


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/04/2026
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 WEST SECOND STREET , SIOUX FALLS, South Dakota, 57104	
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F0000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/3/26 through 2/4/26. Areas surveyed included potential resident neglect related to a resident who fell, and resident safety and supervision related to a resident who was burned while smoking. Good Samaritan Society Sioux Falls Center was found not in compliance with the following requirements: F609 and F689.	F0000	The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law.	
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by:	F0609	Incident involving resident 6 was self-reported to the South Dakota Department of Health on 11/11/2025 and was accepted. Final report was submitted to the South Dakota Department of Health by the facility on 11/19/2025 and was accepted. All state reports submitted by the facility with serious bodily injury over the last 3 months will be reviewed by the administrator/designee to ensure reports were submitted within the required timeframe. All staff were educated by Clinical Lead Development Specialist or designee by 2/27/2026 on the abuse and neglect reporting policy along with the abuse and neglect policy including education on the definition of serious bodily injury, and the difference between 2-hour and 24-hour reporting. A prompt to ensure timely reporting of reportable incidents will be added to the Morning Stand-Up agenda. The administrator/designee will report out when reportable incidents are submitted.	

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 Administrator	(X6) DATE 3/3/2026
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F0609 SS = D	<p>Continued from page 1</p> <p>Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, interview, and policy review, the provider failed to report a known serious bodily injury within the required time frame for one of one sampled resident (6) who fell and sustained a hip fracture.</p> <p>Findings include:</p> <p>1. Review of the provider's 11/11/25 SD DOH FRI (a required reporting of unexpected or adverse events) report revealed:</p> <p>*Resident 6 slipped out of her wheelchair, landed on her left hip, and reported left hip pain on 11/10/25 at 2:20 p.m.</p> <p>*Resident 6's physician ordered an X-ray of her left hip.</p> <p>*Administrator A and director of nursing (DON) B were notified of the fall.</p> <p>*The X-ray results showed resident 6 had a left intertrochanteric fracture of the femur (a common type of broken hip occurring in the upper part of the thigh bone [femur]), and the resident's daughter-in-law wanted to talk to the rest of the family before transferring the resident to the emergency department (ED).</p> <p>*On 11/11/25 at 7:30 a.m., resident 6's daughter-in-law informed clinical care leader (CCL) E that the family decided they wanted resident 6 sent to the ED.</p> <p>*Resident 6 was transferred to the ED on 11/11/25 at 7:55 a.m., was admitted to the hospital, and later passed away.</p> <p>*The FRI report was reported to the SD DOH by administrator A on 11/11/25 at 12:54 p.m.</p> <p>2. Review of resident 6's electronic medical record (EMR) revealed that on 11/10/25 at 6:45 p.m., a progress note written by RN L stated resident 6's X-ray results indicated she sustained a left hip fracture, and the results were faxed to her physician.</p> <p>3. Interview on 2/3/26 at 4:43 p.m. with CCL E revealed a portable X-ray technician came to the facility to</p>	F0609	<p>To monitor compliance, administrator/designee will audit all state reports submitted to ensure timely reporting per facility policy. Audits will occur weekly X 4 weeks, every other week X 2, and Monthly X2 months. Administrator/designee will report findings to the QAPI Committee monthly. The QAPI Committee will determine on-going interventions and monitoring.</p> <p>Substantial compliance will be achieved on 3/6/2026.</p>	3/6/2026

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F0609 SS = D	Continued from page 2 complete resident 6's X-ray. 4. Interview on 2/4/26 at 11:35 a.m. with DON B revealed: *Administrator A and she completed incident reporting to the SD DOH. *Reporting to the SD DOH was to be completed within 24 hours after outside medical attention was provided. *A confirmed hip fracture, even when an X-ray technician came to the facility to take it, would need to be reported to the SD DOH within two hours. 5. Interview on 2/4/26 at 12:40 p.m. with administrator A revealed: *He thought that since resident 6 did not receive outside medical attention immediately after her fall, in which she sustained a hip fracture, the incident would need to be reported to the SD DOH within 24 hours. *He considered a hip fracture a serious bodily injury and would need to follow their policy regarding when to report the incident to the SD DOH. 6. Review of the provider's 4/7/25 Abuse and Neglect policy revealed: **"Designated agencies will be notified in accordance with state law, including the State Survey and Certification Agency." **"If there is an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident/client property, and/or there is serious bodily injury, then it will be reported immediately, but not later than two hours after the allegation is made." **"If there is an allegation that does not involve abuse and there is no serious bodily injury, then it will be reported not later than 24 hours after the allegation is made."	F0609		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F0689		

