STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435095	A. BUILDING _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SCOTLAND	130 6TH STREET SCOTLAND, SD 57059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/24/25 through 3/27/25. Good Samaritan Society Scotland was found not in compliance with the following requirements: F655 and F755.	F 000		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of	F 655	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of defeciencies. The plan of cerrection is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual F-655	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Julie Ramey
TITLE: Administrator
(X6) DATE: 04/17/2025

An 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
	435095	A. BUILDING _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SCOTLAND	130 6TH STREET SCOTLAND, SD 57059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 1 this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, interview, policy review, and job description review, the provider failed to complete a baseline care plan and provide a written summary of the baseline care plan to the resident or their representative for four of four recently admitted sampled residents (8, 133, 183, and 184) within 48 hours of their admission to the facility. Findings include: 1. Review of resident 8's electronic medical record (EMR) on 3/24/25 revealed: *He was admitted on 3/6/25. *There were no progress notes pertaining to a baseline care plan. *The first progress note pertaining to care planning was titled "care plan change" and dated 3/11/25. -It included removing 15-minute checks that had been instituted due to a concern for self-harm. *There were no notes indicating a baseline care plan had been provided to the resident. *A progress note indicating initial care plan was	F 655	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident number 8 has been discharged from the facility. unable to correct deficiency. Resident number 133 had complete careplan review 4-3-25 with resident in attendance. Does not have family or representative. A copy of careplan will be offered to resident. A copy of careplan was offered and reviewed with resident 4-16-25, resident declined to sign. Resident number 183 has been discharged. Unable to correct the deficiency. Resident number 184 had complete careplan review on 4.3.25 with husband, daughter present in person, granddaughter via phone, resident did not attend. A copy of careplan will be offered to resident and family. Copy of the careplan offered to resident and husband 4-16-25, resident declined to review and declined to sign careplan. 2. How will other residents, having the potential to be affected by the same deficient practice be identified? Audit of new admissionssince 1-1-25 revealed 6 additional residents affected. Copies of initial careplan including baseline careplan have been offered to these 6 residents. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? Admission checklist will be revised to include the following regarding baseline care plans. - Date and time of admission - Date and time due - Date, time and staff signature when completed - Date, time and staff signature of baseline careplan reviewed with resident/representative - Date and time careplan offered to resident/ representative - Documentation in resident progress note -Final review by DON/designee Admitting nurse will initiate baseline careplan, subsequent nurses will continue to revise until completed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435095	A. BUILDING _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SCOTLAND	130 6TH STREET SCOTLAND, SD 57059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 2 entered on 3/20/25 by Minimum Data Set (MDS) Coordinator C, for Assessment Reference Date (ARD) of 3/11/25. Interview with resident 8 on 3/26/25 at 11:42 a.m. revealed: *He was not interviewed by staff about his daily routine or preferences. *He did not know what a care plan was. *He had not received a copy of any care plan. A request was made on 3/25/25 at 2:05 p.m. to Administrator A to review resident 8's baseline care plan. No baseline care plan was provided by time of survey exit on 3/27/25. There was no documentation to support a baseline care plan had been completed within 48 hours of his admission. 