STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 5/19/25 through 5/22/25. Good Samaritan Society De Smet was found not in compliance with the following requirements: F578, F655, F657, F658, F695, F761, F812, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 5/19/25 through 5/22/25. Areas surveyed included quality of care and nursing services related to medication administration and resident hygiene, resident abuse and neglect, and resident safety related to mechanical lift use. Good Samaritan Society De Smet was found in compliance.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. the plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purpose 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 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse	F 578	1. On 5/21/2025, DNS updated residents (12 and 86) care plan to reflect correct code status. On 5/23/2025, all residents care plans were reviewed by DNS and Social Services to ensure care plans and physicians orders matched residents' current wishes. 2. All residents have the potential to be affected. On 5/20/2025 and 5/21/2025, Social Services reviewed all residents that did not have advanced directives and reached out to all family/POAs to obtain them. 3. On 6/17/2025, or before their next shift, all staff will be educated in advanced directives and code status by DNS. Beginning on 6/17/2025, DNS/Social Services/MDS will be responsible for ensuring advanced directives are obtained at admission using form GSS #230F-23 and that residents are involved in the decision making of their code status. A progress note will be put in indicating that the resident/POA were both involved in the decision making of code status by DNS/Social Services/MDS. DNS/Social Services will conduct periodic review of code status and resident wishes during quarterly care conferences with residents and family.	6/27/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Buttercup Smith	Administrator	6.25.25

