	Continued From page 3 5. Review of the provider's 12/7/23 Bed-Hold policy revealed: *"Purpose: To ensure that the resident/resident representative is made aware of the facility's bed hold and reserve bed payment policy before and upon transfer to a hospital or when taking a therapeutic leave of absence from the facility." *"Policy: At the time of admission, transfer or therapeutic leave, the location will provide written information to the resident or resident representative that specifies:" -"1. The duration of the state bed-hold policy, if any, during which a resident is permitted to return and resume residence." -"2. The reserve bed payment policy in the state plan." -"3. The location's policy regarding bed-hold periods permitting a resident to return." *"In Case of Emergency Transfer." -"1. b. The charge nurse is responsible for completion of notification procedures if the transfer occurs at a time the social worker is not at the location." -"2. The social worker or designated individual will contact the resident/resident representative to inquire regarding their decision for holding a bed." -"3. In cases where the facility was unable to notify the resident representative, the social worker or designated individual will document multiple attempts to reach the resident's representative."	F 625		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and	F 655	F655- Baseline Care Plan 1. Corrective action to residents affected: Resident 42's care plan was identified as missing a baseline care plan. Resident 42 received copy of care plan and signed it on 12/4/24.	01-08-25

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F 655	Continued From page 4 implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.	F 655	2. Identify other potential Residents affected: All other residents admitted in the past 6 months have been reviewed to identify any others affected. 3. Measures put into place or systemic changes made to ensure that will not recur: Directed in-services education: Interdisciplinary team will be educated on baseline care plans and family notification proccesses. 4. Monitor process for the system change including frequency and person responsible: Administrator or designee will complete audits to ensure Baseline Care Plan was completed and notification given to family/POA for 1 x week for 6 months. All audits will be taken to QAPI quarterly until the facility demonstrates sustained compliance as determined by the committee.	

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F 655	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review the provider failed to ensure one of one sampled resident (42) had reviewed and was provided a summary of her baseline care plan within forty eight hours of admission. Findings include: 1. Review of resident 42's electronic medical record (EMR) revealed: *She had been admitted on 4/30/24. *She was admitted from an inpatient psychiatric facility. *She was diagnosed with unspecified mood [affective] disorder, mild neurocognitive disorder due to known physiological condition with behavioral disturbance, liver cell carcinoma, and long term use of anticoagulants. *Her Brief Interview for Mental Status (BIMS) assessment score was 12 which indicated moderate cognitive impairment. *There was no documentation of a power of attorney (POA) until 9/18/24. *Her baseline care plan was not signed as completed until 11/4/24. *There was no documentation in her EMR that a baseline care plan summary had been reviewed with the resident. 2. Interview on 12/4/24 at 2:25 p.m. with director of nursing (DON) B regarding residents' baseline care plans revealed: *The Minimum Data Set (MDS) nurse F completed the baseline care plans. *She guessed resident 42's baseline care plan had been signed as completed on 11/4/24 at her care conference.	F 655		

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F 655	Continued From page 6 3. Interview on 12/4/24 at 3:11 p.m. with resident 42 about her baseline care plan revealed: *She did not remember reviewing her baseline care plan when she was admitted to the facility. *She did not remember signing a baseline care plan when she was admitted to the facility. 4. Interview on 12/4/24 at 3:46 p.m. with MDS nurse F revealed: *She completed the nursing portion of the baseline care plans. *She did not have any documentation if they had reviewed or given a summary of resident 42's baseline care plan with her at the time of her admission. 5. Review of the provider's revised December 2, 2024 Care Plan policy revealed: *"A baseline care plan includes instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care." *"A baseline care plan will be developed upon admission according to federal and state regulations. The location must provide the resident and resident representative with a written summary of the baseline care plan. Use the PN-Care Conference Note/or Matrix equivalent to document that the meeting occurred with the resident and representative and any significant discussion that occurred."	F 655		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812	F-812 Food Procurement, Store/Prepare/Serve-Sanitary 1. Corrective action to residents affected: No residents were identified. Repair man came and repaired dishwasher. Dirty items were removed and cleaned according to policy. Food was removed from above steam table.	01-08-25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 7 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review the provider failed to ensure: *Necessary food safety guidelines were followed for appropriate storage of resident food items. *Proper cleaning procedures were followed for dishes used to store, prepare, and serve residents' food in one of one main kitchen. Findings include: 1. Observation on 12/2/24 at 3:06 p.m. during the initial tour of the main kitchen revealed: *Three uncovered bowls of breakfast cereal stacked on top of each other inside the cupboard above the steam table. *Three soup bowls and three soup cups inside another cupboard with food residue on them. Interview on 12/2/24 at 3:25 p.m. with cook E regarding the items in the above cupboards revealed: *The bowls of breakfast cereal had been put in the cupboard after breakfast.	F 812	2. Identify other potential Residents affected: No other residents were affected. 3. Measures put into place or systemic changes made to ensure that will not recur: Directed in-services education: Dietary staff will be educated on the proper food porcurement, store/ prepare/serve-sanitary processes according to our GSS policies. 4.Monitor process for the system change including frequency and person responsible: Dietary manager or designee will complete audits to ensure Food Storage and kitchen sanitation was properly followed for 2 x week for 4 weeks, 1 x for 4 weeks, and 1 x monthly for 3 months with all audits will be taken to QAPI quarterly until the facility demonstrates sustained compliance as determined by the committee.	