2. Interview on 3/27/25 at 8:58 a.m. with resident 133 revealed: *He admitted to the facility on 3/19/25 after he was hospitalized due to an amputation of his toes on his right foot, and he was no longer safe at his home. *He did not have a power of attorney (POA) and made his own decisions. *He had an allergy to chocolate. *He was supposed to get therapy. *The director did his admission paperwork but he could not remember her name, and he signed those papers. *He did not remember if his medical needs or cares were discussed with him. *He stated he had not received a summary or paper copy of his care plan. Review of resident 133's electronic (EMR)	F 655	DON/designee will educate nurses 1:1 on new process for baseline care plans by 5/1/25 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? SSD/designee will audit all new admissions for 3 months verify the baseline careplan was completed and reviewed with resident/representative within 48 hours, copy was offered to resident/representative at time of review. Audit findings will be reported to QAPI monthly x3 for review and revision is warranted. 5. What is the date of completion? 5/01/25 Type text here	05/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435095	A. BUILDING _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SCOTLAND	130 6TH STREET SCOTLAND, SD 57059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 3 revealed: *He admitted to the facility on 3/19/25 from the hospital for inability to thrive and right toe amputation. *His admission assessment was not completed inidicated "in progress" and it was signed by MDS coordinator C. *His brief interview for mental status (BIMS) assessment indicated he refused to the answer the questions. *His comprehensive care plan indicated it was not completed until 3/24/25. 3. Interview on 3/25/25 at 2:28 p.m. with resident 183 and his wife in his room revealed: *He was admitted on 3/12/25. *He and his wife could not recall any conversation with staff regarding his plan of care within the first two days of his admission to the facility. *He stated they had not received a summary of his baseline care plan or a list of his medications. -His wife stated his medication list would have been lengthy as he was on many medications. *His wife stated she recalled visiting with administrator A regarding admission paperwork and administrator A had mentioned he would be receiving physical and occupational therapy, but she stated no other services were discussed. Review of resident 183's EMR on 3/25/25 revealed: *He was admitted on 3/12/25 at 11:00 a.m. *His eight-page 3/12/25 Nursing Admit Re-Admit (NARA) Data Collection assessment was signed by registered nurse (RN) J on 3/12/25. -Care planning, including a focus area, goal, and interventions were indicated for: --The six skin/wound areas identified.	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435095	A. BUILDING _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SCOTLAND	130 6TH STREET SCOTLAND, SD 57059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 4 --His limited activities of daily living (ADL) function. -The sleep pattern section indicated he was "experiencing a sleep disturbance [and/]or using any pharmacological ... sleep aides" and noted the sleep aide supplement/medication he used. --The "Care planning for sleep disturbance" indicated no focus, goal, or intervention had been identified to address his sleep. *His progress notes for his first 48 hours included: -On 3/12/25 at 1:22 p.m. registered nurse (RN) J noted the "Skilled services to be provided" included: --Dressing changes and wound assessments. --Diabetes control. --Strengthening with physical therapy and occupational therapy. --Pain control. --Antibiotics for his wounds. -On 3/12/25 at 3:32 p.m. MDS coordinator C noted that his admission orders had been entered into his EMR. *On 3/12/25 at 3:51 p.m. administrator A documented that she had completed his admission agreement with him and his wife and identified his discharge goal as returning home. *On 3/12/25 at 4:04 p.m. RN J noted his oxygen administration orders, chronic low back pain, pain medications, blood sugar checks for his diabetes, and that he was non-weight bearing. *On 3/12/25 at 11:08 p.m. licensed practical nurse (LPN) K noted his right leg had a "warming boot" in place at all times and that he used a full-body mechanical lift with the assistance of two staff members. *On 3/13/25 at 2:58 p.m. activities director L documented she had completed his: -BIMS assessment, which was scored at 14	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435095	A. BUILDING _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SCOTLAND	130 6TH STREET SCOTLAND, SD 57059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 5 indicating he was cognitively intact. -Patient Health Questionnaire (PHQ) indicated he had no mood problems. -Activity preferences. *On 3/13/25 at 3:24 p.m. RN J noted she had received physician orders for side rails on both sides of his bed. *On 3/13/25 at 11:31 p.m. LPN K noted his health status. *There was no progress note regarding any care conference held during his first 48 hours in the facility. *His 3/25/25 care plan indicated his baseline care plan had included focus areas of: -ADL assistance with transferring, toileting, personal hygiene, and bed mobility. -Skin wounds with dressing changes. -Enhanced Barrier Precautions (EBP) related his wounds which included his surgical wound with infection. -Chronic pain/discomfort. -Preferences for independent activity pursuits. *His baseline care plan had not addressed the required areas of his dietary orders, therapy services, and social services. *There was no documentation indicating that the baseline care plan had been reviewed or provided to the resident or his representative. 