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
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 578	Continued From page 1 medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to maintain the resident's rights and ensure: *Advance directive code status (an individual's desire to be resuscitated with cardiopulmonary resuscitation (CPR), specific limited interventions, or not resuscitated (DNR) if their heart stopped) wishes were identified accurately on the physician's orders and the care plans for two of five sampled residents (12 and 86). *The resident or the resident's representative participated in the determination and periodic review of advance directives related to the resident's code status for four of five sampled residents (18, 28, 30, and 86).	F 578	4. Beginning 6/17/2025, the DNS/designee will audit new admissions to ensure advanced directives are available, and progress notes indicate that residents/POA were involved in the decision making for 4 months. Audit reports will be reported monthly to the QAPI committee for 4 months. DNS/designee will audit scheduled care conferences weekly to ensure period review of advanced directives was reviewed and discussed with family and residents for 4 months. DNS/designee will be responsible for bringing audit reports monthly to the QAPI committee for 4 months to determine whether process changes need to be reevaluated. QAPI team will determine whether audits need to be continued based on results.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 578	Continued From page 2 Findings include: 1. Review of resident 12's electronic medical record (EMR) revealed: *She was admitted on 2/28/25. *Her 3/3/25 Brief Interview of Mental Status (BIMS) assessment score was 14, which indicated she was cognitively intact. *A 5/16/25 physician's order indicated, "Okay for DNR, daughter has informed us also." *Her care plan indicated, "Code Status: FULL CODE [to provide life-saving measures]." -Her code status on her care plan did not match her code status in the EMR. Interview on 5/21/25 at 2:04 p.m. with resident 12 revealed: *When she was admitted to the facility a couple of months ago, she had hoped to "get better" and return home, and at that time, she had wanted staff to initiate CPR if her heart stopped. *She stated that she had recently been admitted to hospice, had changed to a DNR code status, and was happy with that decision. *Her daughter was her power of attorney (POA), knew her wishes, and helped her with her medical decisions. 2. Review of resident 86's EMR revealed: *He was admitted on 5/14/25. *His 5/14/25 BIMS assessment score was 13, which indicated he was cognitively intact. *A 5/14/25 physician's order "Advance Directive: Limited - Do not intubate, Do not use ambubag." *His care plan indicated, "Resident is DNR." -It had not reflected the additional directives in the 5/14/25 physician's order. *A 5/20/25 social services progress note indicated resident 86's wife was contacted and	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 578	Continued From page 3 "Re-affirmed DNR code status of DNR for [resident 86]. She [wife] indicated that she had no legal documentation regarding this but [it] was a mutual decision between herself and her husband." -There was no documentation that resident 86 had participated in a discussion about his advanced directives or code status. Interview on 5/21/25 at 11:01 a.m. with resident 86 in his room revealed: *He recalled having a discussion in the hospital about his advanced directives and code status, and he wanted "everything except the tube." *He thought that his wife knew his wishes because they had discussed it before he was admitted to the facility. 3. Review of resident 28's EMR revealed: *She was admitted on 4/30/25. *Her 5/7/25 BIMS assessment score was 9, which indicated she was moderately cognitively impaired. *Her POA was listed as her husband. *A 4/30/25 physician's order indicated, "DNR". *There was no documentation that indicated a code status in resident 28's care plan. *There was no documentation that indicated that resident 28 or her POA had participated in the decision of the resident's advance directive related to her code status. Interview on 5/21/25 at 8:27 a.m. with administrator A and director of nursing (DON) B regarding resident 28's POA and code status revealed: *Resident 28 had a physician's order for DNR. *They had not contacted resident 28's POA regarding the resident's advance directives	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 578	Continued From page 4 because he was living in an assisted living facility. 4. Review of resident 30's EMR revealed: *She was admitted on 9/13/24. *Her 3/20/25 BIMS assessment score was 3, which indicated she was severely cognitively impaired. *Her POA was listed as her husband. *A 9/13/24 physician's order indicated, "DNR". *There was no documentation that indicated a code status in resident 30's care plan. *There was no documentation that resident 30 or her POA had participated in the decision of an advance directive related to resident 30's code status or that her code status had been periodically reviewed with the resident or her POA. 5. Review of resident 18's EMR revealed: *She was admitted on 1/6/22. *Her 5/15/25 BIMS assessment score was 11, which indicated she was moderately cognitively impaired. *Her POA was listed as her son. *A 1/5/22 physician's order indicated, "DNR". *There was no documentation that resident 11 or her POA had participated in the decision of an advance directive related to resident 11's code status or that her code status had been periodically reviewed with the resident or her POA. 6. A request was made on 5/21/25 at 11:35 a.m. to administrator A for documentation that residents 18, 28, 30, and 86, or their representatives, had participated in the formulation of advance directives related to the residents' code status.	