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GOOD SAMARITAN SOCIETY CANTON	1022 NORTH DAKOTA AVENUE CANTON, SD 57013

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F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 5/6/25 through 5/8/25. Good Samaritan Society Canton was found not in compliance with the following requirements: F742 and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 5/6/25 through 5/8/25. Areas surveyed included Admission, Transfer & Discharge Rights, Misappropriation of Property, Quality of Care/Treatment, and Resident/Patient/Client Abuse. Good Samaritan Society Canton was found in compliance.	F 000		
F 742 SS=D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure there was documentation to support interventions had been implemented or offered to treat clinical signs of depression for one of one sampled	F 742	1. Resident #36 will be offered counseling services. SSD followed up with resident and daughter on 5/16/2025 regarding mood and behavior. Resident's BIMS was re-evaluated: 10/15. Resident and family stated at that time they did not want to pursue counseling, declined psychotropics as he had been on other medication interventions. Family would like monitoring quarterly and as needed at this time. Conversation and outcome were documented by SSD on that same day. 2. All residents will be reviewed for mental/ psychosocial concerns and those displaying needs will be offered counseling services. Social Services	6/16/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Scott Larson
TITLE: Administrator
(X6) DATE: 5/27/2025

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

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F 742	Continued From page 1 resident (36) who had a diagnosis of major depression and recently lost a loved one. Findings include: 1. Observation and interview on 5/6/25 at 1:43 p.m. with resident 36 revealed: *He was in his room, sitting in his recliner, and his head facing down towards his chest. *His affect (observable expression of emotion) was expressionless, and his tone of voice was unanimated when responding to questions. *He answered questions but did not initiate any further conversation from them. *When conversing with him he: -Stated; "No, I am not depressed." -Started to cry and stated, "My wife died a few years ago." -Stated, "I take some meds [medication] for depression but feel like I should feel better." *He did not confirm if he had received or been offered any counseling services to help with his depression and grief regarding the loss of his spouse. 2. Interview on 5/6/25 at 2:00 p.m. with social services designee (SSD) C regarding resident 36 revealed: *His wife's death had been unexpected, and he was not able to attend the funeral service in person. *She had sat with him during his wife's telephone bedside service that was provided. *She had not offered or implemented any other interventions to assist the resident with his grief and the loss of his wife. *She: -Was not sure, but thought he had taken an anti-depressant medication. -Stated, "Oh, does he?" when the surveyor	F 742	Designee, MDS coordinator, or designee will track residents that have had psychotropic medications that have been discontinued or have had a gradual dose reduction over the last quarter. Those residents will be discussed quarterly at the Interdisciplinary Team Meetings, which will review current or new resident for aberrant moods or behaviors. Mood and behavior documentation will be reviewed at those meetings by the Interdisciplinary Team to ensure documentation has taken place regarding changes as listed above. PHQ-2/PHQ-9 will continue to be completed upon admission, quarterly, annually, and with significant change. Those with elevated scores will be discussed at the quarterly IDT meetings. SSD or designee will continue to complete the Permission for Use of Psychotropic Medications as per previous. 3. DON/Designee will provide education to Social Worker Designee (SSD) and nurse managers of process. SSD will complete the trauma assessment UDA, BIMS UDA, PHQ-2/PHQ-9 UDAs within 48 hours of admission and quarterly/annual/significant change assessments, 6 days before ARD date.	

