STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435045	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD , SIOUX FALLS, South Dakota, 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) 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 6/29/26 through 7/2/26. Good Samaritan Society Sioux Falls Village was found not in compliance with the following requirements: F550, F684, F761, F812, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/29/26 through 7/2/26. Areas surveyed included potential resident abuse and potential financial exploitation, missing medication patches, an elopement, a resident fall that resulted in a major injury, and the quality of care related to residents who were immunocompromised and received dialysis treatments. Good Samaritan Society Sioux Falls Village was found not in compliance with the following requirement: F689.	F0000		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, record review, observation, and policy review, the provider failed to ensure that one of one certified nursing assistant (CNA) (AA) used a gait belt (a waist strap gripped as support for safe mobility and transfers)	F0689	1. Resident 91's activities of daily living care plan was reviewed and updated by the Clinical Care Leader on 7/21/26 to accurately reflect the assistance required for care and transfers. On 6/29/26 employee AA was educated by Clinical Care Leader on resident 91's care plan and the importance of following resident-specific activities of daily living interventions. 2. By 6/26/26 nurse leadership audited all resident care plans to ensure activities of daily living	7/24/26

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dana Ballou	Administrator	7/27/2026

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F0689 SS = G	Continued from page 1 while ambulating (walking) one of one sampled resident (91) to the bathroom, resulting in a fall and broken femur for resident 91. Findings include: 1. Review of the provider's 6/23/26 SD DOH FRI revealed that at 8 a.m. on 6/23/26, resident 91 was ambulating to the bathroom using her front-wheeled walker (FWW) (a device with two wheels on the front legs and rubber tips on the back legs, designed for individuals who need stability and partial weight-bearing support) as CNA AA provided contact guard assistance (CGA) (hands-on physical light touch to support an individual without actively supporting their body weight), but did not use a gait belt. Resident 91 lost her balance and fell and suffered an elbow abrasion and a broken femur that required surgery to repair. Following surgery, resident 91 readmitted to the facility on 6/26/26. 2. Review of resident 91's electronic medical record (EMR) revealed that she admitted to the facility on 11/11/25. She had diagnoses of chronic obstructive pulmonary disease (a progressive, incurable lung condition that makes it hard to breathe), dementia (a group of symptoms affecting memory, thinking, and social abilities), and repeated falls, with a history of traumatic brain injury (caused by a bump, blow, jolt, or penetrating wound to the head that disrupts normal brain functions). Her 6/29/26 Brief Interview for Mental Status (BIMS) assessment score was 13, which indicated her cognition was intact. A 6/1/26 fall assessment score of 14 indicated she had a moderate risk for falling, displayed intermittent confusion, had an ambulation status of "chairbound," and did not experience any falls during the past three months. Her 6/23/26 fall assessment completed at 1:58 p.m. was six, which indicated she had a low risk of falling, did not experience any falls during the past three months, was alert and oriented, and was chairbound. Resident 91's 6/23/26 care plan (a personalized plan that addresses a resident's care needs, goals, and interventions) indicated that for toileting and transferring, she required one staff member to assist her in a pivot transfer (when assisted to a standing position, the resident then turns their body to move to another surface) using a gait belt, wheelchair, or a sit-to-stand lift (a mechanical lift used to assist from	F0689	interventions accurately reflected the assistance required and how staff were to provide care. 3. To ensure the deficient practice does not recur, the Director of Nursing or designee will educate all nursing staff on their roles, responsibilities, and assigned tasks related to fall prevention and gait belt use, and adherence to resident-specific care plan interventions. Education will be completed by 7/24/26 or prior to the employee's next scheduled shift. 4. To monitor performance and ensure ongoing compliance Director of Nursing or designee will audit five residents at risk for falls, looking at their care plan interventions and observing activities of daily living to ensure cares provided match the care plan. Audits will be completed weekly x4, bi-weekly x2, monthly x1 and quarterly x1. The results of those audits will be brought to the QAPI committee by the Director of Nursing or designee for review and recommendations.	

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F0689 SS = G	Continued from page 2 a seated to a standing position) as needed. 3. Interview on 6/30/26 at 3:12 p.m. with Administrator A revealed that she felt the terminology used in the residents' care plans (personalized plan that addresses a resident's care needs, goals, and interventions) needed to be clarified to avoid misinterpretation of a resident's level of assistance. Before she fell on 6/23/26, resident 91's care plan specified that she needed staff assistance with her activities of daily living (ADLs: routine self-care tasks people perform every day to maintain independence) due to impaired mobility and weakness. Her intervention for ambulation read, "CGA with [the] use of [a] FWW. I use [a] wheelchair for primary locomotion." Administrator A wanted to replace "CGA," a therapy acronym for contact guard assist, with "assist of one staff member with gait belt," so it was clearer for the staff to understand. After resident 91 fell on 6/23/26, Administrator A reviewed all the residents' care plans to update the terminology used for the ambulation and locomotion interventions and to ensure that the resident's fall assessment scores accurately reflected the resident's risk of falling. 4. Observation and interview on 6/30/26 at 4:02 p.m. in resident 91's room with the resident and her family member revealed that before she fell on 6/23/26, for short-distance trips to the bathroom, she used a walker to help keep her balance when she walked. If she left her room, she used a wheelchair and was able to propel it independently. Resident 91 recalled that on the morning of 6/23/26, as she neared the bathroom door, she saw her roommate's pajamas lying on the floor and told CNA AA, "Those are in my way." CNA AA replied, "Go ahead, you'll be ok." Resident 91 said she moved forward, tripped on the pajamas, and fell backwards, hitting the back of her head on the floor. Her family member said he was surprised CNA AA did not pick up the pajamas or use a gait belt. Resident 91 said the staff does not always use a gait belt when assisting her. "It just depends on who's helping me," she said. 5. Interview on 6/30/26 at 4:24 p.m. with registered nurse (RN)/clinical nurse leader I revealed that she	F0689		

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F0689 SS = G	Continued from page 3 expected staff members to reference a resident's Kardex (a report listing the resident's care needs and interventions) to know whether they should use a gait belt when assisting with transfers, walking, and toileting tasks. The staff were to use a gait belt if specified in the Kardex and be aware of all care plan updates posted in the nurse's station. She was aware that resident 91 said she tripped on pajamas that were on the bathroom floor, but CNA AA recalled nothing lying on the floor. RN/clinical nurse leader I said recent complications from resident 91's COPD could have caused resident 91 to become confused. Resident 91 did not require the use of a gait belt when ambulating to the bathroom, and she used a wheelchair when traveling longer distances, such as to the dining room. 6. Interview on 7/1/26 at 11:01 a.m. with certified occupational therapy assistant (COTA) DD revealed that it was standard protocol for the therapy staff to use a gait belt when assisting residents. She did not know whether resident 91 needed to use a gait belt and would prefer that all CNAs used a gait belt when assisting residents, regardless of their status. She said, "If someone were to lose their balance while walking, the gait belt is something they can grab onto." 7. Interview on 7/1/26 at 11:20 a.m. with CNA AA revealed that she referenced a resident's Kardex to know whether they required a gait belt when being assisted by the staff. On 6/23/26, she was assisting resident 91's roommate when resident 91 said she needed to use the bathroom. CNA AA did not know if resident 91 needed a gait belt but knew she used a walker, "so that's what I did with her." As they neared the bathroom door, resident 91 fell. "She said there were clothes on the floor, but I don't think there was anything on the floor," CNA AA stated. 8. Interview on 7/1/26 at 11:30 a.m. with certified medication aide (CMA) Y revealed that she referenced a resident's Kardex to determine their level of assistance and that the Kardex could change frequently. She said, "We work with new residents every day, so I always check [the Kardex] if I don't know." 9. Interview on 7/1/26 at 11:33 a.m. with director of nursing (DON) B revealed that she expected the staff to reference a resident's care plan or Kardex to determine the level of assistance they required. Staff	F0689		