4. Review of resident 184's EMR revealed: *She was admitted on 3/20/25 at 2:32 p.m. *Her eight-page 3/20/25 NARA Data Collection assessment was signed by RN J on 3/20/25. -The Reason for Admission section indicated: --"She had been hospitalized for a cerebrovascular accident (CVA) (stroke) which had affected her "changes in mentation [cognitive abilities], increased weakness on right side, [and] urinary retention."	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435095	A. BUILDING _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SCOTLAND	130 6TH STREET SCOTLAND, SD 57059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 6 --Her skilled care services included "physical therapy strengthening, diabetes control, [and] assist with ADL's. -Care planning included one focus area, her impaired vision in her right eye. -The "Care planning for " indicated no focus, goal, or intervention had been identified to address her: --Increased confusion, disorientation, and forgetfulness. --Need for ADL assistance. --Urinary retention and Foley catheter. *Her progress notes for her first 48 hours included: -On 3/20/25 at 2:32 p.m. administrator A documented her arrival with family members and that the resident was not alert. -Administrator A indicated she had completed the admission agreement with the resident's daughter and noted the discharge goal of returning home. -On 3/20/25 at 4:03 p.m. RN J noted the skilled services to be provided included: --Physical therapy strengthening. --Diabetes control. --Assistance with ADL's. -On 3/20/25 at 5:48 p.m. MDS coordinator C noted that her admission orders had been entered into her EMR and the family members' concerns regarding her not eating, feeling nauseous, and ability to use the call light. -On 3/21/25 at 3:48 a.m. RN M noted she had received physician orders for physical therapy and occupational therapy services for strengthening and the resident's need to be checked on frequently, repositioned routinely, encouraged to drink, and the need for assistance with her cares. -On 3/21/25 between 1:48 p.m. and 6:32 p.m. RN J noted the following: --Resident's elevated temperature of 100.8°F	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435095	A. BUILDING _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SCOTLAND	130 6TH STREET SCOTLAND, SD 57059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 7 (Fahrenheit) and that she had received physician orders for lab work. --Resident's Foley catheter had been removed. --Antibiotic medication order had been received to treat her UTI (Urinary Tract Infection). --Physician order for dietary supplement three times a day had been received. --Nursing interventions required for the resident's care included: --Monitor for any changes in cognition. --Complete vital signs every shift. --Monitor urine output. --Participation with therapy services. --Frequent repositioning. --Encourage food related to her poor intake and loss of appetite. --Need for one person to assist with her ADLs. *There was no progress note regarding any care conference held during her first 48 hours in the facility. *Her 3/25/25 BIMS assessment was three which indicated her cognition was severely impaired. *Her 3/25/25 care plan indicated her baseline care plan had included focus areas of: -Impaired visual function related to "difficulty seeing out of right eye." -ADL assistance with transferring and bed mobility. -"Infection of the (urine)". -Potential for pain. *Her baseline care plan had not addressed the required areas of dietary orders, therapy services, social services, and her need for extensive to total assistance with ambulation, bathing, dressing, eating, oral care, personal hygiene, and toilet use. *There was no documentation to support the baseline care plan had been reviewed and provided to the resident or her representative.	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435095	A. BUILDING _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SCOTLAND	130 6TH STREET SCOTLAND, SD 57059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 8	F 655		