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F0689 SS = G	<p>Continued from page 3 §483.25(d) Accidents.</p> <p>The facility must ensure that -</p> <p>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, observation, record review, and policy review, the provider failed to ensure the safety and staff supervision of seven of seven sampled residents (1, 2, 3, 4, 5, 7, and 8) identified as needing supervision while smoking to prevent physical injury or harm, and specifically one of one sampled resident (1) who subsequently sustained a burn to his face.</p> <p>Findings include:</p> <p>1. Review of the 12/11/25 SD DOH FRI revealed:</p> <p>*On 12/11/25 at 10:20 p.m., resident 1 informed registered nurse (RN) M that he went outside into the facility's enclosed courtyard to smoke. When resident 1 lit his cigarette, an ember began to "smolder" in his winter hat. He removed his hat and placed it in the snow.</p> <p>*Resident 1 knew the door code to the locked exit door and did not inform any staff members before going out into the enclosed courtyard.</p> <p>*The camera footage review completed by administrator A revealed:</p> <p>-Resident 1 and resident 2 entered the courtyard at 10:20 p.m. At 10:21 p.m., resident 1 tilted his head downward while wearing a brimmed hat, and the brim of the hat began "smoldering" when the hat touched the lit cigarette. Resident 1's beard was "singled" near his ear.</p> <p>-Resident 2 assisted resident 1 to "put out the smoldering hat."</p> <p>-Both residents remained in the courtyard to finish</p>	F0689	<p>Resident council meeting held for all residents who smoke on 2/9/2026. All residents who smoke were reeducated by administrator on facility smoking protocol and rules associated with smoking on campus. Facility initiated a smoke free campus effective 2/14/2026 with residents who currently smoke at the facility grandfathered in and must follow facility smoking protocol.</p> <p>All residents who smoke will have care plans individualized and updated to reflect resident current needs, including level of supervision required, ability to independently smoke, safety risks, and required safety equipment, completed by 2/27/2026 to ensure resident safety. Any concerns will be addressed at time of care plan updates.</p> <p>Door code to courtyard smoking area changed on 2/16/2026 with all staff educated to not share the code with any residents. Resident lighters will be kept in the nurses station unless specified in resident's individualized plan of care. All staff directed in-service with be completed by DON or designee related to smoking including assessing for ability and safety needs, ensuring adequate supervision, and identifying and implementing resident-specific interventions for residents who choose to smoke. All staff education provided by DON or designee about their roles and responsibilities, and assigned tasks regarding resident smoking safety including maintaining visual supervision of residents smoking throughout the duration of the time that residents are in courtyard smoking.</p>	

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F0689 SS = G	<p>Continued from page 4 their cigarettes and entered the facility at 10:26 p.m. and told RN M what had occurred.</p> <p>*RN M completed a skin assessment of resident 1, which revealed a reddened area to the top of his head by his hairline, his beard area on the left side of his face near his ear, and on his left cheekbone, with skin remaining intact. Resident 1 denied pain. RN M applied a cold washcloth to those areas for comfort.</p> <p>*RN M completed a skin assessment of resident 2, and no injury was identified.</p> <p>*Resident 2 stated he knew the door code and, without notifying any staff members, he entered the door code, which deactivated the door alarm, so that he and resident 1 could enter the courtyard to smoke.</p> <p>*Resident 1 and resident 2 were educated on the facility's smoking protocol. "Tobacco Use Assessments" were completed on all residents who smoked at the facility, and a resident smoking council meeting was held on 12/17/25.</p> <p>*Education was provided to all staff members to ensure the door code remains unknown to the residents.</p> <p>*Resident 1's family provided smokeless/vaping alternatives for resident 1 to prevent future incidents from occurring.</p> <p>*The facility purchased fire-resistant beard covering for resident 1 to wear while vaping in the courtyard.</p> <p>*Maintenance supervisor P evaluated the door, alarms, and magnetic locks to ensure all were functioning, and changed the code to the door leading to the courtyard.</p> <p>2. Observation and review of the provider's sign-out book on 2/3/26 at 8:00 a.m., revealed:</p> <p>*Resident 3 was outside the front door of the facility in his power wheelchair, picking up cigarette butts off the ground with his reacher stick (a device used to increase a person's reach to grab objects).</p> <p>*He did not sign out in the sign-out book located on the windowsill of the closed receptionist's window at the front door.</p> <p>3. Review of resident 1's Electronic Medical Record (EMR) revealed:</p>	F0689	<p>Education for all staff will be completed by 2/27/2026. All staff who do not complete the mandatory in-service by the designated date will be contacted by DON or designee prior to their next scheduled shift for verbal education to be provided.</p> <p>DON/Designee will audit 5 smoking timeframes to ensure facility smoking protocol is being followed appropriately and supervision is occurring through the duration of the facility smoking time. DON/Designee will also audit sign out sheets at the front reception desk to ensure residents are in compliance with facility protocols by signing out when exiting the facility. Audits will be completed weekly X 4 weeks, every other week X2, and Monthly X2 months. DON/designee will report findings to the QAPI Committee monthly. The QAPI Committee will determine on-going interventions and monitoring.</p> <p>Substantial compliance will be achieved on 3/6/2026.</p>	3/6/2026