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 578	Continued From page 5 7. Interview on 5/20/25 at 11:48 a.m. with social services director (SSD) C regarding residents' advance directives revealed: *He had a "conversation" with residents when they were admitted to the facility, and the resident would "verbally tell" him what they would like their code status to be. *He asked for legal documentation of advance directives and information regarding the resident's POA during those conversations. *He would then confirm the information the resident provided with the resident's "family" to ensure that they "were in agreement." *He provided the resident's code status information to the director of nursing (DON) B, and "she records it," and DON B obtained the physician's order. *He did not document the conversations he had with the resident or the resident's "family" regarding the resident's code status. *He did not assist the resident in developing their advanced directives, but reviewed information on advance directives in the admission packet with the resident when they were admitted. *He expected the resident's code status would be documented in the resident care plan by himself or DON B. 8. Interview on 5/21/25 at 8:20 a.m. with DON B regarding residents' advance directives related to their code status revealed: *The facility followed what the hospital orders had listed for a resident's code status. *They only reassessed that hospital order if a "family member" had a concern or questioned it. *She expected the resident's medical provider or physician to discuss a resident's CPR code status with the resident "on rounds." -She did not expect the medical provider or	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 578	Continued From page 6 physician to discuss a DNR code status. *She would document in a progress note if the physician had discussed a resident's code status with the resident during those "rounds." *She did not think that a DNR would need to be reviewed with the resident, the resident representative, or the medical provider. 9. Interview on 5/22/25 at 9:27 a.m. with administrator A revealed that she confirmed there was no documentation that residents 18, 28, 30, and 86, or their representatives, had participated in the formulation of advance directives related to the residents' code status. Review of the provider's 10/29/24 Advanced Directives including Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator (AED) policy revealed: *"To provide each resident the opportunity to make decisions related to medical care and select a proxy. To define a process to make resident decisions known." *"Residents have the right to formulate advance directives." *"The verbal declination of CPR by a resident, or if applicable a resident's representative, should be witnessed by two staff members." *"Advance directive orders are to be reviewed with resident/healthcare decision-maker at each care plan meeting to ensure no changes are needed. Document this discussion in the PN [progress note]-Care Conference note." *"The BIMS measures the mental status of a resident. If changes are noted in the BIMS score, the physician may need to be notified. It is important that throughout the resident's stay, the resident is assessed for the capacity to make or revoke healthcare decisions."	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 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 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.	F 655	1. Starting on 6/17/2025, all admissions will be offered a copy of the baseline care plan within 48 hours of admissions. The baseline care plan will be offered to the resident and the POA. On 6/16/2025, identified residents have been given a copy of their current care plan and representatives have been notified that care plans are available upon their next visit to the facility. 2. Other residents currently living in the facility were reviewed for offering a baseline care plan. 3. Beginning on 6/17/2025, the baseline care plan will be printed and offered to residents/representatives. All LPNs/RNs/IDT team (dietary manager, DNS, activities and social services) will be educated on the new procedures for delivering baseline care plans on 6/16/2025 by DNS/Administrator. The DNS/designee will be responsible for ensuring the baseline care plan has been provided to residents/POA and that a progress note has been put into PCC indicating that the baseline care plan was provided and whether they accepted or declined a copy of it. 4. Beginning 6/17/2025, the DNS/designee will audit newly admitted residents weekly to ensure baseline care plans were offered for 4 months. DNS/ designee will be responsible for bringing audit reports monthly to the QAPI committee for 4 months to determine whether process changes need to be reevaluated. QAPI team will determine whether audits need to be continued based on results.	6/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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		