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F0689 SS = G	Continued from page 4 members who were helping someone they did not routinely work with should ask another staff member about their needs or refer to the care plan. She said, "All staff have access to the care plan and the Kardex." 10. Interview on 7/1/26 at 3:45 p.m. with physical therapist supervisor EE revealed that before she fell on 6/23/26, resident 91 was participating in physical therapy to increase strength and endurance. She stated that although therapy staff used a gait belt when assisting residents, some staff members did not use a gait belt. "Therapy will recommend how a resident should transfer, whether that's with a gait belt or a lift and one or two staff [members] assisting them," she said, but the nursing team ultimately specified the resident's assistance needs on the resident's care plan. 11. Interview on 7/1/26 at 3:53 p.m. with CMA BB revealed that she referenced the residents' care plans or the Kardex to determine their needs during a transfer. She said the Kardex would specify the use of a gait belt if a resident required that level of assistance, but she did not think resident 91 needed a gait belt. 12. Interview on 7/2/26 at 9:05 a.m. with CNA/restorative nursing aide (RNA) CC revealed that she was working as a CNA in the special care unit (an area where specialized care is provided in a structured, safe, and supportive environment to meet the unique needs of residents with significant memory and cognitive decline, that is secured to minimize unsafe wandering). Her primary role was to assist residents with restorative therapy exercises (designed to help residents maintain or improve their functional independence). She referenced a resident's Kardex to determine their required level of assistance. She said "it's common sense" to use a gait belt when helping residents stand up and when walking with residents who are unstable or cognitively impaired. 13. Interview on 7/2/26 at 9:50 a.m. with DON B revealed the nursing team or the therapy team evaluated residents to determine the level of supervision they required for transfers, toileting, and walking. The nursing team conducted fall assessments quarterly, after each fall, and when a resident's health status changed.	F0689		

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F0689 SS = G	Continued from page 5 15. Review of the provider's 4/30/26 Gait-Transfer Belt policy revealed that gait belts are "a device used for stability and/or support for a short time during the actual transfer or ambulation," and should be used with assisted ambulation unless medically contraindicated. 16. Review of the provider's 12/1/25 Care Plan policy revealed that the residents' care plans were reviewed and modified at least quarterly and when there was a significant change in a resident's condition. The care plan should reflect the care currently required/provided for the resident.	F0689		
F0684 SS = E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on the interviews, record review, observation, and policy review, the provider failed to ensure the staff responded promptly to twelve of thirty-one sampled residents (13, 14, 21, 27, 59, 73, 85, 89, 119, 123, 155, and 164) who reported concerns related to extended call light times. Findings include: 1. Interview on 6/28/26 at 4:03 p.m. with resident 13 revealed that he felt call lights were not answered in a timely manner. He stated, "These [call lights] don't get answered." 2. Review of resident 13's call light response time report (a report of call light usage and time it took for the residents' call lights to be answered by the staff) from 6/1/26 through 6/30/26 revealed that twenty call light response times were more than 20 minutes long, four were more than 30 minutes, one was more than 40 minutes, two were more than 50	F0684	1. By 7/24/26, call light reports for residents 14, 21, 27, 59, 73, 85, 89, 119, 123, 155, and 164 were reviewed, tracked, and trended to identify opportunities for improvement in call light response times. By 7/24/25 Social Services met with residents 14, 21, 27, 59, 73, 85, 89, 119, 123, 155, and 164 to get their perspective on call light wait times and help with action planning. Resident 13 had discharged and was no longer residing in the facility. 2. All residents have the potential to be at risk by this deficient practice. By 7/24/26 call light response reports were reviewed on each unit to identify patterns, trends, and opportunities for improvement in timely staff response to resident requests. 3. To ensure the deficient practice does not recur the Administrator or designee will educate all staff on	7/24/26

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F0684 SS = E	Continued from page 6 minutes, and one response time was greater than 90 minutes. 3. Interview on 6/29/26 at 2:56 p.m. with resident 59 revealed that he had to wait at least 30 minutes to have his call light answered. He sometimes called the facility phone number to get help. The weekends and holidays had longer wait times, and if a holiday occurred during the weekend, it was worse. Nothing bad had happened to him yet, but he worried and got irritated when he had to wait a long time. 4. Review of resident 59's electronic medical record (EMR) revealed he admitted to the facility on 1/25/12. His 5/7/26 Brief Interview for Mental Status (BIMS) assessment score was 10, which indicated his cognition was mildly impaired. His diagnoses included right leg above the knee amputation, anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), major depressive disorder, and Parkinson's disease with dyskinesia (a brain disorder that gradually affects movement, causing symptoms like shaking, stiffness, and slowed motion because the brain loses cells that make dopamine with involuntary, uncontrolled movements). His undated care plan indicated he may need the staff's assistance for long distances in his wheelchair. He needed one staff member's assistance with bathing, bed mobility, dressing, grooming, oral care, personal hygiene, and toilet use. He needed two staff members' assistance for transfers using the total body lift (a mechanical lift and sling used to lift a person's full body). 5. Review of resident 59's call light response time report from 6/1/26 through 6/30/26 revealed he had ten call light response times over 20 minutes long, and one call light response time was 150 minutes long. 6. Interview on 6/29/26 at 3:09 p.m. with resident 164 revealed that she has had to wait up to 20 minutes for her call light to be answered. She said, "When I have to go to the bathroom, that gets really bad. I end up peeing, and that makes me feel inhumane."	F0684	their roles, responsibilities, and assigned tasks regarding timely call light responses and the importance of promptly responding to resident needs. Education will be completed by 7/24/26 or prior to the employee's next scheduled shift. An audit of all pagers in the facility will be completed by the Ancillary Services Supervisor by 7/24/26 and determined if more pagers need to be ordered by 7/24/26. 4. To monitor performance and ensure ongoing compliance the Administrator or designee will audit five residents, from various units, their call lights for an entire 24-hour period weekly x4, bi-weekly x2, monthly x1 and quarterly x1. Administrator or designee will interview 5 residents' weekly r/t their satisfaction with call light wait times weekly x4, bi-weekly x2, monthly x1 and quarterly x1. The results of those audits and interviews will be brought to the QAPI committee by the Administrator or designee for review and recommendations.	