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F0689 SS = G	<p>Continued from page 5</p> <p>*He was admitted to the facility on 7/21/21.</p> <p>*His 12/11/25 Brief Interview of Mental Status (BIMS) assessment score was 11, which indicated his cognition was moderately impaired.</p> <p>*His diagnoses included Multiple Sclerosis (a chronic, often disabling autoimmune disease of the central nervous system), paraplegia (the inability to voluntarily move the lower parts of the body), intellectual disability, and tobacco use.</p> <p>*His 4/26/25 Tobacco Use Evaluation indicated it was "related to: Smoking/Vaping."</p> <p>-“Has the resident had any incidents of dropping a cigarette, falling asleep while smoking, burning self, furniture or clothing, or other unacceptable tobacco-related behavior in the past?” was marked “yes” and “resident with previous incident- new safety implementations placed.”</p> <p>--It did not indicate what those safety implementations included.</p> <p>-Resident 1 needed “supervision during smoking times for safety reasons,” was sometimes able to light his own cigarette, and required a smoking apron and supervision.</p> <p>*There was no documentation that a Tobacco Use Evaluation was completed quarterly in July or in November 2025.</p> <p>*A 12/11/25 incident report indicated resident 1 reported to his nurse that “he went outside to smoke and his lighter ignited his hat.”</p> <p>-The nurse’s assessment “revealed a minor burn to the frontal hairline, beard area, and left cheekbone.”</p> <p>-“Resident did not inform staff prior to going outside.”</p> <p>*His 12/11/25 Tobacco Use Evaluation indicated it was “related to: Smoking/Vaping.”</p> <p>-Resident 1 had dexterity problems that affected his ability to smoke/vape, needed assistance opening doors, and his cognition was moderately impaired. He had a previous incident of burning clothing and needed “supervision during smoking times for safety reasons.” He was sometimes able to light his own cigarette and</p>	F0689		

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F0689 SS = G	<p>Continued from page 6 safely operate his e-cigarette device, and required a smoking apron and supervision.</p> <p>*His care plan indicated:</p> <p>-A 3/24/24 Focus area that "The resident has a history of elopement R/T [related to] disregard for signing himself out and neglecting to advise staff that he was leaving the building," with a goal that the resident will not leave the facility unattended except for planned community outings."</p> <p>-A 3/24/24 Focus area that "The resident uses tobacco products E/B [evidenced by] use of cigarettes/e-cig." Interventions included... "remind resident to utilize smoking safety equipment including smoking apron, fire retardant jacket.. and flame retardant beard protector.</p> <p>-"Resident must have staff accompany him when he smokes."</p> <p>-"Resident allowed to have cigarettes in [his] room. Encourage resident [1] to keep [his] lighter at [the] nurse's station. Resident [1] routinely refuses to return [his] lighter. Continue to provide education of risks associated with the lighter in the room."</p> <p>*There was no documentation that resident 1 vaped or where his vape was stored.</p> <p>4. Review of resident 2's EMR revealed:</p> <p>*He was admitted to the facility on 9/29/23.</p> <p>*His 11/20/25 BIMS assessment score was 15, which indicated his cognition was intact.</p> <p>*His 9/16/24 Tobacco Use Evaluation indicated "Resident able to use cigarettes independently, however, facility protocol states residents to be supervised while smoking," and he required a smoking apron and supervision.</p> <p>*There was no documentation that a Tobacco Use Evaluation was completed quarterly or annually between 9/16/24 and 12/16/25.</p> <p>*His 12/16/25 Tobacco Use Evaluation indicated he required a smoking apron and supervision.</p> <p>*His care plan had an 11/27/25 goal that "Resident [2] will safely use tobacco products in designated areas." Interventions included, "Facility protocol states that</p>	F0689		

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F0689 SS = G	<p>Continued from page 7 all residents are to be supervised while smoking. Resident [2 is] known to go out to the courtyard on [his] own." He was provided with and expected to follow designated smoking times, to wear a smoking apron, and to store his lighter at the nurse's station."Resident [was] known to refuse to give up [his] lighter."</p> <p>5. Review of resident 3's EMR revealed:</p> <p>*He was admitted to the facility on 5/23/24.</p> <p>*His 11/28/25 BIMS assessment score was 15, which indicated his cognition was intact.</p> <p>*His 12/16/25 Tobacco Use Evaluation indicated he required a smoking apron and supervision.</p> <p>*His care plan had a 1/6/26 goal that he would "safely use tobacco products in designated areas."</p> <p>-Interventions included:</p> <p>--"Resident [3] is independent with tobacco use per assessment; however, per facility protocol, [he] will only smoke in designated areas with supervision at all times." Resident 3 was "known to be non-compliant," and education was provided on the importance of his compliance.</p> <p>--Resident 3 was to be supervised at all times and "allowed to smoke in the courtyard only."</p> <p>--"Put smoking apron on resident."</p> <p>--"Keep lighter at nurses' station." Resident 3 was known to "refuse to hand over [his] lighter."</p> <p>6. Review of resident 4's EMR revealed:</p> <p>*She was admitted on 3/5/24.</p> <p>*Her 11/26/25 BIMS assessment score was 15, which indicated her cognition was intact.</p> <p>*Her 3/12/24 Tobacco Use Evaluation indicated that she was educated on "smoking/vaping in designated areas." There was no adaptive equipment needed for resident safety. There was no indication of what level of supervision she required.</p> <p>*There was no documentation that a Tobacco Use Evaluation was completed quarterly or annually since</p>	F0689		