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F 742	Continued From page 2 commented on how sad the resident had appeared. -Thought they had offered counseling services to him or his family but they had declined. -Was not able to locate any documentation to support they had offered to assist him with counseling services or initiated interventions to further support his grief process from the loss of his spouse. 3. Continued interview on 5/8/25 at 2:25 p.m. with SSD C regarding resident 36 revealed: *She confirmed he had a diagnosis of major depression and that his spouse had passed away on 12/9/24. *She stated: -He had always refused to take anything [medication] for his depression. -"He did have weepy episodes after his wife passed away and I believe we asked him and his family about an anti-depressant [medication] at that time." -He had refused and medication and so did his family. -His daughter said he had always been sensitive with mental issues and that behavior was not abnormal for him. -"I'm pretty sure we've offered him counseling services too and that was declined also." *She had no documentation to support those conversations with the resident or his family had occurred. *She stated: "We talk about these things all the time and it's discussed in our care conference meetings." *She agreed that if those conversations were not documented, there was no evidence to support that they had occurred. *She was not a licensed social worker (LSW) and	F 742	Changes in mood or behavior noted by the nursing staff will be reported to the SSD, and mood and behavior charting will be initiated for 14 days every shift to determine if aberrant mood and behaviors continue. When new psychotropic medications are added or changed to the resident's medication regimen, an additional 14 days of mood and behavior charting will be completed by the nursing staff to determine if improvement in mood and behaviors are noted. 4. MDS or designee will complete audit of these UDSs monthly for 3 months, then quarterly for 3 quarterly. All new admission will be audited and 3 established or long-term care residents will be audited during the specified monitoring period. MDS or designee will report audit finding at IDT/QAPI meetings monthly for 3 months, then quarterly for 3 quarters. SSD will meet quarterly with LSW overseeing the SSD per state requirements and as needed. The first quarterly meeting will be completed on May 27, 2025 between the LSW and SSD. Written documentation of these meetings including issues covered during the visit, chart audits, plans for the next visit, and areas that might require administrator intervention will be completed by the consulting LSW and given to the administrator and SSD	

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F 742	Continued From page 3 required oversight by one. *The LSW worked in another sister facility, and she had traveled to meet with the LSW every three months. Those meetings were confirmed as having been scheduled on her Outlook calendar. *She had no documentation to support: -What was reviewed and discussed at those meetings with the LSW. -What guidance and education the LSW had provided for her during those meetings. -If resident charts had been reviewed to ensure appropriate processes had been followed to support their emotional well-being. 4. Review of resident 36's electronic medical record (EMR) revealed: *He had a diagnosis of recurrent major depressive disorder. *His 2/6/25 Brief Interview for Mental Status (BIMS) assessment score was 8, which indicated he had moderate cognitive impairment. *He had been on an anti-depressant in the past, but it was discontinued on 2/23/24 by the medical director based on a gradual dose reduction (GDR) recommendation by the pharmacist and was never resumed. *There were no orders that indicated he took any medications to help with his depression. *From 2/2/24 through 5/8/25 there was no documentation that indicated the interdisciplinary team had discussions with both the resident and his family regarding his depression and the capability for counseling or oral medication to assist him with his weepy episodes and the loss of his spouse. *The IDT had scheduled care conferences every three months from 2/29/24 through 2/20/25. -He had declined to attend those meetings. -On 2/29/24 the IDT documented, "Res [resident]	F 742	within 1 week of the meeting. These meeting documents will be kept on file for 3 years.	

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F 742	Continued From page 4 wife passed this quarter and has had some tearful days. Resident has been opting to eat meals in his room more often but does still eat some meals in the dining room." -On 8/22/24 the IDT documented, "Res does get tearful after outings when visiting his wife but doesn't last for long periods." -There was no documentation that indicated the resident had been offered counseling services or follow-up with the physician to evaluate and possibly resume his anti-depressant medication for his continued weepy and tearful episodes. 5. Review of resident 36's physician progress notes from 12/18/24 through 3/14/25 revealed: *On 12/18/24 the physician had documented, "Nurses notes in PCC [point click care] reports resident was weepy (his spouse passed away 1 week ago). He reports [he is] tired, but feeling pretty good." *On 3/24/25 the physician had documented, "Nursing staff notes that he has good and bad days." *There was no documentation that indicated the physician had visited with the resident about possibly resuming his anti-depressant medication or offering to order him counseling services to assist him with his depression and grieving process regarding the recent passing of his spouse. 6. Review of resident 36's 12/10/24 revised comprehensive care plan revealed: *A focus area initiated on 2/15/23 and revised on 12/10/24 indicated the resident had a potential for psychosocial well-being deficit related to recent confusion, change in his functional ability, and the loss of his wife on 12/9/24. *A goal that the resident would have no	F 742		