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F0684 SS = E	Continued from page 7 7. Review of resident 164's EMR revealed she admitted to the facility on 6/10/26. Her 6/15/26 BIMS assessment score was 15, which indicated her cognition was intact. Her diagnoses included chronic kidney disease stage 3, history of urinary tract infections (UTIs), and repeated falls. Her 7/1/26 care plan indicated she used a wheelchair for mobility. She needed the assistance of one staff member for bathing, bed mobility, dressing, eating, oral care, personal hygiene, toilet use, and transfers. She was to be toileted after each meal and at bedtime to prevent skin breakdown due to incontinence (involuntary urine or bowel leakage) and brief use. 8.Review of resident 164's call light response time report from 6/2/26 to 6/30/26 revealed she had two call light response times over 20 minutes long. 9. Interview on 6/30/26 at 9:15 a.m. with resident 21 revealed that about a week ago, resident 21's call light was on for over an hour. She had turned her call light on, and no one came to assist her. Resident 21 went down to breakfast and when she returned, her call light was still on. Resident 21 went to restorative therapy, and when she returned, her call light was shut off. No one came to find out what she needed; someone just turned her call light off. She stated, "I am scared no one will answer my call light, when I need help." Her roommate, resident 27, used her call light "a lot." 10. Review of resident 21's EMR revealed her 6/24/26 BIMS assessment score was 15, which indicated her cognition was intact. Her diagnoses included Diabetes Mellitus Type II (a condition involving disruptions in how the body regulates blood sugar), chronic pain syndrome, muscle weakness, and a history of falling. 11. Review of resident 21's call light response time report from 6/1/26 through 6/30/26 revealed she had two call light response times over 20 minutes long, and one call light response time was 127 minutes long. 12. Review of resident 27's EMR revealed her 5/27/26 BIMS assessment score was 0, which indicated her cognition was severely impaired. Her diagnoses included hemiplegia (complete or severe paralysis of one entire side of the body), and hemiparesis (partial weakness or loss of strength on one side of the body) following a cerebral infarction	F0684		

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F0684 SS = E	Continued from page 8 (stroke) affecting her left side, major depressive disorder, and down syndrome (genetic condition which alters typical development resulting in intellectual disability, development delays and distinct physical characteristics). 13. Review of resident 27's call light response time report from 6/1/26 through 6/30/26 revealed she had ninety-two call light response times over 20 minutes long, and twenty-nine call light response times over 60 minutes long. 14. Observation and interview on 6/30/26 at 8:05 a.m. in resident 85's room revealed she was lying in bed, wearing a hospital gown, and had a tracheostomy tube (a tube surgically placed through the neck into the windpipe to allow airflow) and did not require ventilatory support (a machine to breathe for her). She stated that there was a resident down her hallway that CNAs were in her room for two to four hours at a time, and that she and other residents down that hallway have to wait a long time for staff's assistance. Sometimes, when she had to wait a long time for staff to answer her call light, she needed a nebulizer treatment to loosen her secretions. She did not have any shortness of breath. She was more worried about the other residents having to wait a long time for staff assistance. She completed some of the care for her trach by herself, and she took the cap off to clear the secretions around it. When doing this once, the trach came out. Nothing bad happened when that occurred, and the nurse came in right away and replaced it. 15. Review of resident 85's EMR revealed she admitted to the facility on 1/8/20. Her 5/22/26 BIMS assessment score was 15, which indicated her cognition was intact. She had diagnoses of dysphagia (difficulty swallowing), tracheostomy, hypertension (elevated blood pressure), Major Depressive Disorder (a mental health condition that causes a persistent feeling of sadness, emptiness, and loss of interest in activities once enjoyed), atrial fibrillation (irregular heartbeat), and weakness. Her 5/26/26 care plan revealed that she had a tracheostomy and sometimes pulled it out when she adjusted it. She required the assistance of one staff member and the sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position) to be transferred and one staff member to get dressed and reposition in bed. She required	F0684		

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F0684 SS = E	Continued from page 9 extensive assistance with using the toilet and for personal hygiene care. 16. Review of resident 85's call light response time report from 6/1/26 to 6/30/26 revealed she had three call light response times over 20 minutes long and one call light response time over 40 minutes long. 17. Observation and interview on 6/30/26 at 9:53 a.m. in resident 14's room revealed she was lying in bed wearing a hospital gown, and had her left arm and both legs propped up with pillows. She stated that it sometimes took staff "hours" to answer her call light. She stated that sometimes she needed to have the staff position her legs differently, and she experienced pain when she waited a long time for the staff to answer her call light. 18. Review of resident 14's EMR revealed she admitted to the facility in October 2025. Her 5/5/26 BIMS assessment score was 15, which indicated her cognition was intact. She had diagnoses of complex regional pain syndrome of the right upper limb (a chronic neurological condition causing severe, persistent pain to her right arm), depression, generalized anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), muscle spasms (a sudden, involuntary contraction of a muscle), and quadriplegia (the partial or total paralysis of all four limbs and torso). Resident 14's 6/30/26 care plan indicated that she had chronic pain, and non-pharmacological (non-medicated) interventions to reposition her. She required two staff members to reposition her in bed and total staff assistance with getting dressed and her personal hygiene. She required two staff members and a total body lift (a mechanical lift and sling used to lift a person's full body) to be transferred. She was particular about her care and sometimes required three staff members to assist her. 19. Review of resident 14's call light response time report from 6/1/26 to 6/30/26 revealed she had twenty-three call light response times over 20 minutes long, nine call light response times over 30 minutes long, four call light response times over 40 minutes long, one call light response time over 60 minutes long, one call light response times were	F0684		

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F0684 SS = E	Continued from page 10 over 80 minutes long, and one call light response time of 112 minutes long. 20. Interview on 6/30/26 at 10:38 a.m. with resident 73 revealed that he had waited 45 minutes to get his call light answered. He would get anxious when he had to wait a long time for his call light to be answered because he was blind and unable to see anyone to get help. 21. Review of resident 73's EMR revealed he admitted to the facility on 4/22/26. His 5/7/26 BIMS assessment score was 15, which indicated his cognition was intact. His diagnoses included legal blindness, sensorineural hearing loss (a permanent type of hearing loss caused by damage to the inner ear), retention of urine, and weakness. His 7/1/26 care plan indicated he required one staff member's assistance for wheelchair mobility, bathing, bed mobility, dressing, grooming, eating, oral care, personal hygiene, and toilet use. He required two staff to assist him with transfers. He had an indwelling urinary catheter (flexible tubing inserted into the bladder to drain urine). 22. Review of resident 73's call light response time report from 6/1/26 to 6/30/26 revealed he had four call light response times over 20 minutes long. 23. Interview on 6/30/26 at 2:30 p.m. with certified nursing assistant (CNA) D revealed that the staff were expected to answer the residents' call lights within five minutes. She carried a radio that alerted her when the residents' call lights were turned on, and monitors located in the hallway near the ceiling alerted the staff of the activated call lights. 24. Observation and interview on 6/30/26 at 3:05 p.m. of resident 155's call light with activity assistant II revealed that she turned on resident 155's call light and was waiting for the staff to transfer resident 155 to her wheelchair. Activity assistant II would then take resident 155 to an activity. Activity assistant II indicated that both CNAs that were assigned to resident 155's hallway were in resident 14's room.	F0684		