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F0689 SS = G	<p>Continued from page 8 3/12/24.</p> <p>*Her 4/3/24 updated care plan indicated she used tobacco products with a goal that she would "safely use tobacco products in [the] designated area." Interventions included that she was able to smoke with supervision "in designated smoking areas while on facility property," she was to face the windows if the staff members were unable to be outside with her. She was encouraged to wear two smoking aprons at all times, "one across her chest and one across her legs for safety." She often refused the second apron. "Continue to encourage." She was allowed to have her cigarettes in her room. "Encourage [the] resident to keep [her] lighter at the nurses station."</p> <p>7. Review of resident 5's EMR revealed:</p> <p>*She was admitted on 12/28/22.</p> <p>*Her 1/14/26 BIMS assessment score was 15, which indicated her cognition was intact.</p> <p>*Her 12/16/25 Tobacco Use Evaluation indicated that she was "needing more help with ADLs [activities of daily living]," wore oxygen, was able to remove her oxygen when she smoked, was sometimes able to light her own cigarette, and required a smoking apron and supervision.</p> <p>*Her 9/9/25 updated care plan indicated she used tobacco products with a goal that she would "safely use tobacco products in [the] designated area." Interventions included that she was independent with tobacco use. She understood and followed the smoking schedule. "Remove the resident's oxygen prior to smoking... put smoking apron on [the] resident," and "monitor resident during the use of smoking."</p> <p>8. Interview on 2/3/26 at 8:41 a.m. with resident 3 in his room revealed:</p> <p>*There were changes made to the smoking policy after resident 1 burned himself while smoking. There were specific times when he was allowed to smoke in the courtyard, and the door code to the courtyard was changed. He was not allowed to know the new door code.</p> <p>*He thought that staff members were required to stay by the courtyard doors when he went out to smoke in the courtyard, but they did not. He was frustrated that there were times he got "stuck out there" waiting for</p>	F0689		

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F0689 SS = G	<p>Continued from page 9 the staff to answer the doorbell to let him back inside.</p> <p>*He was independent with his power wheelchair for his mobility and preferred to smoke outside the front of the facility building because he was allowed to go out there to smoke anytime.</p> <p>*He kept his cigarettes and his lighter with him and did not need to let staff members know when he went outside the front doors to smoke.</p> <p>*He was told that he needed to sign out in the book on the receptionist's desk when he left the facility and to go across the street or down to the corner of the block to smoke. He smoked outside the facility's front doors when it was cold in the evening or early in the morning. He was not sure if he had signed out in that book when he went outside to smoke that morning (2/3/26).</p> <p>*He used his reacher stick to pick up the cigarette butts on the ground outside the facility's front doors because there was no receptacle for them. He knew that other residents smoked out there, and he didn't want the staff members to have to clean up after them because then the staff members would not let him smoke out there.</p> <p>*The front doors of the facility were not locked during the day and would open automatically for him. He knew the front door code, and he entered and exited the facility through those doors in the evening and on the weekends, when the receptionist was not working.</p> <p>9. Observation and interview on 2/3/26 at 8:50 a.m. with resident 2 in his room revealed:</p> <p>*He recalled the evening that resident 1's "hat caught on fire" while he was in the courtyard smoking. He had helped resident 1 remove his hat and had thrown the hat on the ground to put out the fire. He did not think resident 1 was hurt, but was frustrated that the smoking rules changed after that incident.</p> <p>*He was independent with his power wheelchair for his mobility and was allowed to smoke in the courtyard or to leave through the front doors and smoke "out front and down a block."</p> <p>*There were no specific times when he smoked. He kept his cigarettes and his lighter with him and went outside through the front doors of the facility to</p>	F0689		