(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 interview, observation, record review, and policy 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 eleven of eleven recently admitted sampled residents (5, 12, 18, 25, 27, 28, 29, 30, 31, 32, and 86) within 48 hours of their admission to the facility.
Findings include:

1. Observation and interview on 5/20/25 at 9:50 a.m. with resident 86 in his room revealed:
*A Continuous Positive Airway Pressure (CPAP) machine (a machine that uses air pressure to keep breathing airways open) was on the nightstand next to his bed.
*He stated his wife brought his CPAP from home, and he wore it every night.

Interview on 5/21/25 11:01 a.m. with resident 86 revealed he had not received a list of his medications or a copy of his baseline care plan when he was admitted to the facility about two weeks ago.

Review of resident 86's electronic medical record (EMR) revealed:
*He was admitted on 5/14/25.
*His 5/14/25 Brief Interview of Mental Status (BIMS) assessment score was 13, which indicated he was cognitively intact.
*His baseline care plan did not indicate his use of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 the CPAP. *There was no documentation that indicated his baseline care plan was reviewed with him or that he had been provided or offered a copy of his baseline care plan within 48 hours of his admission. *A 5/16/25 progress note (PN) indicated resident 86's wife had been notified, "Reported that baseline care plan for [resident 86] was ready and we could send her a copy if desired." -There was no indication if the content of that baseline care plan was discussed, if she had indicated that she wanted a copy, or if a copy had been sent. 2. Interview on 5/21/25 at 2:04 p.m. with resident 12 revealed: *She had been told there would be a meeting about her care and to develop a plan, but she had not attended a meeting. -She thought they would probably have it this week. *Her daughter was her power of attorney (POA) and helped her with her medical decisions. *She did not recall having been provided a baseline care plan or a medication list when she was admitted to the facility a few months ago. Review of resident 12's EMR revealed: *She was admitted on 2/28/25. *Her 3/3/25 BIMS assessment score was 14, which indicated she was cognitively intact. *There was no documentation that indicated the resident's baseline care plan was developed and reviewed with her, her representative, or that she had been provided or offered a copy of her baseline care plan within 48 hours of her admission.	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 3. Review of resident 30's EMR revealed: *She was admitted on 9/13/24. *Her 3/20/25 BIMS assessment score was 3, which indicated she was severely cognitively impaired. *Her POA was listed as her husband. *There was no documentation that indicated the resident's baseline care plan was developed and reviewed with her, her representative, or that they had been provided or offered a copy of her baseline care plan within 48 hours of her admission. 4. Review of resident 28's EMR revealed: *She was admitted on 4/30/25. *Her 5/7/25 BIMS assessment score was 9, which indicated she was moderately cognitively impaired. *Her POA was listed as her husband. *There was no documentation that indicated the resident's baseline care plan was developed and reviewed with her, her POA, or that they had been provided or offered a copy of her baseline care plan within 48 hours of her admission. *A 5/2/25 PN indicated that resident 28's grandson had been contacted to clarify her emergency contact information and that resident 28's son was to be listed as the first emergency contact and her grandson as the second emergency contact and, "He was informed that [the] resident's care plan could be sent to him if he desired and that it was available anytime." Interview on 5/21/25 at 8:27 a.m. with administrator A and director of nursing (DON) B regarding resident 28's POA and baseline care plan revealed: *Resident 28's son was the first emergency contact, however, the grandson had been	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 contacted. *She confirmed that the resident or her POA had not been provided a copy of resident 28's baseline care plan and that they had not had contact with the POA because he was living in an assisted living facility. *She expected that the baseline care plan information would have been shared with the resident and her POA within 48 hours of her admission. 5. A request was made on 5/21/25 at 11:35 a.m. to administrator A for documentation that baseline care plans had been developed and the resident or their representative was offered a copy for newly admitted residents 5, 18, 25, 27, 28, 29, 30, 31, and 32. 6. Interview on 5/22/25 at 9:27 a.m. with administer A revealed: *There was no documentation that care plans had been developed or provided to the resident or their representative for the above-listed residents. *They had recently started a performance improvement project in their quality assurance and performance improvement plan regarding baseline care plans, but she was unaware of the documentation needed to support that they were being completed, and a summary of the baseline care plan had been provided to the resident and their representative. *She expected that the baseline care plan information would have been shared with the residents and their representative or POA within 48 hours of the resident's admission to the facility. 7. Interview on 5/22/25 at 1:12 p.m. with administrator A and DON B regarding baseline	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 care plans revealed: *The baseline care plan was initiated upon a resident's admission to the facility by DON B or Minimum Data Set (MDS) registered nurse RN S. *The baseline care plan and the comprehensive care plan were not separate documents; the baseline care plan "rolled into" the comprehensive care plan when more information was added. *The care plan indicated the date the care plan was initiated, but there was no documentation of when the baseline care plan had been completed. *If a family member or representative was at the facility or came to the facility in person, they would be offered and provided a copy of the care plan. *If a family member or representative was not at the facility when the resident was admitted, they would have called and offered to mail a copy of the care plan. *A voicemail would have been left if a family member or representative was not contacted to indicate that they should return the call if they want to review the care plan. *Administrator A expected that the phone call to have been documented in a progress note and completed within 48 hours of the resident's admission to the facility. Review of the provider's 12/2/24 Care Plan policy revealed: *"Baseline care plan- Includes instructions needed to provide effective and person-centered care to the resident that meet professional standards of quality care." *"A baseline care plan will be developed upon admission according to federal and state regulations. The location must provide the resident and resident representative with a written	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 13 summary of the baseline care plan. Use the PN Care Conference Note ... to document that the meeting occurred with the resident and representative and any significant discussion that occurred." *"The resident/family or legal representative will have the opportunity to participate in the planning of his or her care to the extent practicable."	F 655		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657	1. Immediate action taken by DNS: On 5/21/2025, DNS updated resident 12 care plan to reflect correct code status, per physician and resident wishes. On 5/20/2025, DNS updated resident 28 care plan to reflect the use of fall mat and proper sling size for sit-to-stand lift. On 5/21/2025, DNS updated resident 86 care plan to reflect the use of a CPAP machine and correct code status, per physician and resident wishes. 2. All residents have the potential to be affected by the deficient practice. On 6/9/2025, all residents' care plans were reviewed to reflect current care needs by DNS/MDS. 3. Education was provided to all LPNs, RNs & IDT team (dietary manager, DNS, activities and social services) by DNS on 6/16/2025, or before their next shift, on updating care plans when changes occur to ensure appropriate care is provided to the resident. DNS/designee will utilize morning stand up meetings to discuss resident changes and ensure care plans are updated when needed. 4. Beginning 6/17/2025, the DNS/MDS will audit 5 care plans weekly for 4 weeks, then 3 care plans weekly for 3 months to ensure appropriate changes have been added. DNS/MDS will be responsible for bringing audit reports will be reported monthly to the QAPI committee for 4 months to determine whether process changes need to be reevaluated. QAPI team will determine whether audits need to be continued based on results.	6/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 657	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to ensure care plans were reviewed and revised to reflect the current care needs for three of twelve sampled residents (12, 28, and 86). Findings include: 1. Review of resident 12's electronic medical record (EMR) revealed: *She was admitted on 2/28/25. *A 5/16/25 physician's order indicated, "Okay for DNR [do not resuscitate], daughter has informed us also." *Her care plan indicated, "Code Status: FULL CODE [to provide life-saving measures]." -Her code status had not been updated to DNR in her care plan. 2. Observation and interview on 5/19/25 at 2:56 p.m. with resident 28 in her room revealed: *There was a thick blue fall mat folded up next to her bed. *There was a mechanical sit-to-stand lift sling (a fabric safety harness used with a mechanical lift that requires the resident to bear weight on at least one leg when assisted from a seated position to a standing position) on her bed. -That lift sling had an unreadable, faded tag, and was labeled "506." *She stated that staff had used a machine to transfer her because she had not been strong enough to get up alone. Review of resident 28's EMR revealed: *She was admitted on 4/30/25. *Her 5/7/25 BIMS assessment score was 9, which indicated she was moderately cognitively	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 657	Continued From page 15	F 657		