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F 742	Continued From page 5 indications of psychosocial well-being deficit by/through the next review date. -The interventions had not been updated since 2/15/23 to support how the provider would have helped him to achieve that goal. *There was no documentation that indicated he had been offered and refused assistance with his depression and weepy episodes through counseling, medication, or methods of supportive interventions. 7. Interview on 5/8/25 at 2:30 p.m. with registered nurse (RN)/Minimum Data Set (MDS) coordinator D regarding resident 36 revealed: *She was not able to locate any further documentation in the resident's chart to support: -The IDT or the nursing staff had visited with his family, the practitioner, or him about the possibility of resuming his anti-depressant medication to help with his weepy and tearful episodes. -Counseling services had been offered to the resident to help him with the grieving process from the recent loss of his spouse. *She stated they had talked to him and his family about his offered counseling and possible resumption of his depression medication, but they had refused. *She agreed that was an important piece of his care that was not documented but should have been. 8. Interview on 5/8/25 at 3:00 p.m. with director of nursing B regarding resident 36 revealed: *She was aware that resident 36 had recently lost his spouse, but was unaware about his diagnosis of major depression. *Most of her information that she received on the residents came from the 24 hour notes.	F 742		

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F 742	Continued From page 6 -The leadership team reviewed those notes during morning huddle meetings. -She could not recall if they had discussed a concern with his mood and behaviors. *Most of the nursing documentation on a resident's mood and behavior was directed from [SSD name] and those assessments that she had done. *She would have expected whoever discussed these things with him or his family to have documented on it. *She agreed that if those conversations had not been documented there was no evidence to support that it occurred. 9. Interview on 5/8/25 at 3:15 p.m. with administrator A revealed: *He would have expected documentation of any conversation that occurred between resident 36 or his family regarding his mood and increase in his weepiness and the refusal of counseling or the potential use of an antidepressant medication. *He confirmed: -The SSD had oversight from an LSW from a sister facility. *He had no documentation of what the SSD and LSW had reviewed, what educational support was provided, or any guidance that SSD needed related to those meetings. 10. Review of the provider's revised 12/30/24 Documentation, Social Services - Rehab/Skilled policy revealed: *"The purpose was to systematically and continuously collect information about the psychosocial status of the resident and to furnish documentary evidence of the care and services provided during a resident's stay. *Frequency of documentation will be determined	F 742		

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F 742	Continued From page 7 depending on the condition and the plan of care of the resident. "When social work personnel provide intervention, evidence of the intervention will be documented." The provider was unable to find a mood/behavior or psychosocial policy by the survey exit date of 5/8/25.	F 742		
F 880 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:	F 880	1. Employee E will be provided one on one education regarding PPE and infection prevention on types of precaution by Infection Preventionist or designee. 2. Education was deployed on May 6, 2025 via electronic learning system by CLDS to all employees regarding the use of PPE and when it should be utilized. CLDS will continue to deploy electronic learning regarding hand hygiene annually. This training includes the four moments of hand hygiene, strategies used to identify residents that are on transmission-based precautions, donning and doffing PPE, and proper sanitation of equipment to prevent the spread of infection. CLDS or designee will monitor the completion of these electronic learnings to ensure timely completion. 3. Infection Preventionist or designee will educated proper use of PPE at all staff meeting on June 4, 2025. IP will also complete one on one education	6/16/25