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F0684 SS = E	Continued from page 11 25. Observation on 6/30/26 at 3:06 p.m. in resident 14's room revealed that certified medication aide (CMA) KK and CNA LL were assisting resident 14 with personal hygiene care. 26. Observation and interview on 6/30/26 at 3:24 p.m. revealed that CMA KK answered resident 155's call light. Activity assistant II reported she had to wait almost every day for a long time for staff to transfer a resident for her so she could take them to the activity, and stated, "Now the activity is over." There was a teaching cooking activity in the main dining room that resident 155 missed. She said she turned resident 155's call light on about five to seven minutes before talking to her on 6/30/26 at 3:05 p.m. 27. Interview on 6/30/26 at 3:27 p.m. with CNA LL and CMA KK revealed CNA LL started working at the facility in March 2026 and CMA KK started in November 2025. Resident 14 required two staff members to assist her with part of her care. Her morning care could take up to three hours, and her afternoon care took about an hour. Two staff members would be in her room for about 30 to 45 minutes. CNA LL and CMA KK were scheduled to work the 600 hall, and they did not have an extra CNA to help that day. They notified the nurse before going into resident 14's room to help answer call lights. Neither CNA LL or CMA KK had used a radio to communicate with other staff members since they began working at the facility due to there not being enough radios available. 28. Observation and interview on 6/30/26 at 3:40 p.m. with registered nurse (RN) FF and licensed practical nurse (LPN) GG revealed that they were sitting in the nurses' station. RN FF was assigned to work on the 500 hall, and LPN GG was assigned to work on the 600 hall. They did not carry radios and stated that there were two radios in the charging station at the nurses' station, which were usually turned on and would alert them if a call light was activated. They used the monitors hanging in the hallways to alert them if a residents call light was activated, which they could not see from the nurses' station. They verified that CNA LL and CMA KK notified them that they went into resident 14's room. They thought the CNAs on the 500 hall would	F0684		

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F0684 SS = E	Continued from page 12 help watch the 600 hall's call lights since both CNAs were in with resident 14. They used to carry radios, but they either got lost or quit working. When they were in a resident's room, they did not know when another resident's call light was on. They were expected to answer the residents' call lights within the first few minutes or to at least inform the resident that someone was coming to assist them. LPN GG stated that resident 85 had a tracheostomy tube that typically only needed to be suctioned after her nebulizer treatments and did not typically have respiratory problems. Resident 85's tracheostomy tube had fallen out once before and that "thankfully the nurse manager was really close and she came back and put one in." The staff does not know what a resident needs when they turn their call light on, and it could be an emergency. 29. Interview on 6/30/26 at 4:10 p.m. with CNA MM and CMA JJ revealed they were working on the 500 hall and were not watching for the call lights on the 600 hall. CNA MM had worked at the facility for three weeks, and CMA JJ had worked at the facility for five days, and was still on orientation. They did not carry a radio or know if they were expected to. They knew when a resident's call light went off because there was a single beep from the monitor in the hallway, and the room number would be displayed on it. If they were in a resident's room, they did not always hear the beep when another resident turned their call light on. 30. Interview on 6/30/26 at 4:15 p.m. with CNA HH revealed he was working the 500 hall. Everyone was supposed to carry the radio, but he did not grab one. When a resident's call light was turned on, the monitor screen in the hallway would make a single beep, and display on the screen. Sometimes the beep could be heard when in a resident's room if the door was not closed. He was not sure if radios were programmed to alert all staff of all call lights or if it was specific to the hallway they were working. The monitor screen on the 500 wing showed call lights for residents on the 500 wing. The monitor screen at the end of the 500 hall and to the 600 hall showed both the 500 and 600 hall call lights. Door alarm alerts went to the radios as well. 31. Interview on 7/1/26 at 8:30 a.m. with CNA D revealed she had worked at the facility since 2019 and worked on the 300 hall. She felt a resident's call light should be answered within three to five	F0684		

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F0684 SS = E	Continued from page 13 minutes. She did not have a radio on her and observed the monitors hanging in the hallways for residents' call lights. 32. Interview on 7/1/26 at 8:38 a.m. with LPN E revealed she had worked for the facility for about two years and worked on the 300 hall. She expected the residents' call lights to be answered within ten minutes in ideal situations. 33. Interviews on 7/1/26 at 10:07 a.m. at the resident council meeting revealed resident 123 stated, there were some wait times for call lights but mostly because there were other residents that needed more help and they would take up more of the staff's time. Call lights have been brought up at resident council, and [the] staff were doing what they could, but it seems like it could take a while to get a call light answered. Resident 89 indicated that she had waited two hours one morning for staff assistance before she took herself to the bathroom. 34. Observation and interview on 7/1/26 at 2:14 p.m. with resident 119 revealed that his call light was on, he was lying in bed, and was using the bedpan. He said his call light had been on for a long time. He was waiting for the staff to help him off the bedpan and then he wanted to go play Bingo. An activity assistant was waiting outside his door to assist him to Bingo. 35. Observation on 7/1/26 at 2:23 p.m. revealed resident 119's call light was answered by CNA HH. 36. Interview on 7/1/26 at 2:30 p.m. with CNA HH revealed he just started his shift at 2:15 p.m. and was working the 500 hall. He was not aware that resident 119 was using the bedpan. CNA LL was working the 500 hall with him. 37. Interview on 7/1/26 at 2:34 p.m. with CNA LL revealed she did not have a radio, and she was not aware resident 199 was on the bedpan. The other CNA just went home after the change of shift. 38. Interview on 7/1/26 at 4:00 p.m. with resident 119 revealed his call light is on for a long period of time, "more often than I like". Nothing bad happened when he had to wait for the staff, but it made him feel like he was not important.	F0684		

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F0684 SS = E	Continued from page 14 39. Review of resident 119's EMR revealed he admitted to the facility on 10/21/25. His 6/5/26 BIMS assessment score was 14, which indicated his cognition as intact. He had diagnoses of acquired absence of the right knee, dysphagia, hyperkalemia (elevated potassium [electrolytes]), End Stage Renal Disease (permanent kidney failure), essential hypertension (elevated blood pressure), Major Depressive Disorder, type 2 diabetes (a condition involving disruptions in how the body regulates blood sugar) with hyperglycemia (high blood sugar), and weakness. Resident 119's 6/18/26 care plan indicated he required supervision and touching assistance with repositioning in bed, dressing, and personal hygiene care. He required extensive assistance with using the bathroom. Staff were to offer him the bedpan for using the bathroom. He transferred using the total lift. He had falls on 11/21/25, 12/12/25, and 12/26/25, and the staff was to remind him to use his call light for assistance. 40. Review of resident 119's call light response time report from 5/30/26 to 6/30/26 revealed he had 18 call light response times over 20 minutes long, and 6 call light response times were over 30 minutes long. 41. Interview on 7/1/26 at 2:35 p.m. with CNA N revealed that she felt the resident's call lights should be answered within five to ten minutes. 42. Interview on 7/1/26 at 2:45 p.m. with CNA M revealed that he felt an appropriate time for a resident's call light to be answered was two minutes. 43. Interview on 7/1/26 at 2:58 p.m. with director of nursing (DON) B revealed she expected the resident's call lights to be answered within 20 minutes. She expected the staff to wear radios while working for communication between staff and for notifications of the call lights, and to observe the monitors in the hallways for activated call lights. She was aware of the residents' call light concerns, and educated the staff at every staff meeting to check in with the residents to ensure there were no emergencies, and to let them know the staff will return to assist them.	F0684		