impaired.
*Her care plan indicated "TRANSFER: Resident requires extensive assist [assistance] x1 [by one staff member] with pivot transfers. STS [sit-to-stand] [lift] as needed.
-The lift sling size to be used to transfer resident 28 was not addressed in her care plan.
*A 5/18/25 progress note indicated, "Bed is in low position with fall mat in place."
*Her care plan did not address that resident 28 required the use of a fall mat.

Interview on 5/22/25 at 10:01 a.m. with certified nursing assistant (CNA) R regarding transfers with resident 28 revealed CNA R:
*Had used the mechanical sit-to-stand lift to assist resident 28 out of bed into her wheelchair that morning.
*Stated she had used the lift sling that was in resident 28's room and had known which lift slings to use when transferring resident 28 because the lift sling size was listed in resident 28's care plan.

Interview on 5/20/25 at 3:03 p.m. with director of nursing (DON) B regarding fall mats revealed:
*"Thick blue fall mats" were used as a fall intervention.
*The need for a resident to have a fall mat next to their bed was determined by the "team," and when a fall mat was to be used, it should have been care planned.
*It was not the facility's policy to require a formal assessment or a physician's order for a fall mat.
*She clarified that staff should have known when to use a fall mat because it should have been in the resident's care plan.

Interview on 5/22/25 at 1:06 p.m. with DON B and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 657	Continued From page 16	F 657		

administrator A regarding the lift slings revealed:
*Lift slings came in a few different sizes and were based on a resident's weight. The DON or Minimum Data Set (MDS) RN S would assess each resident who required the use of a lift for the correct size sling.
*DON B or the MDS RN S should have documented the lift sling size in the resident's care plan.
*Administrator A expected the CNAs to know which lift sling to use when transferring a resident because it should have been listed in the resident's care plan.
*DON B was unaware that the lift sling size was not included in resident 28's care plan and expected that it would have been because the care plan had indicated the use of the sit-to-stand lift "as needed."

3. Observation and interview on 5/20/25 at 9:50 a.m. with resident 86 in his room revealed:
*A Continuous Positive Airway Pressure (CPAP) machine (a machine that uses air pressure to keep breathing airways open) was on the nightstand next to his bed.
*He stated his wife brought his CPAP from home, and he wore it every night.

Review of resident 86's EMR revealed:
*He was admitted on 5/14/25.
*His 5/14/25 BIMS assessment score was 13, which indicated he was cognitively intact.
*His care plan did not indicate his use of the CPAP.
*A 5/14/25 physician's order "Advance Directive: Limited - Do not intubate, Do not use ambubag."
*His care plan indicated, "Resident is DNR [do not resuscitate]."
*A 5/20/25 social services progress note indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 657	Continued From page 17	F 657		

resident 86's wife was contacted and "Re-affirmed DNR code status of DNR for [resident 86]. She indicated that she had no legal documentation regarding this but [it] was a mutual decision between herself and her husband."
*The code status in his care plan did not match his physician's order or the resident's wishes.

Interview 5/21/25 at 4:25 p.m. with DON B and administrator A regarding resident 86's CPAP revealed DON B expected that his use of the CPAP would have been indicated on resident 86's care plan.

4. Interview on 5/20/25 at 8:45 a.m. with CNA K revealed:
*She was a contracted traveling CNA and had worked at the facility for approximately six months.
*She used the residents' care plans in the EMR to learn how to care for each resident.
*The care plan would tell her how a resident should have been transferred, which size sling to use if they transferred with a mechanical lift, any special equipment the resident required, and other resident-specific information.
*She reviewed resident care plans every day she worked because "things always change."

5. Interview on 5/20/25 at 11:48 a.m. with social services director (SSD) C regarding advance directive revealed that he expected a resident's code status would be documented in the resident's care plan by himself or DON B and the care plan to be updated if there had been a change.