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F 880	Continued From page 8 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons 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:	F 880	regarding PPE and infection prevention to one individual in each department biweekly for 1 quarter, then quarterly at all staff meetings for 3 additional quarters. Cleaning supplies for those on transmission-based precautions will be kept in a lock box in the resident's bathroom and discarded after transmission-based precautions have ended. The infection preventionist or designee will educate staff on June 4, 2025 at the all staff meeting on when and how hand hygiene should be performed. All staff will sign off on the hand hygiene policy and the standard, enhanced barrier, and transmission-based precautions policy. 4. 10 audits will be conducted by infection preventionist or designee on proper PPE use when entering and exiting room with resident on precautions each month. This will be audited monthly times 3 months and then quarterly times 3 quarters. The infection preventionist or designee will complete 30 hand hygiene observations each month for 12 months to ensure compliance and understanding of infection prevention practices. These audit results will be discussed at the quarterly QAPI meetings.	

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F 880	Continued From page 9 Based on observation, interview, document review, and policy review, the provider failed to ensure appropriate infection control practices were followed by one of one observed housekeeper/laundry aide (E) when cleaning one of one sampled resident's (37) room who was on contact precautions for a highly infectious disease that had the potential to spread to others. Findings include: 1. Observation on 5/6/25 at 11:05 a.m. with housekeeper/laundry aide E revealed: *She had prepared to clean resident 37's room. *There was a sign on the resident's door that indicated she was on contact precautions and everyone must wear gloves and a gown when entering her room. Staff were to wash their hands with soap and water after assisting the resident. *The resident had been isolated to room for a diagnosis of Clostridium Difficile (C-DIFF) (a highly infectious disease that can easily spread to others). *Housekeeper/laundry aide E: -Sanitized her hands, put on gloves and a gown, and then entered the resident's room. -Took a spray bottle of toilet bowl cleaner and a container of bleach sanitary wipes into the resident's room and placed them onto the resident's dresser. *After housekeeper/laundry aide E finished cleaning the resident's room she: -Removed her gloves and gown, and placed the toilet bowl cleaner and the container of bleach wipes on top of an opened box of clean gloves. The box of clean gloves was on top of the housekeeper's cleaning cart that was located outside of the resident's room. *Housekeeper/laundry aide E: -Had not cleaned the toilet bowl spray bottle or	F 880		

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F 880	Continued From page 10 container of bleach prior to taking it out of the resident's room and placing it on the opened box of clean gloves. -Left the resident's room without washing or sanitizing her hands. -Went to the soiled utility room that was approximately 25 feet from the resident's rooms, touched the door handle to open the door, and washed her hands. Interview on 5/6/25 with housekeeper/laundry aide E right after the observations above revealed: *She was not sure if supplies could have been brought out of the resident's room who was on contact precautions for an infectious disease. *She stated, "I probably should have cleaned them with bleach wipes before I did that." *She had not realized that placing the supplies on top of the open box of clean gloves had contaminated them. *She stated: -"Well, I can't wash my hands in the resident's room because we have to wear gloves and a gown in there. She's on contact precautions." -"I guess I could sanitize my hands before I leave the room, but we were told to wash our hands." -"I'm not sure what her actual diagnosis is, all I know is that she is on contact precautions, I have to use bleach, and she is last for cleaning [her room] on my list of rooms." *The housekeeping director had reviewed the process for cleaning resident 37's room which had included washing their hands with soap and water. -She was unsure, but thought they were supposed to leave the resident's room to wash their hands. *No one had watched them clean resident 37's	F 880		

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F 880	Continued From page 11 room to ensure the correct processes were followed. *During the interview an unidentified staff person was observed going into the soiled utility room. *She stated, "Well, I suppose I better go clean that door handle now." Interview on 5/7/25 at 10:00 a.m. with housekeeper/laundry aide F regarding the cleaning process of rooms for residents contact precautions revealed: *She would have put on a pair of gloves and gown prior to entering the resident's room. *The cleaning of that room would have been last to do on her list. *She would have taken the spray bottle of toilet bowl cleaner into the resident's room, it could not be left in the room, and she needed it to use in other residents' rooms. *She would have sanitized the spray bottle with a bleach wipe before taking it out of the room. *She would have left the room to wash my hands. *She stated: -"Actually, I'm not sure how else I would do that." -"I'm pretty sure that is what we were told to do." Interview on 5/7/25 at 10:20 a.m. with environmental services supervisor G regarding the above observation and interviews revealed: *She could not recall the last time that she had completed audits on the housekeeping staff while cleaning a room for a resident with an infectious disease. *She would have reviewed the process with the staff prior to them cleaning those rooms. *The housekeepers take the toilet bowl cleaner out of the residents' rooms because they could not leave chemicals in them. *She stated:	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435101	A. BUILDING _____ B. WING _____	C 05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY CANTON	1022 NORTH DAKOTA AVENUE CANTON, SD 57013