5. Interview on 3/25/25 2:49 p.m. with RN J revealed she:
*Had worked at the facility since 9/24/24.
*Worked as a charge nurse on the day shift and was responsible for completing the nursing assessments which included newly admitted residents.
*Stated her responsibilities were "not so much for the care plan" of the residents.
*Stated MDS coordinator C or director of nursing (DON) B completed the residents' care plans.

Interview on 3/25/25 at 4:12 p.m. with MDS coordinator C revealed:
She had worked at the facility for nearly thirty years.
*Completing the resident care plans was the responsibility of the interdisciplinary team (IDT) including social services, activities, dietary, and nursing staff.
*The baseline care plan was her responsibility.
-She stated the charge nurses did not have the time to complete resident care plans.
-She used the provider's EMR care planning software to complete the baseline care plan.
-Three months ago they had tried to organize the process for the baseline care plan, that "fell apart" with staff challenges.
-She acknowledged completing the baseline care plan and its requirements were an area for improvement.
-She agreed that resident baseline care plans had not been completed within 48 hours of their admission and the baseline care plans had not been given to the resident or representative as required.

Interview and record review on 3/26/25 at 11:03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435095	A. BUILDING _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SCOTLAND	130 6TH STREET SCOTLAND, SD 57059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 9 a.m. with MDS coordinator C regarding resident 184's baseline care plan revealed: *The electronic care plan that initially had her baseline care plan had been developed into her comprehensive care plan and included: -A focus area initiated on her admission day, 3/20/25, indicated "The resident has impaired visual function R/T [related to] CVA [Cerebrovascular Accident] E/B [evidenced by] difficulty seeing out of right eye." -No goal or interventions had been identified for that focus area. -A focus area initiated on 3/22/25 indicated "The resident has an ADL self-care performance deficit R/T [related to] non traumatic cerebral hemorrhage E/B [evidenced by] Alzheimer's Dementia, convulsions" with two goals initiated on 3/22/25. -Three interventions regarding bed mobility were initiated on 3/21/25. -One intervention regarding transfers was initiated on 3/21/24. -A focus area initiated on 3/21/25 indicated "The resident has infection of the (urine) R/T [related to] (having Foley catheter in hospital) E/B [evidenced by] (lab results)" with a goal and three interventions initiated on 3/21/25 indicated. -A focus area initiated on 3/21/24 indicated "The resident has P/F [potential for] pain." -No goal or interventions had been identified for that focus area. *MDS coordinator C confirmed that not all the required components of the baseline care plan were included within the required 48-hour timeline. *She confirmed the baseline care plan had not been provided to the family or representative as required. *She agreed that the resident's dietary orders,	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435095	A. BUILDING _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SCOTLAND	130 6TH STREET SCOTLAND, SD 57059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 10 therapy services, and social services were not included in the baseline care plan within the required 48-hour timeline and should have been. *The focus area addressing the resident's dietary orders which included her nutritional problem and unplanned weight loss had been initiated on 3/25/25, five days after her admission. *The focus area addressing the resident's social services which included her psychosocial well-being deficit and discharge plan to return home had been initiated on 3/25/25. *The ADL interventions that addressed her therapy services which indicated "PT [physical therapy] and OT [occupational therapy] had been initiated on 3/25/25. *She agreed they were not meeting the requirements for the baseline care plan. Interview and policy review on 3/26/25 at 1:19 p.m. with DON B regarding the baseline care plan revealed: *It was her expectation that the charge nurses completed the required nursing assessments. *Specific assessments included care planning functionality that helped develop the resident's individual care plan. *The required NARA Data Collection assessment which was completed on a resident's admission day included: -"Section B Physical Exam" with care planning features. -"Section C Clinical Data" with care planning features. -Further assessments have been triggered depending on how the NARA Data Collection was completed by the admitting nurse. *She confirmed MDS coordinator C's responsibilities included completing residents' baseline care plans.	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435095	A. BUILDING _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SCOTLAND	130 6TH STREET SCOTLAND, SD 57059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 11 *She agreed the 12/2/24 Care Plan policy which referred to the baseline care plan was their current policy. *She stated there were different options available to document the baseline care plan was provided to the resident or representative according to the policy. Those included: -A care conference progress note could have been completed. -The baseline care plan could have been printed and the resident and/or representative could have signed that document to acknowledge they had received it. --The provider could have scanned that signed document into the resident's medical record. *She confirmed they were not meeting the requirements for the baseline care plan to be completed within 48 hours of a resident's admission and ensuring the resident or representative had received a summary. -She stated with their staffing challenges "sometimes it was the decision between providing care to the resident or complying with the requirement for the baseline care plan." Interview and record review on 3/27/25 at 