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F0689 SS = G	<p>Continued from page 10 smoke whenever he wanted. He did not need to tell the staff members or sign out in a book.</p> <p>*He did not smoke in the courtyard very often because there were specific times, he did not know the door code, and he did not like waiting for staff to answer the doorbell to let him back inside when it was cold. He knew the code to the front doors of the facility and did not have to wait for staff to help him.</p> <p>*He needed to wear a smoking apron if he smoked in the courtyard, but did not wear one when he smoked out front.</p> <p>10. Observation on 2/3/26 at 8:59 a.m. of the resident smoking area revealed:</p> <p>*The smoking area was in the courtyard, located outside the activities room. There was a locked door with a keypad.</p> <p>*There were smoking aprons, an umbrella, and a fire blanket near the door.</p> <p>*The sign posted on the door indicated there were five scheduled smoking times. The first scheduled smoking time was half an hour from 6:30 a.m. to 7:00 a.m. The remaining four scheduled times were for one hour, with the last scheduled smoking time scheduled from 6:00 p.m. to 7:00 p.m.</p> <p>*There were several cigarette butts on the ground. There was a large outdoor cigarette receptacle for cigarette butts. What appeared to be a ceramic bowl and a tin can on the table also contained cigarette butts.</p> <p>11. Interview on 2/3/26 at 9:03 a.m. with certified medication assistant (CMA) F regarding residents who smoked revealed:</p> <p>*She worked on both day and evening shifts.</p> <p>*She knew which residents smoked and if they kept their cigarettes or lighters with them or if those items were stored at the nurses' station, because it was listed in the residents' care plan (personalized plan that addresses a resident's care needs, goals, and interventions).</p> <p>*Residents were care planned to smoke in the courtyard, but she knew at least two residents, resident 2 and resident 3 would go outside the front doors to smoke</p>	F0689		

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F0689 SS = G	<p>Continued from page 11 without staff assistance.</p> <p>*The courtyard door code was recently changed, and there were specific times when residents were allowed to smoke in the courtyard. She thought there were five times during each day and that those times were for approximately half an hour each.</p> <p>*She was aware that a resident was burned while smoking about a month ago. She was not working that day. It was after that incident that the courtyard door code was changed, and the facility began enforcing specific smoking times. Before that incident, residents were constantly wanting to be let in and out of the courtyard doors, and it was "chaotic."</p> <p>*During the day, the activities staff members let residents who smoked in and out of the courtyard doors.</p> <p>*When the activities staff members were not working (during the first and last scheduled smoking times and on the weekend), the nursing staff let the residents out into the courtyard to smoke by entering the door code, and then let them back in when they rang the doorbell.</p> <p>*There were no specific nursing staff members assigned to assist or supervise the residents when they smoked during the scheduled times. She felt like all the staff members worked as a team to let the residents outside in the courtyard and to answer the doorbell when the residents wanted to come back in.</p> <p>*Most residents had their own cigarettes and lighters and were able to smoke without staff assistance. She knew that two residents who were not smoking very frequently had their cigarettes and lighters stored at the nurses' station.</p> <p>12. Interview on 2/3/26 at 9:21 a.m. with CMA D regarding residents who smoked revealed:</p> <p>*Most residents were allowed to keep their cigarettes with them in their rooms, but all resident lighters were to be stored at the nurse's station. He knew that residents 2 and 3 refused to return their lighters and kept them in their rooms.</p> <p>*There was a change in the smoking policy about a month ago, after resident 1 was burned while smoking. The courtyard door code was changed, and residents were no longer allowed to go in and out of the courtyard on their own to smoke. A staff member had to enter the</p>	F0689		

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F0689 SS = G	<p>Continued from page 12 door code to let them out and answer the doorbell when the residents wanted to come back in.</p> <p>13. Observation and interview on 2/3/26 at 9:27 a.m. of the residents' smoking area with activities director (AD) C revealed:</p> <p>*There were between eight and ten residents who smoked each day outside in the courtyard during the scheduled smoking times.</p> <p>*The new smoking times were scheduled so that the residents' smoking times did not interfere with the activities that were scheduled in the activities room. A schedule of activities was posted on the door to the courtyard to remind residents who smoked of those activity times, because opening and closing the courtyard door allowed the cold air and smoke from outside to drift into the activities room.</p> <p>*Activities staff members took turns assisting the residents who smoked by entering the courtyard door code and assisting the residents through the doors during the day, but the nursing staff assisted residents on the weekends and for the first and last scheduled smoking times during the week, when the activities staff were not working.</p> <p>*When it was nice outside, she would sit outside with the residents, but when it was cold, she watched the residents from the window next to the door.</p> <p>*Resident 4 and resident 7 were outside smoking, both of whom wore a smoking apron. They were facing away from the window and door. AD C stated that she liked it when the residents faced the door and window, but it was their right to move about outside in the courtyard while they smoked.</p> <p>*She assisted some residents with lighting their cigarettes, and others were able to light their own.</p> <p>*She thought all the residents who currently smoked kept their cigarettes with them in their rooms, and most of the residents had their own lighters.</p> <p>*Residents were allowed to leave the facility grounds to smoke by going directly across the street or down the sidewalk to the end of the facility grounds.</p> <p>14. Observation and interview on 2/3/26 at 9:43 a.m. at the nurses' station with CMA F revealed:</p>	F0689		