6. Interview and record review 5/21/25 at 4:32 p.m. with DON B and administrator A regarding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 657	Continued From page 18 care planning revealed: *DON B confirmed that resident 12's care plan indicated that she was a "full code." The resident had started to receive hospice services on 5/16/25, and her code status had changed to DNR but her care plan was not updated. -She expected resident 12's care plan to have been updated when that code status had changed. *DON B confirmed that resident 86's physician's order for his code status and his care plan did not match. -She expected that resident 86's care plan would match the physician's order and the resident's wishes. *Administrator A and DON B expected that residents' care plans would be updated whenever a significant change occurred so that the care plan accurately reflected the resident's current care needs. Review of the provider's 12/2/24 Care Plan policy revealed: *"Purpose- To develop a comprehensive care plan using an interdisciplinary team approach." *"Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables ... " *"The care plan will emphasize the care and development of the whole person ensuring that the resident will receive appropriate care and services." *"Care plans also will be reviewed, evaluated and updated when there is a significant change in the resident's condition."	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 658	Continued From page 19 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to accurately document correct doses of tube feedings for one of one resident (31). Findings include: 1. Review of 31's electronic medical record (EMR) revealed: *She had a physician's order to administer "Bolus [a concentrated dose] Jevity [liquid nutritional formula] 1.5 Cal. [calorie] to give 237 milliliter [ml] (1-8 fl oz. [fluid ounce] container) via PEG [percutaneous endoscopic gastronomy feeding tube] tube 5x/day [5 times per day]. May hold post-meal bolus if 50% [of the] meal [was] consumed." *On 5/12/25, Jevity 1.5 Cal became unavailable to the provider. A physician's order was obtained for "May use Jevity 1.2 cal to give 237ml (1-8 fl oz. container) via PEG tube 5x/day until Jevity 1.5 is available again. When Jevity 1.5 is available, stop use of Jevity 1.2 cal. May hold post meal bolus if 50% meal is consumed." *Both orders remained active in resident 31's EMR as of 5/21/25. *On 5/13/25 at 10:00 a.m., licensed practical nurse (LPN) G documented resident 31 received 237 ml of Jevity 1.5 cal, although it had been unavailable. *On 5/15/25 at 10:00 a.m. and 2:00 p.m., LPN G documented resident 31 received 237 ml of Jevity	F 658	1. On 5/21/2025, immediate education was provided to (LPN) G by DNS on documenting the correct tube feeding formula in the EMR. On 5/22/2025, (RN) D was educated by DNS in ensuring to check the percentage of meals consumed in the EMR to determine whether or not tube feeding should be administered, according to provider orders. 2. One resident has the potential to be affected by the deficient practice. 3. Education was provided to all RN/LPN staff by DNS on 6/16/2025, or before their next shift, on following provider orders and documenting the correct tube feeding formula when administering. Staff were also educated by DNS on how to check the MAR to see the percentage of meals consumed to determine whether tube feedings were needed, per provider's orders. LPNs/RNs were educated by DNS in how to place medications on hold in the event that they are unavailable, to avoid documentation errors. If meds are unavailable, they will also need to notify the physician and get order to hold until available. 4. Beginning 6/17/2025, the DNS/designee will audit proper tube feeding dose documentation and following provider orders related to tube feeding for 3X weekly for 4 weeks, then 2X weekly for 4 weeks, then 1X month for 2 months. Audit reports will be reported monthly to the QAPI committee for 4 months. DNS/designee will be responsible for bringing audit reports to the QAPI committee for 4 months to determine whether process changes need to be reevaluated. QAPI team will determine whether audits need to be continued based on results.	6/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 658	Continued From page 20 1.5 cal, although it had been unavailable. *On 5/16/25 at 10:00 a.m., registered nurse (RN) D documented resident 31 received 237 ml of Jevity 1.5 and 237 ml of Jevity 1.2 cal. *On 5/21/25 at 10:00 a.m., it was documented in resident 31's EMR that she ate between zero and twenty-five percent of her morning meal, indicating she should have received her Jevity through her feeding tube, but RN N documented resident 31's Jevity 1.2 cal was not given because she consumed greater than 50% of her morning meal. 2. Interview on 5/21/25 at 5:13 p.m. with LPN G revealed: *Resident 31 should have had her tube feedings administered if she consumed less than 50% of her meals. *She would determine how much of resident 31's meal had been consumed by checking documentation in the EMR, then administering her tube feeding when appropriate. 3. Interview on 5/22/25 at 12:30 with director of nursing (DON) B revealed: *The order for Jevity 1.5 calorie should have been placed on hold when it became unavailable on 5/12/25 to eliminate confusion and the likelihood of error by staff administering the formula. *It was her expectation staff would administer resident 31's tube feeding based on the physician's order. -If the resident were to refuse her tube feeding, there should have been documentation to reflect her refusal. Review of the providers 4/2025 Physician/Practitioner Orders policy revealed: *"Purpose. To provide individualized care to each	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 658	Continued From page 21 resident by obtaining appropriate, accurate and timely physician/practitioner orders." *A physician, physician's assistant, nurse practitioner or clinical nurse specialist must provide orders to the resident's immediate care, consistent with the resident's present physical and mental status needs."	