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F0684 SS = E	Continued from page 15 44. Interview on 7/1/26 at 3:00 p.m. with contract travel RN L revealed that she expected a call light to be answered within two to three minutes. 45. Observation on 7/1/26 at 3:55 p.m. in the 600 hall revealed there was a call light on, it showed on the monitor screen in the 600 hall and on the monitor where halls 600 and 500 met. The call light did not show on the 500 hall monitor screen. 46. Review of the provider's 7/8/25 Call light policy revealed the purpose was "To ensure residents always have a method of calling for assistance. To promptly answer resident's call light."	F0684		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on the observation, interview, and record review, the provider failed to ensure medications were securely stored in three of ten observed medication carts by registered nurse (RN) V, RN FF,	F0761	1. By 7/21/26, medications for residents 47, 75, 89, 150, and 181 were audited by Director of Nursing to ensure they were secured when not attended by staff to ensure medications were stored appropriately and inaccessible to unauthorized individuals. By 7/24/26 employee V, FF and Z were educated on securely storing medications and medication carts when not attended by staff. 2. All residents have the potential to be at risk by this deficient practice. By 7/22/26 all medication carts and medication storage rooms were audited by Director of Nursing to ensure medications were securely stored when unattended per policy/procedure. 3. To ensure the deficient practice does not recur the Director of Nursing or designee will educate all nurses and Certified Medication	7/24/26

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F0761 SS = E	Continued from page 16 and certified medication aide (CMA) Z. Findings include: 1. Observation on 6/30/26 at 2:10 p.m. in the 700 hallway outside of resident 75's room revealed there was an opened bottle of liquid Amoxicillin-Pot Clavulanate Oral Suspension (an antibiotic) for resident 181 on top of the medication cart. There were no staff members present. 2. Observation on 6/30/26 from 2:10 p.m. to 2:13 p.m. revealed that CMA X, activities assistant W, and two unidentified visitors walked past the medication cart that had the open bottle of resident 181's unsecured antibiotic medication on top of it. 3. Observation and interview on 6/30/26 at 2:13 p.m. with clinical care leader (CCL) S revealed that she removed the bottle of antibiotic medication from the top of the medication cart and was going to return the medication to the refrigerator. RN V was the nurse assigned to that medication cart, and CCL S was unsure how long the antibiotic medication was left on top of the medication cart. CCL S expected RN V to have returned the antibiotic medication to the refrigerator or taken it with her when she left the medication cart. 4. Interview on 6/30/26 at 2:15 p.m. with CMA X revealed that she was not administering any medications that day and was not aware that there was an antibiotic medication left on top of the medication cart when she had walked past that medication cart earlier. 5. Interview on 6/30/26 at 2:27 p.m. with registered nurse RN V when she returned to the medication cart revealed she acknowledged that she had left resident 181's antibiotic medication on top of the medication cart and forgot to return the antibiotic medication to the refrigerator. She wondered where it went and was unaware that CCL S had returned that medication to the refrigerator. 6. Review of resident 181's electronic medical record (EMR) revealed she had a 6/30/26 physician's order for "Amoxicillin-Pot Clavulanate Oral Suspension. Reconstituted 400-57 MG[milligrams]/5ML[milliliter]	F0761	Aides on the proper storage of medications in accordance with Good Samaritan policy and procedure and manufacturer guidelines. Education will be completed by 7/24/26 or prior to the employee's next scheduled shift. 4. To monitor performance and ensure ongoing compliance the Director of Nursing or designee will audit three medication carts and three medication storage areas to ensure medications are stored in a locked medication cart, drawer or cupboard and stored per manufacturer guidelines. Audits will be completed weekly x4, bi-weekly x2, monthly x1 and quarterly x1. The results of those audits will be brought to the QAPI committee by the Director of Nursing or designee for review and recommendations.	

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F0761 SS = E	Continued from page 17 (Amoxicillin & Pot Clavulanate) Give 6.2 ml via [by] NG-Tube [nasogastric tube] two times a day for Acute cystitis without hematuria [a bladder infection without blood in the urine]." 7. Observation on 7/1/26 at 8:21 a.m. of RN FF preparing medications for resident 47 revealed that there was a bottle of Fluticasone nasal spray for resident 89 on top of the medication cart. RN FF prepared resident 47's medications, which included pills and a bottle of Polyethylene Glycol (a laxative). She locked the medication cart, left the bottle of Polyethylene Glycol and the Fluticasone nasal spray sitting on top of the medication cart, walked into the dining room, gave resident 47 her medications, and walked back to the medication cart that was in the hallway. 8. Observation on 7/1/26 at 8:39 a.m. of RN FF preparing medications for resident 150 revealed she prepared the medications, locked the medication cart, left the bottle of Polyethylene Glycol and Fluticasone nasal spray on top of the medication cart, walked into the dining room, gave resident 150 her medications, and walked back to the medication cart that was in the hallway. 9. Interview on 7/1/26 at 8:40 a.m. with RN FF revealed that she left the Fluticasone nasal spray on top of the medication cart so she would not forget to administer it to resident 89, who was eating. RN FF stated, "It is not a medication." She was not supposed to leave the Polyethylene Glycol bottle on her medication cart unsecured. 10. Observation and interview on 7/2/26 at 8:43 a.m. in the 200 hallway with RN/clinical nurse leader I and CMA Z revealed an unlocked medication cart with no medication aide or nurse attending it. The medication cart drawers were easily opened. RN/clinical nurse leader I witnessed the medication cart being unlocked and agreed that the medication cart should have been locked while unattended. CMA Z returned to the medication cart and reported that she thought she had locked the medication cart. She agreed that the medication cart should have been locked while it was unattended. 11. Interview on 7/2/26 at 10:00 a.m. with director of nursing (DON) B revealed that she expected medications to be locked in the medication cart and	F0761		

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F0761 SS = E	Continued from page 18 not left on the medication carts unattended, so residents would not be able to have access to them. She expected medications that needed to be refrigerated to be placed back in the refrigerator after they were used. She stated, "There are confused residents everywhere". 12. Review of the provider's 3/30/26 Medications: Acquisition Receiving Dispensing and Storage policy revealed that "medications will be stored in a locked medication cart, drawer or cupboard. All medications will be stored in accordance with manufacturers' recommendations."	F0761		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F0550	1. By 7/21/26, Resident 145 was assessed to ensure there was no lasting trauma related to the incident. By 7/6/26, Employee QQ was educated by Director of Nursing on treating residents with dignity in accordance with Good Samaritan policy and procedure. 2. All residents have the potential to be at risk by this deficient practice. Eight other residents were interviewed by QAPI RN regarding concerns r/t dignity and respect from staff. Any concerns will be addressed immediately per policy/procedure. 3. To ensure the deficient practice does not recur the Social Services Supervisor or designee will educate all staff on treating residents with dignity in accordance with Good Samaritan policy and procedure. Education will be completed by 7/24/26 or prior to the employee's next scheduled shift.	7/24/26