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F0689 SS = G	<p>Continued from page 13</p> <p>*A basket on the counter contained two lighters and two packs of cigarettes labeled with resident 9's name and one pack of cigarettes labeled with resident 10's name.</p> <p>*CMA F stated that residents 9 and 10 were not allowed to keep their cigarettes or their lighters in their rooms.</p> <p>15. Observation and interview on 2/3/26 at 11:51 with resident 1 in his room revealed:</p> <p>*He used a power wheelchair for mobility. He sat with his power wheelchair reclined and had a hard time holding his head up when he spoke. He wore a brimmed hat and rested his head downward between each response.</p> <p>*He remembered his hat and beard were burned when he went outside to smoke about a month ago with resident 2.</p> <p>*Resident 2 knew the door code and was able to hold the door open for him. Staff did not go outside with him when he smoked.</p> <p>*His brother provided him with a vape, and he was told he needed to use that now when he wanted to smoke. He kept that vape with him and in his room.</p> <p>16. Observation on 2/3/26 at 12:32 p.m. of the residents' courtyard smoking area revealed:</p> <p>*Resident 5 arrived at the courtyard door in her power wheelchair and put on a smoking apron.</p> <p>*Activities assistant G entered a code on the keypad and opened the courtyard door for resident 5 to enter the courtyard, then returned to her desk behind the partition wall.</p> <p>*Resident 8 arrived at the courtyard door in his power wheelchair and put on a smoking apron.</p> <p>*Activities assistant G entered a code on the keypad and opened the courtyard door for resident 8 to enter the courtyard, then walked away from the doors.</p> <p>*Resident 4 arrived at the courtyard door with her walker, and resident 7 arrived in her wheelchair. They each put on a smoking apron, and activities assistant G repeated the task of entering the door code to allow them to enter the courtyard.</p>	F0689		

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F0689 SS = G	<p>Continued from page 14</p> <p>*While residents were in the courtyard, smoking activities assistant G carried items from the cabinets to her desk, assisted a resident who was leaving the dining room, and sat at her desk behind the partition wall. She occasionally looked out the window next to the door.</p> <p>*Resident 3 drove past the courtyard door in his electric wheelchair and told the surveyor he was going to the front of the facility to smoke because he did not like smoking in the courtyard, because he could not get back in.</p> <p>*When residents rang the doorbell, activities assistant G returned to the door and entered the code so the residents could come inside.</p> <p>*Activities assistant G did not provide cigarettes or lighters to any residents, did not assist the residents with lighting their cigarettes, or attempt to collect any cigarettes or lighters when the residents came inside from smoking.</p> <p>17. Interview on 2/3/26 at 12:56 p.m. with activities assistant G regarding residents smoking revealed:</p> <p>*She confirmed that all residents had come back inside after smoking.</p> <p>*Each resident had their own cigarettes and lighter, and she did not need to assist those residents with lighting their cigarettes. The one resident who needed assistance with lighting his cigarette did not smoke at that time.</p> <p>*Residents did not know the new door code, and she assisted the residents by entering the door code and opening the door.</p> <p>*She was not allowed to leave the activities room while residents were outside smoking because she needed to enter the door code and let them back in when they were finished smoking. She did not need to stand at the door because she could hear the doorbell anywhere in the activities room.</p> <p>*Resident 1 arrived at the courtyard door, and activities assistant G assisted him in putting on a smoking apron. She stated that resident 1 vaped most of the time but occasionally "bummed" cigarettes from other residents. Activities assistant G entered the door code and opened the door so that resident 1 could</p>	F0689		

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F0689 SS = G	<p>Continued from page 15 go outside into the courtyard.</p> <p>-She did not put a flame-retardant beard protector on resident 1.</p> <p>18. Interview on 2/3/26 at 1:47 p.m. with minimum data set/registered nurse (MDS/RN) O regarding residents who smoked revealed:</p> <p>*She completed a Tobacco Use Evaluation on all the residents who smoked when they were admitted, quarterly, annually, and with any significant changes regarding their care needs.</p> <p>*She observed the resident while they smoked to determine if they required assistance with lighting their cigarettes, if they needed to wear a smoking apron, or if there were any issues with their safety.</p> <p>*Some residents were independent with smoking, and other residents required supervision. She thought only a couple of residents required assistance with smoking.</p> <p>*She confirmed residents 1, 2, 3, 4, 5, 7, and 8 required supervision when they smoked in the courtyard during the designated smoking times.</p> <p>*She reviewed the smoking rules with the residents when she completed their Tobacco Use Evaluations and expected the residents to smoke in the courtyard during the designated smoking times.</p> <p>*Staff members were expected to sit outside with the residents or stand at the window to supervise while the residents were outside smoking.</p> <p>*Some residents were allowed to leave the facility to smoke. They needed to leave the facility property and were not allowed to smoke near the front doors of the facility, but not all the residents followed the smoking rules.</p> <p>*Residents 9 and 10 were not allowed to keep their cigarettes and lighters with them. They were stored at the nurses' station.</p> <p>*She used the same Tobacco Use Evaluation for residents who vaped or smoked.</p> <p>*Resident 1 vaped and was allowed to keep his vape with him in his room.</p> <p>*Resident care plans indicated whether residents were</p>	F0689		