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F 812	Continued From page 8 *The booster heater had gone out of the commercial dishwasher and had not been working for two weeks. *The staff were washing the dishes by hand. *The staff were checking water temperatures and sanitizer levels while doing dishes by hand. *The new booster heater was scheduled to be delivered on 12/3/24. Interview and record review on 12/2/24 at 5:03 p.m. with nutrition and food services supervisor D regarding the items in the cupboard and the commercial dishwasher revealed: *She did not know why the bowls of cereal were in the cupboard. *Her expectation was no food items would be stacked on top of each other or uncovered. *She confirmed the booster heater for the commercial dishwasher had gone out two weeks ago. *The soup bowls and cups observed above had been rewashed to ensure they were clean before being used. *The staff were monitoring water temperatures and sanitizer levels while washing dishes by hand. *Review of the documented water temperatures and sanitizer level logs confirmed the levels were in compliance. Observation on 12/4//24 at 3:45 p.m. of the commercial dishwasher in the main kitchen revealed the booster heater was being replaced by a service technician. Review of the provider's 5/7/24 Food-Supply Storage-Food and Nutrition Services policy revealed: *"7. Foods that have been opened or prepared	F 812		

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F 812	Continued From page 9 are placed in an enclosed container, dated, labeled and stored properly." *"8. Items being prepared for the next meal do not have to be dated and labeled but must be covered. Once meal service is over, cover, date and label trays of individually-portioned items such as desserts, salads, glasses of juice, milk and supplements." Review of the provider's 3/25/24 Warewashing-Mechanical and Manual-Food and Nutrition policy revealed: *"Food and nutrition employees ensure that food preparation equipment, dishes and utensils are effectively cleaned, sanitized to destroy potential disease carrying organisms and stored in a protective manner." *"Manual Ware Washing. Pots, pans and any other utensils or wares will be scraped, washed, rinsed and sanitized."	F 812		

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	435087	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/03/2024**

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GOOD SAMARITAN SOCIETY CANISTOTA	**700 WEST MAIN ST** **CANISTOTA, SD 57012**

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K 000	INITIAL COMMENTS A recertification survey for compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities was conducted on 12/3/24. Good Samaritan Society Canistota was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 12/4/24. Please mark an F in the completion date column for K241 and K374 deficiencies identified as meeting the FSES, in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	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 the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
K 241 SS=C	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced by: Based on observation and record review, the provider failed to maintain at least two conforming exits from each floor of the building. One of two floors (basement) did not have two conforming exits. Findings include: 1. Observation on 12/3/24 at 12:43 p.m. revealed	K 241		F

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

TITLE: Administrator

(X6) DATE: 12/24/24

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K 241	Continued From page 1 there was only one exit provided from the basement boiler room. The only exit was a stair enclosure that discharged into the vestibule on the main level. Review of previous survey data also identified that condition. The building meets the FSES. Please mark an F in the completion date column to indicate the provider's intent to correct deficiencies identified in K000. That deficiency would only affect one or two maintenance personnel if in the basement during a fire emergency.	K 241		
K 374 SS=C	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on measurement and document review, the provider failed to maintain at least thirty-two inches of clear width for two of two smoke barrier doors (100 and 200 wings). Findings include:	K 374		F

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 374	Continued From page 2 1. Measurement on 12/3/24 at 2:21 p.m. revealed the cross-corridor doors to the 100-wing measured thirty-one inches of clear width. Further measurement revealed the cross-corridor doors to the 200-wing adjacent to the nurses' station measured thirty inches of clear width. Review of the previous life safety code survey confirmed those findings. The building meets the FSES. Please mark an F in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K 374		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435087	A. BUILDING _____ B. WING _____	12/03/2024

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GOOD SAMARITAN SOCIETY CANISTOTA	700 WEST MAIN ST CANISTOTA, SD 57012

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness requirements for Long Term Care Facilities, was conducted on 12/3/24. Good Samaritan Society Canistota was found in compliance.	E 000		

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

Administrator | 12/24/24

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 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.

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10603	A. BUILDING: _____ B. WING _____	12/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 12/2/24 through 12/4/24. Good Samaritan Society Canistota was found in compliance.	S 000		

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

Administrator | 12/24/24