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F 880	Continued From page 12 -"They should sanitize it [the cleaner] with a bleach wipe before bringing it out and they shouldn't be setting it down in the room." -"This is why I have them park the carts right in front of the entrance, that way they are not leaving the rooms." -"They are to wash their hands before leaving the [resident] rooms, not go down the hall to do it." *She could not recall the last time competencies had been completed on the housekeepers related to IC. *She stated, "I think it was during COVID. That was the last time I did any competency checks." *She agreed the above processes were infection control concerns and had the potential to spread an infectious disease to others. Interview on 5/7/25 at 12:40 p.m. with director of nursing B regarding the above observation and interviews revealed: *She had been the previous infection control (IC) nurse and was still assisting the current IC nurse with some IC things. *She could not recall the last competencies that had been completed on all the staff related to IC. *She stated: -"I believe it was with COVID." -"I didn't do competencies on the housekeeping staff. I've always left that up to the director [housekeeping]." -"But, yes, as the IC nurse, we probably should be involved with other departments to make sure they are following the correct processes." *The staff should not have taken anything into the resident's room that could not have been left in there. *Chemicals were not to be stored in resident rooms for safety purposes. *Any item that was brought out of a room where	F 880		

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	435101	A. BUILDING _____ B. WING _____	C 05/08/2025

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GOOD SAMARITAN SOCIETY CANTON	1022 NORTH DAKOTA AVENUE CANTON, SD 57013

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F 880	Continued From page 13 the resident had C-DIFF or an infectious disease, it should have been sanitized with bleach wipes. *Her expectations had been for the staff to wash their hands prior to leaving a resident's room where a resident was isolated with an infectious disease such as C-DIFF. -C-DIFF required hand washing versus sanitizing to kill the bacteria and stop the infectious disease from spreading to others. *She agreed the housekeeper's process observed above had created the potential for the infectious disease to spread to other residents. 2. Review of the provider's undated Housekeeping Resource packet revealed: *Role and Responsibilities of Environmental Cleaning in the Infection Control Program: -"Environmental cleaning plays an important role in an infection control program. ...the spread of infections from contaminated surfaces is significant and supports the need for good procedures and practices related to cleaning and disinfecting of surfaces. -All staff members play a role and should be aware of the general principles of environmental cleaning and safety." *Procedure: "If working in a resident room with a recent known infectious disease or if cleaning supplies or equipment have been used to clean blood or body fluids, the ...cleaning equipment should be properly cleaned before storing." Review of the provider's October 2017 Clostridium Difficile (C-DIFF) policy revealed: *The staff should "perform hand hygiene after removing gloves. Alcohol does not kill Clostridium difficile spores; therefore, the use of soap and water is more effective than alcohol-based hand rubs."	F 880		

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	435101	A. BUILDING _____ B. WING _____	C 05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY CANTON	1022 NORTH DAKOTA AVENUE CANTON, SD 57013

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F 880	Continued From page 14 *"Refer to Environmental Services policies and procedures on the Web Portal regarding cleaning processes."	F 880		