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F0689 SS = G	<p>Continued from page 16 independent or what level of assistance a resident required when they smoked.</p> <p>19. Interview on 2/3/26 at 4:12 p.m. with RN M revealed:</p> <p>*On 12/11/25, sometime after 10:00 p.m., resident 1 told her that he and resident 2 were outside in the courtyard smoking and that his hat had caught on fire. They did not notify her or any other staff that they were going out there.</p> <p>*The residents had an evening smoking time, she thought, around 6:00 p.m. to 7:00 p.m., and the nursing staff members assisted residents into the courtyard to smoke and then answered the doorbell when they were ready to come back inside. Residents were not allowed in the courtyard after 7:00 p.m.</p> <p>*She completed a skin assessment of resident 1 at that time and found a small burn to his forehead and his cheekbone. The front of his hair, his beard, and his left eyebrow were burned and smelled like smoke. Resident 1 stated he did not have any pain, but she placed a cool washcloth over those areas to clean and cool them.</p> <p>*She reported the incident to resident 1's brother, his physician, and the administrative staff members. Resident 1 used a vape now because that was safer for him.</p> <p>*Some residents were independent with their wheelchairs and could use the elevator, go downstairs, and out the front doors of the facility to smoke. Those residents did not tell her when they went downstairs to smoke because they were independent and could sign out.</p> <p>20. Interview on 2/3/26 at 4:45 p.m. with director of nursing (DON) B regarding residents who smoke revealed:</p> <p>*A Tobacco Use Evaluation was completed on each resident who smoked annually, and if there was an incident that occurred while they were smoking. She did not expect that evaluation to be completed quarterly.</p> <p>*It was their policy that all residents were assessed to determine if they required supervision while they smoked and to only smoke in the courtyard.</p> <p>*The courtyard was the residents' designated smoking area. There were specific times that the residents</p>	F0689		

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F0689 SS = G	<p>Continued from page 17</p> <p>could smoke, and she expected any staff member who assisted a resident into the courtyard to smoke to be outside with that resident or, when it was cold, to stand at the window to ensure constant supervision.</p> <p>*She expected the residents to sit facing the window so that the staff member supervising could see them.</p> <p>*She confirmed residents 1, 2, 3, 4, 5, 7, and 8 required supervision when they smoked in the courtyard during the designated smoking times.</p> <p>*A staff member who was talking to other residents in the activities room and seated at the desk was not considered supervision.</p> <p>*She was aware that some residents left the facility property to smoke, and she expected them to go to the corner down the block or across the street when they smoked to be off the facility's property.</p> <p>*The Tobacco Use Evaluation addressed residents' smoking on the facility's property, not when they left the facility to smoke.</p> <p>*She felt that residents 2 and 3 were safe leaving the facility property independently to smoke and expected them to tell a staff member and sign out in the sign-out book near the front door. She was unsure if any other residents left the facility property to smoke.</p> <p>*She was unsure if an assessment was completed of residents 2 and 3's ability to leave the facility in their power chairs in the winter on their own, or if residents' care plans indicated they left the facility independently to smoke off the property.</p> <p>*On 12/11/25, residents 1 and 2 went into the courtyard without notifying staff members, and resident 1 was burned by his cigarette.</p> <p>*Resident 1 was unable to leave the facility or open the door independently. Resident 2 opened the door and assisted resident 1 out into the courtyard and back inside that day.</p> <p>*She agreed that it was cold in December and there were risks of residents being outside smoking without staff knowledge, related to the cold and getting burned.</p> <p>*After resident 1 was burned, his brother provided vapes for him. His Tobacco Use Evaluation did not differentiate between smoking and vaping, and resident</p>	F0689		