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F0550 SS = D	Continued from page 19 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, observation, and policy review, the provider failed to protect the resident's rights to dignity and respect for one of thirty-one sampled residents (145) who was told by registered nurse (RN) (QQ) to 'stop talking' when asking her about his medications. Findings include: 1. Observation on 7/1/26 at 8:44 a.m. of resident 145 sitting in his wheelchair in the hallway talking to RN QQ revealed he asked RN QQ, "What time should I be getting my meds [medications]?" RN QQ replied, "They are at 8:00 a.m., but I am behind today." Resident 145 said, "Well, I want to know what I get and when I get them." RN QQ said, "I'm behind, and this isn't the time, so stop talking." Resident 145 then sat in his wheelchair in the hallway and waited until RN QQ gave him his morning medications at 8:50 a.m. 2. Review of resident 145's electronic medical record (EMR) revealed he admitted to the facility on 6/2/22. His 6/3/26 brief interview for mental status (BIMS) assessment score was 12, which indicated his cognition was moderately impaired. His diagnoses included dependent personality disorder (a long-lasting mental health condition where a person has an excessive need to be taken care of and relies heavily on others for emotional and physical support), anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), obsessive-compulsive disorder (a chronic mental health condition where a person has unwanted, repeated thoughts (obsessions) and feels driven to perform repetitive actions or mental rituals (compulsions) to ease the distress), malignant neoplasm of the brain (is a harmful tumor made of cancer cells that grow and spread inside the brain), schizoaffective disorder (a serious mental illness with symptoms of impaired reality perception, mood swings, disorganized thinking, and altered behavior), and bipolar type.	F0550	4. To monitor performance and ensure ongoing compliance Social Services Supervisor or designee will audit five staff to resident interactions to ensure residents are being treated with dignity. Audits will be completed weekly x4, bi-weekly x2, monthly x1 and quarterly x1. The results of those audits will be brought to the QAPI committee by the Director of Nursing or designee for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435045	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0550 SS = D	Continued from page 20 His undated care plan indicated he had impaired thought processes related to his mental illnesses and a history of brain cancer. The care plan's interventions directed the staff to use communication techniques that enhance interactions, allow for adequate time for him to respond, repeat as necessary, do not rush, and request feedback clarification from him to ensure his understanding. The staff were to face him when they were speaking to him, make eye contact, and to explain all procedures, treatments, and medications. 4. Interview on 7/1/26 at 2:45 p.m. with certified nursing assistant (CNA) M revealed that dignity was treating the residents with respect, giving them options to help them live comfortably, listening to their concerns, and treating them fairly. If the staff were busy, they needed to find the time to ensure they did not rush the residents. Rushing made mistakes happen. 5. Interview on 7/1/26 at 4:06 p.m. with RN QQ revealed that dignity meant giving respect, comfort, and privacy to the residents. "Treat them as you would like to be treated." She did not consider the staff telling a resident to "stop talking" to be treating them with dignity. 6. Interview on 7/2/26 at 9:11 a.m. with the director of nursing (DON) B revealed that treating a resident with dignity meant respecting everything about them, as the facility was their home. If the resident asked for something, the staff should get it or educate the resident about their request. Telling a resident to "stop talking" was not treating them with dignity. 7. Interview on 7/2/26 at 9:25 a.m. with administrator A revealed that she would refer to the facility's dignity policy to determine what the dignity expectations were. She did not consider telling a resident to "stop talking" to be treating them with dignity. 8. Review of the provider's reviewed 12/18/25 resident dignity policy revealed "the location will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The interdisciplinary team will assist all staff members in maintaining the dignity of every resident."	F0550		
F0812 SS = D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F0812	1. Unable to correct past deficient practice for residents 23, 51, 147, and 161. By 7/21/26 Employee K	7/24/26

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	435045	A. BUILDING B. WING	07/02/2026

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F0812 SS = D	Continued from page 21 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to follow standard food safety practices to ensure that one of one licensed practical nurse (LPN) (K) performed hand hygiene (washing hands with soap and water or using hand sanitizer) when she assisted four of four sampled residents (23, 51, 147, and 161) to eat the evening meal, and that one of one cook (P) wore a hairnet over his beard while preparing food in the main kitchen. Findings include: 1. Observation on 6/29/26 from 5:21 p.m. to 5:31 p.m. in the 400-hall dining room revealed LPN K did not perform hand hygiene before she assisted residents 23, 51, 147, and 161 at the supper table with their food. She placed a spoon in resident 23's hand, touched his leg and shoulder, and added the pudding onto his plate from the container. At 5:25 p.m., LPN K handed resident 161 her silverware and bowls to begin eating. At 5:27 p.m., LPN K assisted resident 51 and fed her a spoonful of food.	F0812	was educated by Infection Prevention RN on proper hand hygiene during dining services in accordance with facility policy and procedure. By 7/24/26, Employee P was educated on the proper use of beard guards while preparing food in accordance with facility policy and procedure. 2. All residents have the potential to be at risk when proper hand hygiene during dining services is not followed. All residents have the potential to be at risk when the applicable staff do not wear beard guards according to policy and procedure. No negative outcome was identified. 3. To ensure the deficient practice does not recur the Infection Prevention Nurse or designee will educate all nursing staff on proper hand hygiene when assisting residents with meals. Education will be completed by 7/24/26 or prior to the employee's next scheduled shift. The Dining Director or designee will educate all applicable dining staff on the proper use of beard guards while preparing food. Education will be completed by 7/24/26 or prior to the employee's next scheduled shift.	

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F0812 SS = D	Continued from page 22 At 5:29 p.m., LPN K assisted resident 147 with his supper. She touched resident 147's clothing protector, wheelchair, and his thumb that was in his mouth, before she used his fork to give him a bite of food. At 5:31 p.m., LPN K picked up resident 51's silverware and helped her take another bite of food. LPN K then touched the top of the cranberry juice glass to give resident 51 a drink. LPN K went back to resident 147 and continued using his fork to give him bites of food. 2. Interview on 7/1/26 at 4:06 p.m. with RN QQ revealed that expected hand hygiene to be completed in between helping residents eat their food. 3. Observation on 7/1/26 at 10:00 a.m. of cook P in the main kitchen revealed that he was preparing raw chicken and did not have a hairnet covering his beard. 4. Interview on 7/1/26 at 10:50 a.m. with cook P revealed that he was not wearing a hairnet over his beard and he should have been. He usually had his beard covered while he prepared food and that he had made a mistake. 5. Observation on 7/1/26 at 12:40 p.m. of cook P at a food preparation table in the kitchen revealed he was preparing food without a hairnet covering his beard. 6. Interview on 7/1/26 at 12:42 p.m. with systems chef O revealed that he expected the staff with beards to have them covered with a hairnet anytime they were preparing food. 7. Interview on 7/2/26 at 8:46 a.m. with infection preventionist (IP) C revealed that she expected the staff to perform hand hygiene in between assisting residents to eat in the dining room. 8. Observation on 7/2/26 at 9:35 a.m. outside of the kitchen entry door revealed there was a bin with bold lettering indicating "HAIRNETS" and a sign on the door that stated, "HAIR RESTRAINT[S] ARE REQUIRED AT ALL TIMES IN THE KITCHEN."	F0812	4. To monitor performance and ensure ongoing compliance the Infection Prevention Nurse or designee will audit five employees and their hand hygiene practices when assisting residents with meals. The Dining Director or designee will audit five meals and compliance with beard guard use. Audits will be completed weekly x4, bi-weekly x2, monthly x1 and quarterly x1. The results of those audits will be brought to the QAPI committee by the Infection Prevention Nurse or Designee, Dining Director or designee for review and recommendations.	