12:23 p.m. with administrator A regarding the residents' baseline care plan revealed: *She agreed the baseline care plan was required to be developed and completed within 48 hours of a resident's admission. *She agreed that resident 183's and resident 184's baseline care plans were missing the required dietary orders, therapy services, and social services. *She agreed the baseline care plan should have been given to the resident or representative within 48 hours of the resident's admission. -She stated "If I was a family member, I'd want	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435095	A. BUILDING _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SCOTLAND	130 6TH STREET SCOTLAND, SD 57059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 12 that information close to admit." -She stated it was the MDS coordinator's responsibility to provide the baseline care plan to the resident or representative. 6. Review of the provider's 12/2/24 Care Plan policy revealed: *"Purpose: To provide guidance to the interdisciplinary team in developing the initial care plan." *"Definitions: Baseline care plan - Includes instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care." *"Policy: A baseline care plan will be developed upon admission according to federal and state regulations. The location must provide the resident and resident representative with a written summary of the baseline care plan. Use the PN [Progress Note] - Care Conference Note ... to document that the meeting occurred with the resident and representative and any significant discussion that occurred." Review of the provider's undated job description for RN, MDS, LTC [Long Term Care] Nurse revealed: *"Summary The MDS Nurse uses independent judgment in the planning, organizing, directing, and evaluation of activities of the professional and supportive nursing staff engaged in resident plan of care. Evaluates care provided to each resident and keeps care plans current ..." *"Collaborates with the resident, family or advocate, other inter-disciplinary colleagues, including providers, to assure ongoing care of each resident to provide the best quality of life possible."	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435095	A. BUILDING _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SCOTLAND	130 6TH STREET SCOTLAND, SD 57059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 13	F 755		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, interview, policy review, and job description review, the provider failed to ensure staff had administered 2 of 13 sampled	F 755	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident number 11 regarding Tamiflu, physician notifed on 2/13/25. Resident 11 spironolactone was addressed and resolved prior to survey.No negative outcome was identified r/t Tamiflu and spironolactone. Resident 11 medication record has been reviewed and no other discrepancies noted. Resident number 3 regrading duloxetine has been corrected. Resident 3 regrading clozaril has been corrected, correct medication has been filled, and orders are being followed. Staff involved with medication errorshave been reeducated. 2. How will other residents, having the potential to be affected by the dame deficient practice be identified? All residents have potential to be afffected. Pharmacy completes monthly chart reviews for all residents. Random administration audits medication administrations. MDS coordinatordoes chart reviews for quarterly MDSand compares current orders to new orders received. All identified medication errors are addressed timely after discovery. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Nurses and medication aides will be reeducated by DNS/designee on medication administration policy, including the 5 rights (drug,dose, resident, route, time). Medication administration has been added to routine monthly audit schedule.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435095	A. BUILDING _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SCOTLAND	130 6TH STREET SCOTLAND, SD 57059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 14 residents (3 and 11) medications as ordered by their physicians. *Resident 3 had errors related to a diuretic medication for heart failure and an antiviral medication. *Resident 11 had errors related to two different psychotropic medications (medications that affect mental state). Findings include: 1. Review of resident 11's electronic medical record (EMR) revealed: *She had a Brief Interview For Mental Status (BIMS) assessment score of 14, indicating she was cognitively intact. *Her diagnoses included congestive heart failure and chronic respiratory failure with hypoxia (inadequate supply of oxygen to the body's tissues). *Her medications included: -Spironolactone 50 mg oral tablet, ordered on 12/18/24, 1 tablet every morning for heart failure. -Tamiflu 30 mg oral capsule, ordered on 2/7/25, 1 capsule twice a day for 12 doses for influenza. *She was hospitalized from 2/2/25 to 2/7/25 for influenza. *Her discharge orders included a prescription for Tamiflu, 30 mg. capsule, twice a day for 12 capsules, last taken 2/6/25 at 9:06 p.m. *The facility staff entered this order into resident 11's MAR as one capsule by mouth at bedtime only. *Resident was given one capsule per day until 2/12/25 when the error was found. *The physician was notified of the error and ordered to stop the medication on 2/13/25. *The resident had not received six total doses of Tamiflu as ordered initially on 2/7/25.	F 755	4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? DNS/designeed will audit admission and return from hospital orders for accuracy of order entry for each admisson an readmission x3 months. Audits will be completed medication administration 3x per week for 1 month, 1x weekly for 1 month and continue monthly as part of new process. 5. What is date of completion? 05/01/25	05/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435095	A. BUILDING _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SCOTLAND	130 6TH STREET SCOTLAND, SD 57059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 15	F 755		