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	435101	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/06/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY CANTON	**1022 NORTH DAKOTA AVENUE** **CANTON, SD 57013**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey was conducted on 5/6/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Good Samaritan Society Canton was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K211 and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to provide an operable egress door as required at one randomly observed exit door location (600 wing west exit door). Findings include: 1. Observation beginning at 11:03 a.m. on 5/6/25 revealed the west exit door to the 600 wing was unable to be opened. Testing of that door in the direction of the path of egress revealed it would not open without applying force greater than fifty pounds in the direction of the path of egress.	K 211	1. Egress door on 600 wing did meet egress standards. Maintenance Supervisor/Designee adjusted the doors on May 6, 2025 and retested egress and was deemed to meet the standard. 2. All staff and residents within smoke compartment are affected. Maintenance Supervisor/Designee inspected all 12 egress doors and no other concerns noted. 3. Maintenance supervisor/Designee will inspect egress locking system on all egress doors on a monthly basis and will be recorded on appropriate form and in Tels 4. Administrator/Designee will audit egress doors monthly and report to QAPI committee for review monthly for 3 months and then quarterly time 3 quarterly.	May 6, 2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Scott Larson	Administrator	5/21/25

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435101	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/06/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY CANTON	**1022 NORTH DAKOTA AVENUE** **CANTON, SD 57013**

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K 211	Continued From page 1 Interview at the time of the observation with the maintenance manager confirmed those conditions. He stated he was unaware that door was not able to be opened. Failure to provide working egress doors as required increases the risk of death or injury due to fire. The deficiency affected 100% of the smoke compartment occupants. Ref: 2012 NFPA 101 Section 19.2.2.2.1, 7.2.1.4.5.1(2)	K 211		
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and plan review, the provider failed to ensure corridors and exit routes were kept clear of any obstructions to ensure smooth and rapid evacuation during a fire drill or emergency. (500 wing). Findings include:	K 712	1. During survey a fire drill was conducted and there were several obstructions that were not cleared during the drill 2. All staff and residents were potentially affected.	June 20, 2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435101	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/06/2025**

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GOOD SAMARITAN SOCIETY CANTON	**1022 NORTH DAKOTA AVENUE CANTON, SD 57013**

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K 712	Continued From page 2 1. Observation on 5/6/25 at 9:17 a.m. revealed the fire alarm was sounded to initiate a drill via simulated smoke being spread into the smoke detector for a simulated fire in resident room 501. The staff persons responding to the simulated fire location did not clear the corridor of obstructions to ensure smooth and rapid evacuation. A medication cart, a 13-gallon trash container(can), and a toolbox (contact precaution PPE kit storage) were left in the affected smoke compartment for the duration of the fire drill. Interview with the maintenance manager at the time of the observation confirmed those findings. The deficiency had the potential to affect 100% of the occupants of that smoke compartment.	K 712	3. Administrator/Designee will educated staff on the fire alarm policy and fire drill policy at All Staff Meeting on June 4, 2025. During the next Fire Drill Maintenance/Designee will walk thru the policy with staff to ensure that the guidelines are followed. Areas of importance will be to identify where the fire is either by physically seeing the fire or by looking at the fire panel to indicate location. once identified location is known fill follow the "R.A.C.E." First we will rescue those within the smoke department, clear out hallways, activating the alarm and calling fire department and then finally confining the fire and extinguishing if able to. 4. Fire Drills will be conducted by maintenance supervior or designee per policy, one per shift per quarter and no closer than 90 minutes from the last drill time and not in the same hour during the year for any shift. Evaulation of Fire Drills will be discussed at QAPI at least quarterly to determine future follow-up education that is needed.	

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
	10604	A. BUILDING: _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY CANTON	1022 N DAKOTA AVENUE CANTON, SD 57013

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 5/6/25 through 5/8/25. Good Samaritan Society Canton was found in compliance.	S 000		
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 5/6/25 through 5/8/25. Good Samaritan Society Canton was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Scott C. Larson | TITLE: Administrator | (X6) DATE: 5/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435101	A. BUILDING _____ B. WING _____	05/06/2025

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 5/6/25 Good Samaritan Society Canton was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Scott C. Larson	Administrator	5/21/2025

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