F 658		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to ensure: *Proper infection control practices had been followed for the cleaning and storage of oxygen equipment for two of two sampled residents (18 and 29) who required the use of continuous oxygen. *Proper infection control practices had been followed for the cleaning and storage of nebulizer masks (a mask worn when using a nebulizer machine that converts liquid medication into an inhalable mist) for two of two sampled residents (18 and 29). *One of one sampled resident (86) who required the use of a Continuous Positive Airway Pressure (CPAP) machine (a device that uses air pressure to keep breathing airways open) had a current	F 695	1. On 5/21/2025, DNS removed and cleaned oxygen equipment for residents (18 and 29) and reviewed all residents in the facility who use oxygen for proper cleaning. Immediate education was provided by DNS to nurses on shift for proper cleaning and storage of nebulizer masks after use. On 5/21/2025, DNS requested an order for CPAP use for resident 86 updated care plan to reflect the use of CPAP machines. 2. Residents who require the use of oxygen or CPAPs have the potential to be affected by the deficient practice. Those residents have been reviewed and cleaning/storage processes implemented where warranted. 3. On 6/16/2025, or before their next shift, all LPNs/RNs will be educated on proper storage and leaning of oxygen and nebulizer equipment by DNS/CLDS. The MAR will have a nurse's order to prompt LPNs/RNs to check off when the task has been completed. 4. Beginning on 6/17/2025, DNS/designee will audit MAR to ensure LPNs/RNs are cleaning the oxygen machines and changing the tubing weekly. DNS/designee will conduct audits on all residents on oxygen and nebulizer treatments for proper cleaning and storage of nebulizer masks and orders. Audits for both will be conducted weekly for 4 months. DNS/designee will be responsible for bringing audit reports to the QAPI committee for 4 months to determine whether process changes need to be reevaluated. QAPI team will determine whether audits need to be continued based on results.	6/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 695	Continued From page 22 physician order for the use of a CPAP machine and that the CPAP was addressed on the resident's care plan. Findings Include: 1. Observation and interview on 5/20/25 at 10:13 a.m. with resident 18 in her room revealed: *She had an oxygen (O2) concentrator (a medical device that purifies room air into concentrated oxygen) next to her recliner chair, which contained: -An undated, long O2 tubing and nasal cannula tubing (flexible tubing that delivers oxygen through the nose) that allowed her to receive O2 when she used the bathroom. -An undated humidifier bottle. -A filter on the right side of the concentrator with a thick gray dust that dispersed into the air when the filter was touched. -Unidentified particles that appeared to be food and dust covered the top of the concentrator. *The over-the-bed table next to her chair contained: -A long, undated, coiled-up O2 tubing. -An undated nasal cannula (NC) tubing that was not attached to anything and hung towards the floor. -A nebulizer machine (a machine that converts liquid medication into an inhalable mist) with an attached mask dated 5/11/25, covered in small white spots and was stored in a plastic emesis basin. *A small table next to her chair had two open half half-full, undated jugs of distilled water on the shelf. *An open, undated jug of "purified water" was on the floor next to the window. *A bag on the back of her wheelchair contained a portable O2 tank and an undated NC tubing.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 695	Continued From page 23 Observation on 5/21/25 at 4:49 p.m. with director of nursing (DON) B and administrator A in resident 18's room revealed: *The O2 tubing on the over-the-bed table marked with a date of 5/19/25 was not being used *DON B confirmed: -The NC tubing, long O2 tubing, and humidifier attached to the concentrator used by resident 18 were undated. -The nebulizer mask dated 5/11/25 remained connected to the nebulizer machine, contained a small amount of residual medication, and was spotted with white residue. -The two jugs of distilled water and the one jug of purified water were opened and undated. -The O2 concentrator was dirty, and the filter contained a thick gray dust. *DON B thought that resident 18's daughter may have brought in the jug of purified water and extra oxygen tubing. Review of resident 18's electronic medical record (EMR) revealed: *She was admitted on 1/6/22. *Her diagnoses included emphysema (a chronic lung disease) and heart disease. *A 2/21/22 physician order "Oxygen via nasal cannula 1-4 liters per minute continuously for dyspnea, hypoxia (O2 saturation less than 88%) or acute angina. every day and night shift related to EMPHYSEMA." *A 6/29/24 "NURSING ORDER: Change 02 tubing weekly. Put the date on the tubing when it is changed. Wipe down oxygen concentrator and clean oxygen concentrator filter. every night shift every Sat [Saturday] related to EMPHYSEMA," was documented as completed in May on 5/3/25, 5/10/25, and 5/17/25.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 695	Continued From page 24 *A 11/30/24 "NURSING ORDER: Change oxygen tubing on portable concentrator weekly. Date tubing when changing it. every night shift every Sat related to EMPHYSEMA," was documented as completed in May on 5/3/25 and was discontinued on 5/10/25. *A 11/30/24 "NURSING ORDER: Change nebulizer tubing/mask/supplies weekly and date with day of change. Clean off nebulizer machine. every night shift every Sat related to EMPHYSEMA," was documented as completed in May on 5/3/25, 5/10/25, and 5/17/25. 2. Observation and interview on 5/20/25 at 9:50 a.m. with resident 86 in his room revealed: *A CPAP was on the nightstand next to his bed. *The CPAP mask hung over the back of the nightstand towards the floor *The CPAP humidifier was more than half full. *He stated his wife brought his CPAP from home, and he wore it every night. Observation and interview on 5/21/25 at 11:01 a.m. with resident 86 in his room regarding his CPAP machine revealed: *The CPAP machine remained on the nightstand with the mask attached. *There was no distilled water in his room or bathroom. *He stated he wore his CPAP "every night," to help him sleep better. *Since arriving at the facility last week, he had relied on the staff to help him put the CPAP mask on and to care for the machine. *He asked his wife to bring in distilled water for the humidification, but did not see a jug in his room. -He stated, "I hope they aren't putting tap water in it."	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 695	Continued From page 25	F 695		