2. Review of the provider's 3/5/25 medication error report #2357 for resident 11 revealed:
*The resident's spironolactone dose had been held beginning on 2/3/25 related to a physician's order.
*On 2/21/25 there was an order for her to resume the spirinolactone.
*The resumption of the medication was missed by the facility staff and identified as a medication error on 3/5/25.
*The resident had missed 12 doses of sprinolactone from 2/22/25 to 3/5/25.

3. Review of provider's 3/7/25 medication error report #2358 for resident 11 revealed:
*The facility staff had misread the resident's 2/21/25 physician order to renew the spirinolactone and believed they had missed 12 doses resulting in a medication error.
*On 3/7/25 the staff identified that medication error report #2357 was not an actual medication error of missed doses, but because of the 3/5/25 error report staff had restarted the resident's spironolactone on 3/6/25.
*Facility staff had restarted the spirinolactone without a physician order on 3/6/25.
*On 3/7/25 the physician was contacted and clarified that the spirinolactone should had not been resumed on 2/21/25.
*The 2/21/25 physician order had been to renew the holding of the spirinolactone for the resident, not to resum.

4. Interview on 3/27/25 at 10:30 a.m. with director of nursing (DON) B regarding resident 11's medication errors above revealed:
*On 2/21/25 the physician had marked to renew the hold on the spirinolactone.
*The facility staff misread the order as resuming

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435095	A. BUILDING _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SCOTLAND	130 6TH STREET SCOTLAND, SD 57059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 16	F 755		

the medication and completed a medication error report that the resident had missed 12 doses.
*Then they restarted the medication on 3/6/25 without an order.
*On 3/7/25 they clarified the order from the physician and found that the medication was to have remained on hold, not be restarted.
*The staff incorrectly transcribed the Tamiflu order as one dose per day instead of two doses per day, causing the resident to miss six doses.

5. Record review of resident 3's EMR revealed:
*She had a BIMS score of 3, indicating she had severe cognitive impairment.
*Her diagnoses included severe vascular dementia other behavioral disturbance, bipolar disorder, and generalized anxiety order.
*She had ongoing episodes of extensively calling out which had been documented to be disturbing to other residents, family members, and staff.
*Her medications included:
-Cymbalta (duloxetine, an antidepressant medication) for mood, related to bipolar disorder, current episode depressed, major depressive order.
-Clozaril, (an antipsychotic medication that treats mental health conditions to help regulate mood.)

6. Review of the provider's 3/13/25 medication error report #2360 for resident 3 revealed:
*The resident's 2/27/25 order for Cymbalta had increased her dose on 2/27/25 from 30 mg. daily to 60 mg. daily to start on 2/28/25.
*On 3/13/25 a medication aide notified DON B that the blister pack of Cymbalta in the medication cart was labeled for and contained 30 mg. tablets, while the medication administration record showed the dose should have been 60 mg.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435095	A. BUILDING _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SCOTLAND	130 6TH STREET SCOTLAND, SD 57059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 17	F 755		

*The 30 mg. doses were missing from the 3/1/25 to 3/12/25 dates of the blister pack indicating they had been administered..
*The blister pack with the 60 mg. tablets had been located on the counter of the medication storage room with no tablets missing.
*The pharmacy had delivered the 60 mg. dose blister pack initially on 2/27/25 to start on 2/28/25 according to the physician order.
*On 3/10/25 the 60 mg. dose card had been sent back to the pharmacy by staff with no doses missing or administered.
*On 3/11/25 the pharmacy had returned the 60 mg. dose blister pack back to the facility as the pharmacy had not received an order to discontinue that dose.
*After the 3/11/25 pharmacy delivery, the 60 mg. blister pack had been left in the medication storage room and not put in the medication cart.
*The resident had missed 13 doses of the increased Cymbalta order from 2/28/25 to 3/12/25.

7. Review of the provider's 3/11/25 medication error report #2359 for resident 3 revealed:
*The resident's Clozaril 12.5 mg was to start on 3/10/25 at bedtime.
*The resident's MAR was signed off as having the medication given by certified medication aide (CMA) E.
*The ordering physician was in the facility and pointed out that the resident could not have received the Clozaril dose as it had not been filled by the pharmacy yet.
*That was a medication omission as CMA E had charted that he gave an ordered medication that was not available in the medication cart and had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435095	A. BUILDING _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SCOTLAND	130 6TH STREET SCOTLAND, SD 57059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 18 not been reported to the charge nurse that the medication had not available in the cart. 8. Interview with CME on 3/26/25 at 5:20 p.m. revealed: *He had been a certified nurse's aide (CNA) for about ten years and a Certified Medication Aide (CMA) aide for about five years. *He would have known if a resident had a new medication as it would have been included in the nursing report (communication between outgoing and incoming nursing and care staff at the end of shift.) *The first dose of a new medication for a resident should have been given by the nurse, not the CMA. *He had not gotten report on 3/10/25 so he was not aware that the Clozaril was a new medication. *He described that he should have used the five rights (process for medication administration) as "right person right medication and all the rest of the things but I must have missed it." *He had received verbal education from the DNS about the process and following it after the 3/11/25 medication error report. 9. Interview on 3/27/25 at 10:30 a.m. with DON B revealed: *The steps for administering the correct dose of Cymbalta had not been followed from 2/28/25 to 3/12/25 resulting in a medication error for resident 3. *The resident's MAR had incorrectly reflected that the resident had been administered Clozaril on 3/10/25 and 3/11/25. -That was also a medication error. *She was doing rounds with the ordering physician on 3/11/25, who indicated that the medication could not have been given yet as it	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435095	A. BUILDING _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SCOTLAND	130 6TH STREET SCOTLAND, SD 57059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 19	F 755		

had not been provided by the pharmacy.
*She had provided verbal education to CMA E about the five rights of medication administration, the administration of new medication by a nurse only, and ensuring accuracy.
*CMA E had received report on 3/10/25 including information that the Clozaril for resident 3 was a new medication.
*She had provided verbal education to CMA F, CMA G, CMA H, and CMA I, who had incorrectly administered the 30 mg. dose and had documented that they had administered the 60 mg. doses from 2/28/25 to 3/12/25 for resident 3.