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F0812 SS = D	Continued from page 23 9. Review of the provider's 6/10/26 Employee Hygiene and Dress Code- Food and Nutrition Services revealed a purpose of "To promote a professional appearance, safety, and sanitation." The section regarding hairnets stated "1. Hairnets or hair restraints and beard nets or beard restraints are used: a. When cooking, preparing, assembling food or ingredients. This includes dish room and storage areas." 10. Review of the provider's 6/8/26 reviewed hand hygiene policy revealed "the purpose is to prevent the spread of infection to residents/patients/clients, employees, and visitors through hand hygiene practices."	F0812		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons	F0880	1. By 7/20/26, employees KK and LL were educated on proper hand hygiene and appropriate gown use when providing care to residents on Enhanced Barrier Precautions in accordance with facility policy and procedure. Unable to correct past deficient practice for resident 14. 2. By 7/24/26, rooms of residents on Enhanced Barrier Precautions were reviewed to ensure appropriate infection prevention measures were in place, including the availability of hand hygiene supplies and appropriate personal protective equipment (PPE). PPE was verified to be readily accessible to staff providing resident care, and any identified concerns were corrected at the time of review.	7/24/26

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F0880 SS = D	Continued from page 24 in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure the staff followed infection prevention and control practices by one of one certified medication aid (CMA) (KK) and one of one certified nursing assistant (LL) who did not wear a gown or perform hand hygiene (wash hands with soap and water or sanitize hands) while providing care to one of one sampled resident (14) on enhanced barrier precautions (EBP) (glove and gown	F0880	3. To ensure the deficient practice does not recur the Infection Prevention Nurse or designee will educate all nursing staff on proper hand hygiene and gown use when providing care to residents on Enhanced Barrier Precautions. Education will be completed by 7/24/26 or prior to the employee's next scheduled shift. 4. To monitor performance and ensure ongoing compliance, Infection Prevention Nurse or designee will audit five moments of hand hygiene and gown wearing when staff are providing care to residents on enhanced barrier precautions. Audits will be completed weekly x4, bi-weekly x2, monthly x1 and quarterly x1. The results of those audits will be brought to the QAPI committee by the Director of Nursing, Dining Director or designee for review and recommendations.	

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F0880 SS = D	Continued from page 25 use when providing contact care). Findings Include: 1. Observation on 6/30/26 at 3:06 p.m. in resident 14's room revealed she had a magnet on her door frame that indicated she required EBP. When the surveyor went into her room, CNA LL and CMA KK had gloves on, did not have gowns on, and were providing care to resident 14. Resident 14 was lying partially on her left side, and her nephrostomy tube (a flexible tube surgically inserted into the kidney to drain urine) was clipped and hanging on the right side of the bed. CNA LL and CMA KK placed an incontinence (involuntary urine or bowel leakage) brief under resident 14. CNA LL removed her gloves, discarded them in the trash can, did not perform hand hygiene, put on a clean pair of gloves, and assisted CMA KK with repositioning resident 14 and situating her pillows to her comfort. CMA KK removed her gloves, discarded them in the trash can, did not perform hand hygiene, situated the resident's bedside table, handed resident 14 her tablet and phone, and brushed resident 14's hair. CMA KK put on a clean pair of gloves, grabbed the garbage bag from the trash can and the bag of used linens, and left the residents' room. CMA KK placed the bag of garbage and dirty linens in the dirty utility room, removed her gloves, discarded them in the trash can, and sanitized her hands. 2. Interview on 6/30/26 at 3:27 p.m. with CMA KK and CNA LL revealed that with residents who were on EBP, the staff needed to wear a gown when completing perineal (private area between the legs) care, and not when they repositioned the resident. They verified they did not wear gowns when completing perineal care for resident 14 and they should have. They did not perform hand hygiene every time they removed their gloves in resident 14's room. They were supposed to perform hand hygiene before and after resident personal care, when they removed their gloves, and before putting on a new pair of gloves. 3. Review of resident 14's electronic medical record (EMR) revealed she admitted to the facility 10/27/25. Her 5/5/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. Her diagnoses included	F0880		

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F0880 SS = D	Continued from page 26 calculus of the kidney with calculus of the ureter (kidney stones), and quadriplegia (the partial or total paralysis of all four limbs and torso). Resident 14's 6/30/26 care plan indicated she was on EBP and the staff were to "don [put on] gown and gloves when performing high contact care activities including: dressing, bathing, transferring, providing hygiene such as shaving or brushing teeth, changing linens, repositioning, checking and changing [her incontinence brief], device care and/or use, and wound care." She had a right-sided nephrostomy tube due to a history of kidney stones. She required two staff members to reposition her in bed, assist her with dressing, and personal hygiene, and to transfer her with a total body lift (a mechanical lift and sling used to lift a person's full body). 4. Interview on 7/2/26 at 10:00 a.m. with director of nursing (DON) B revealed she expected the staff to wear gowns and gloves during all high-contact resident care for residents who were on EBP, which was indicated on the magnet on the resident's door frame. 5. Review of the provider's 4/30/26 Standard, Enhanced Barrier, and Transmission-Based Precautions policy revealed that the purpose of the policy was "to prevent the spread of infection and communicable diseases to residents/patients, employees, and visitors through infection prevention and control practices." EBP... "refer to the use of a gown and gloves during high-contact resident care activities that provide opportunities for transfer of multidrug-resistant organisms (MDROs) to staff hands and clothing." EBP is used for residents with "indwelling medical devices." "High-contact resident care activities include transfers, dressing, assisting during bathing, providing hygiene, changing briefs or assisting with toileting,...changing linens, indwelling medical device care or use..., and wound care." 6. Review of the provider's 11/13/25 Hand Hygiene policy revealed that the purpose of the policy was "to establish hand hygiene as the single most	F0880		

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F0880 SS = D	Continued from page 27 important factor in preventing the spread of disease-causing organisms to patients and personnel in healthcare settings". The staff were to perform hand hygiene before going into a resident's room, before performing a clean task, after removing their gloves, and when leaving the room.	F0880		

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	435045	A. BUILDING B. WING	06/30/2026

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E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 6/30/26. Good Samaritan Society Sioux Falls Village 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
Dawn Ballinger	Administrator	7/24/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING 01 - SIOUX FALL... B. WING	06/30/2026

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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 6/30/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Good Samaritan Society Sioux Falls Village was found not in compliance. Please mark an F in the completion date column for the K252 deficiency identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies via the Fire Safety Evaluation System (FSES) dated 6/30/26.	K0000		
K0252 SS = C Bldg. 01	Number of Exits - Corridors CFR(s): NFPA 101 Number of Exits - Corridors Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4 This STANDARD is NOT MET as evidenced by: Based on observation and record review, the provider failed to maintain two conforming exits from the basement. Findings include: 1. Observation on 6/30/26 at 3:15 p.m. revealed the basement level was not provided with two conforming exits. One exit was through the boiler room (hazardous area), and the other discharged into the main level kitchen area. Review of previous survey data confirmed those conditions. This deficiency would affect a small number of maintenance staff. 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 K252.	K0252		F

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dawn Ballou	Administrator	7/24/26