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F0689 SS = G	<p>Continued from page 18</p> <p>1 was not assessed as unsafe to smoke, but it was "strongly encouraged" that he vaped because there was no active flame.</p> <p>*She was unaware that resident 1 "bummed" cigarettes from other residents, but felt that he was safe to smoke outside while he was supervised by a staff member.</p> <p>21. Observation and interview on 2/4/26 at 8:55 a.m. with resident 5 in her room revealed:</p> <p>*She used a power wheelchair and wore oxygen. She stated she removed her oxygen when she smoked.</p> <p>*She was allowed to keep her cigarettes and her lighter in her room with her.</p> <p>*Sometimes she smoked in the courtyard during the designated times, and other times she went downstairs and smoked in front of the facility. She knew the door code to open the front door, but she did not know the door code for the courtyard door.</p> <p>*There was a smokers' meeting recently, and they were told they needed to sign out in the book at the front door and leave the facility's property when they wanted to smoke outside of the designated smoking times in the courtyard.</p> <p>22. Observation on 2/4/26 at 9:00 a.m. of the residents' courtyard smoking area revealed:</p> <p>*Resident 4 walked to the courtyard door holding her lighter and a cigarette in her hand. Activities assistant H entered the door code and opened the door for resident 4 to go out into the courtyard. Activities assistant H then stood about eight feet from the door and read a book.</p> <p>*While resident 4 was outside smoking, activities assistant H walked over to the desk behind the partition wall. AD C told activities assistant H to stand next to the door, and she returned to the door.</p> <p>*A few moments later, activities assistant H walked away from the door and assisted a resident as they left the dining room by wiping her face. Administrator A told activities assistant H to stand next to the door, and she returned to the door.</p> <p>*Activities assistant H stood at the door, read her</p>	F0689		

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F0689 SS = G	<p>Continued from page 19 book, and glanced out the window occasionally. When resident 4 rang the doorbell, activities assistant H opened the door and she did not collect resident 4's lighter.</p> <p>23. Interview on 2/4/26 at 9:10 a.m. with resident 4 in her room revealed:</p> <p>*She kept her cigarettes and her lighter in her room.</p> <p>*She usually smoked in the courtyard during the day when the staff members would enter the door code and open the door for her.</p> <p>*She sat on her walker outside the front doors of the facility to smoke in the evening because the staff members were not available to open the courtyard door past 7:00 p.m.</p> <p>*She knew the door code to the front door of the facility and smoked whenever she wanted. She did not need to tell the staff members or sign out in a book.</p> <p>24. Interview on 2/4/26 at 9:25 a.m. with activities assistant H regarding residents smoking revealed:</p> <p>*She assisted residents by entering the door code to let them out into the courtyard to smoke and answered the doorbell when they were done and ready to come back in.</p> <p>*She stayed in the activities room and checked on the residents when they were outside smoking, but she did not need to watch them the whole time.</p> <p>*Most of the residents were independent with smoking and kept their own cigarettes and lighters.</p> <p>*There was only one resident she needed to help light his cigarette, but she was unsure if he still smoked.</p> <p>25. Interview on 2/4/26 at 10:10 a.m. with administrator A regarding residents' smoking revealed:</p> <p>*He held a smokers' resident council on 12/17/25 to educate the residents on the facility's smoking policy after resident 1 was burned while smoking.</p> <p>*The door code to the courtyard door was changed, and he expected residents to smoke in the courtyard during the designated times.</p>	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/04/2026
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 WEST SECOND STREET , SIOUX FALLS, South Dakota, 57104	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = G	<p>Continued from page 20</p> <p>*He expected the staff members to stand by the window and watch the residents outside while they smoked. He confirmed that activities assistant H did not supervise resident 4 the entire time she was outside smoking.</p> <p>*Some residents left the facility property to smoke, and he expected them to let a staff member know when they were leaving or to sign out in the book near the front door.</p> <p>*He was unaware that residents knew the front door code and that they went out those doors in the evening to smoke.</p> <p>*Residents who smoked had a Tobacco Use Evaluation completed, and he expected that the staff members and residents followed the recommendations made in that evaluation.</p> <p>*He was unsure if an assessment was completed for the residents' safety and ability to leave the facility property to smoke.</p> <p>26. Review of the provider's 12/17/25 Smoker's Council Meeting minutes revealed:</p> <p>**Residents discussed placing 'No Smoking' signs out front of the facility to alert visitors."</p> <p>**Administrator [A] educated residents of the requirement to let an employee know and to sign out at the front desk if they are safe to leave the facility property."</p> <p>27. Review of the provider's 12/17/25 Smoking Protocol revealed:</p> <p>**The Tobacco Use Assessment [Evaluation]should be completed in PCC [Point Click Care] at [the] time of admission, readmission, quarterly, and with a resident issue that involves smoking safety."</p> <p>**Reasonable accommodations for all residents will include supervised smoking, scheduled smoking times, a designated smoking area of the courtyard, and required adaptive equipment that will be individualized to the resident's needs."</p> <p>**Resident care plans should reflect any specialized instructions or safety interventions that have been implemented."</p>	F0689		

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F0689 SS = G	Continued from page 21 *The designated smoking location was listed as the courtyard. The smoking times listed were 6:30 a.m. to 7:00 a.m., 8:30 a.m. to 9:30 a.m., 12:30 p.m. to 1:30 p.m., 3:30 p.m. to 4:30 p.m., and 6:00 p.m. to 7:00 p.m.	F0689		