10. Interview on 3/27/25 at 8.37 a.m. with registered nurse (RN) D revealed:
*A licensed nurse should have given a new medication to the resident because a CMA was not supposed to give a first dose of a new medication.
*The new medication blister pack would have been kept separate from the current medications and placed into the top drawer of the medication cart with a note on it.
*That information would have been mentioned in their nursing report to the next shift.
*When there was a change in the medication dose the current medication should have been pulled from the medication cart and replaced with the new medication blister pack and a CMA could give that new dose to the resident.

Review of provider's undated certified long term care medication assistant job description revealed the medication assistant administers prescribed medications as delegated by a licensed nurse and within their scope of practice as defined by state regulations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435095	A. BUILDING _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SCOTLAND	130 6TH STREET SCOTLAND, SD 57059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 20 Review of the provider's 12/11/19 onboarding manual draft revealed: *All new/refill medications will be delivered to the facility with a paper manifest. *The facility nurse was to match the delivered medications to the manifest. *The manifest required a nursing signature and the date of receipt of the medications. Review of the provider's revised 3/4/25 medication acquisition, receiving, dispensing, and storage policy revealed: *Licensed nursing employees are responsible for checking of all new orders of medications from the physician's orders. *Licensed nurses and medication aides (when allowed by state law) are responsible for reconciling medications received.	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435095	A. BUILDING _____ B. WING _____	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SCOTLAND	130 6TH STREET SCOTLAND, SD 57059

(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
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 3/25/25. Good Samaritan Society Scotland was found in compliance.	E 000		04/17/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Julie Ramey
TITLE: Administrator
(X6) DATE: 04/17/2025

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435095	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/25/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SCOTLAND	**130 6TH STREET** **SCOTLAND, SD 57059**

(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 3/25/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Good Samaritan Society Scotland was found in compliance.	K 000		04/17/2025

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

TITLE
Administrator

(X6) DATE
04/17/2025

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.

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
	10675	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SCOTLAND	130 6TH ST SCOTLAND, SD 57059

(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 3/24/25 through 3/27/25. Good Samaritan Society Scotland was found in not in compliance with the following requirement: S157.	S 000	1. Sited as being deficient in a portion; west wing of the facility is not being properly ventilated by supplying and returning air from the buildings air-handling system. 2. All residents have the potential of being affected.	05/09/25
S 157	44:73:02:13 Ventilation A facility shall provide electrically powered exhaust ventilation in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation for three randomly observed resident rooms (resident rooms 221, 222, and 223) Findings include: 1. Observation and testing on 3/25/25 at 11:5 a.m. revealed the exhaust ventilation in the bathroom of resident room 221 was not functioning. Testing of the grille with tissue paper at the time of the observation confirmed that finding. Interview with the maintenance manager at the time of the above observation confirmed that finding. He revealed he was aware the exhaust ventilation was not working. He added the rooftop exhaust fan serving that room also served all other rooms on the west end of that wing. Further testing of additional bathroom for rooms	S 157	3. Requested quotes from contractor to repair or replace air handling system identified in the west portion of the facility. 4/17/25 verbal estimation received, waiting for written estimation so that air handling system repair/ replacement request can be submitted, approved and repaired by 05/11/25. 4. To ensure compliance on proper ventilation, maintenance/designee will audit weekly x4 to observe ventilation is supplying and returning air from building's air handling system. Then 1x month for 3 months. Completed audits and findings will be submitted to QAPI committee. The QAPI committee will determine the final reporting of scheduled auditing or interventions are required to ensure ongoing compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Julie Ramey — TITLE: Administrator — (X6) DATE: 04/17/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10675	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SCOTLAND	130 6TH ST SCOTLAND, SD 57059

(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 157	Continued From page 1 222, and 223 at that same time confirmed that statement. He further stated the facility had been trying to get approval from the corporate office to replace that unit for a while.	S 157		