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
	10680	A. BUILDING: _____ B. WING _____	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION ROAD 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/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 6/29/26 through 7/2/26. Good Samaritan Society Sioux Falls Village was found not in compliance with the following requirement: S169.	S 000		
S 169	44:73:02:18(5-7) Occupant Protection The facility shall: (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically-activated audible alarm on all unattended exit doors. Any other exterior doors must be locked or alarmed. The alarm must be audible at a designated staff station and may not automatically silence when the door is closed; (7) Prohibit the use of a portable space heater, portable halogen lamp, household-type electric blanket, or household-type heating pad in the facility; This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to operate the facility in a manner to avoid the potential for injury or danger to residents related to one of one rehabilitation wing exit doors that exited to the facility's parking lot that remained unlocked and was not alarmed or monitored daily between the hours of 8:00 a.m. and 5:00 p.m. Findings include:	S 169	1. Resident 71 was assessed and determined to be able to independently operate his electric wheelchair both within the facility and outdoors. As of 7/3/26, the rehab exit door was placed in lock mode to ensure the door was secured and functioning as intended. 2. All residents were identified as having the potential to be at risk if exit doors were not properly secured, alarmed, or monitored. The rehab exit door was immediately secured by placing it in lock mode on 7/3/26. By 7/24/26 a review of all exit doors in the facility was completed to ensure they were properly secured, alarmed, or monitored.	7/24/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Ballou — TITLE: Administrator — (X6) DATE: 7/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10680	A. BUILDING. _____ B. WING _____	07/02/2026

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S 169	Continued From page 1 1. Observation on 6/30/26 from 8:29 a.m. to 8:41 a.m. of the rehabilitation wing exit doors that opened to the parking lot revealed that those doors opened automatically when the surveyor approached. There were no staff members present near the doors. At 8:33 a.m., an unidentified person entered through those doors and continued down the hall and out of the entry area. At 8:34 a.m., a second unidentified person entered through those doors. There were no staff members present. At 8:41 a.m., clinical care leader (CCL) S entered through those doors, went into her office, and then left the area. At 8:41 a.m., resident 71 approached the rehabilitation wing exit doors in his power wheelchair; as he approached, those doors opened automatically, and he and a male visitor exited through those doors. 2. Observation and interview on 6/30/26 at 2:30 p.m. with licensed social worker (LSW) R revealed that the rehabilitation wing exit doors were outside of LSW R's office, and those doors opened automatically as the surveyor approached them. LSW R stated that those exit doors were unlocked and that they would open automatically when approached from 8:00 a.m. until 5:00 p.m. daily. After 5:00 p.m., those exit doors were locked and required a code to open. LSW R did not monitor those doors between 8:00 a.m. and 5:00 p.m. because she was not in her office at all times during those hours. Those doors locked automatically if a resident with a WanderGuard (a wearable door alarming device) approached them, and an alarm would sound if a resident with a WanderGuard exited	S 169	3. By 7/24/26 Clinical Care Leader (CCL S), Social Worker (LSW R), and MDS Coordinator (MDS T), as well as, all staff were educated regarding facility expectations for exterior doors to be locked, alarmed, or monitored in accordance with facility procedures. All staff education will be completed by 7/24/26 or prior to the employee's next scheduled shift. 4. To monitor performance and ensure ongoing compliance Ancillary Services Manager or designee will audit five exit doors to ensure they are locked, alarmed or monitored. Audits will be completed weekly x4, bi-weekly x2, monthly x1 and quarterly x1. The results of those audits will be brought to QAPI committee by the Ancillary Services Manager or designee for review and recommendations.	

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S 169	Continued From page 2	S 169		

through them. A code was required to unlock the doors and silence the alarm.
LSW R stated that some residents were allowed to exit the building through those doors independently and that other residents were only allowed to go outside through those doors with the staff's assistance. All residents were assessed for their elopement (leaving the facility without staff knowledge) risk, and any residents at risk wore a WanderGuard.
There was a camera that monitored the rehabilitation wing exit doors, and that camera's video footage was displayed on a monitor at the nurse's station. Those cameras were not monitored by a staff member at all times.

3. Observation and interview on 7/1/26 at 8:51 a.m. with minimum data set (MDS)/registered nurse (RN) T regarding the rehabilitation wing exit doors revealed that those exit doors were located near her office. MDS/RN T was unsure what time those doors unlocked automatically, but knew that they were locked after 5:00 p.m. She was unable to see those doors from her office and did not monitor who entered the building or exited the building through those doors.
She confirmed that not all residents with cognitive impairment wore a WanderGuard, only those residents who were at risk for elopement wore one. The rehabilitation exit doors would open automatically if any resident who did not wear a WanderGuard approached those doors.

4. Observation and interview on 7/1/ 26 at 11:31 a.m. with ancillary services manager U revealed that when he approached the rehabilitation wing exit doors with a WanderGuard, those doors locked automatically. When the surveyor approached those doors, they opened automatically. The rehabilitation wing exit doors

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were scheduled to lock automatically at 5:00 p.m. and unlock at 8:00 a.m. Ancillary services manager U confirmed that those doors were not locked, alarmed, or monitored by a staff member during those hours, but stated that the WanderGuard locked the doors automatically during that time.
The rehabilitation wing exit doors were monitored by a camera, but he was unsure where the monitor was located or if that monitor was always observed by a staff member.
He stated that the main building doors were unlocked between 8:00 a.m. and 5:00 p.m. daily but were monitored by a receptionist. He was unsure why the rehabilitation wing exit doors were not monitored.

5. Interview on 7/1/ 26 at 11:38 a.m. with director of nursing (DON) B regarding the rehabilitation wing exit doors confirmed that those exit doors opened automatically between 8:00 a.m. and 5:00 p.m. and were not alarmed or monitored by a specific staff person during that time. She stated that it was "everyone's job" to monitor the exit doors.
DON B confirmed that all residents had access to the rehabilitation wing exit doors, but that those doors would lock automatically if a resident with a WanderGuard approached that area.

6. Interview on 7/1/26 at 2:31 p.m. with administrator A regarding the rehabilitation wing exit doors revealed that she acknowledged those doors exited the building to the parking lot and were not alarmed, locked, or monitored at all times between 8:00 a.m. and 5:00 p.m. She expected MDS/RN T, LSW R, and CCL S to monitor the doors, but acknowledged that they were always not in their offices.
Administrator A acknowledged that all residents in

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S 169	Continued From page 4 the facility had access to those doors and that those doors locked automatically between 8:00 a.m. and 5:00 p.m. if a resident with a WanderGuard approached. There were residents in the rehabilitation wing and throughout the facility with cognitive impairment who did not wear a WanderGuard. She acknowledged that the doors being unlocked, unalarmed, and not monitored placed those residents at risk. The rehabilitation wing exit doors were put into a lock/night mode earlier that day (7/1/26) when she became aware that those doors were not monitored by the staff while the doors were unlocked and unalarmed. 7. Review of the provider's undated document provided to the residents when they admitted to the rehabilitation wing revealed "Sliding Glass doors unlocked from 8 am - 5 pm ... Please make sure other residents do not exit with you." 8. Review of the provider's reviewed 8/29/25 Alarms- Bed Chair and Door policy revealed that it did not indicate when the facility exit doors were locked, alarmed, or monitored.	S 169		