Review of resident 86's EMR revealed:
*He was admitted on 5/14/25.
*His diagnoses included obstructive sleep apnea (a chronic condition in which the throat muscles relax during sleep and the airway may become partially or fully blocked) and morbid (severe) obesity.
*His 5/14/25 Brief Interview of Mental Status (BIMS) assessment score was 13, which indicated he was cognitively intact.
*There was no physician's order for the use of his CPAP in his EMR.
*There was no documentation in his EMR that indicated his CPAP mask and tubing were being cleaned.
*His care plan did not indicate his use of the CPAP.

Interview on 5/21/25 4:42 p.m. with DON B and administrator A regarding resident 86's CPAP revealed:
*DON B was unaware that resident 86 had brought his CPAP from home and was using it.
*DON B expected that there would be a physician's order for the use of the CPAP and a nursing order to ensure that the CPAP was cleaned between uses.
*Administrator A stated that the jugs of distilled water were provided by the facility. Those should have been dated when opened and stored in the resident's room.
3. Observation and interview on 5/19/25 at 4:30 p.m. with resident 29 in her room revealed she:
*Had an O2 concentrator in her room.
-Had nasal canula NC tubing attached to the O2 concentrator that the resident was actively using that was not dated.
-Could not verify how long she had been using

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 695	Continued From page 26	F 695		

that NC tubing or how often she received a new one.
*Had a coiled NC tubing in a plastic bag that was opened and lying on the floor.
-Could not verify if the NC tubing on the floor was new or where it had come from.

Review of resident 29's EMR revealed she:
*Was admitted on 7/10/24.
*Had a BIMS assessment score of 3, which indicated she was severely cognitively impaired.
*Had a diagnosis of heart failure.
*Had a terminal prognosis and was receiving Hospice care.
*Had an order in her care plan with a date of 3/19/25 to indicate that she had been receiving oxygen therapy.
-"May use O2 at 1-5 liters per minute per NC for comfort measures."
-Had been monitored for signs and symptoms of respiratory distress and staff were to report to her health care provider as needed.

Observation on 5/20/25 at 8:35 a.m. in the dining room revealed:
*Resident 29 had been using an O2 concentrator labeled #8.
*The NC tubing resident 29 had been using was not labeled to identify which resident it belonged to or what date the tubing was issued.

Observation on 5/20/25 at 4:33 p.m. revealed resident 29 was being pushed in her wheelchair to the dining room for the supper meal by nurse G and she did not have an 02 concentrator or NC tubing.

4. Observation on 5/19/25 at 4:52 p.m. in the dining room revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 695	Continued From page 27 *An O2 concentrator machine labeled #13 had NC tubing connected to it and coiled up inside of a plastic bag that was attached to the machine. -The end of the NC tubing was resting on the floor. *An O2 concentrator labeled #8 had NC tubing coiled up and tucked under the handle on the top of the concentrator. *There was no label attached to either of the NC tubings to indicate which resident the tubings belonged to. -There was no date noted on either of the NC tubing to have indicated what date the tubing was opened. *The filters on the back of both O2 concentrators had visible buildup of dust noted on them. 5. Interview on 5/21/25 4:42 p.m. with DON B and administrator A revealed: *DON B expected: -The nebulizer mask, nasal cannulas, and oxygen tubing to have been changed and dated weekly and documented in the resident's EMR medication administration record (MAR) by the nurse. *The nebulizer mask was to be rinsed out and cleaned after each use. -The oxygen concentrator and the filter were to have been cleaned weekly and documented in the EMR. *Administrator A expected that the cleaning of the oxygen equipment was being completed and documented. 6. Review of the provider's 7/8/24 Oxygen Administration policy revealed: *"Purpose- To keep oxygen equipment clean and maintained in good condition ..." *"All oxygen therapy equipment will be clean, safe	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 695	Continued From page 28 and functional at all times." *"Follow the manufacturer's recommendation for cleaning the concentrator unit and filters." *"Document cleaning of concentrator and filters where appropriate." *"Disposable equipment should be changed weekly or according to the manufacturer's instructions and marked with date and initials." *"Oxygen concentrators are assigned to an individual resident and should not be shared without proper cleaning between residents. Best practice is to label each concentrator with the resident's name." Review of the provider's 10/30/24 Non-Invasive Respiratory Support policy revealed: *"Purpose- To provide guidance to location staff when caring for residents using noninvasive respiratory support technology." *"CPAP - Continuous Positive Airway Pressure. CPAPs are "titrated" to blow air at a constant set pressure that will keep air passages open. They are the most common way to treat sleep apnea." *"Provider orders must be obtained ..." *"Cleaning: Follow the manufacturer's recommendation for cleaning and maintaining equipment." Review of the provider's oxygen concentrator Operator's Manual revealed: *"Cleaning the Cabinet Filter ... Remove each filter and clean at least once a week depending on environmental conditions."	F 695		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761	1. All expired medications and supplies were immediately removed from the storage area by DNS and Administrator when identified on 5/21/2025. 2. All residents have the potential to be affected by the deficient practice.	6/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 761	Continued From page 29 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure expired medications and supplies were discarded in a timely manner in one of one nurse supply storage room and one of one nurse's station storage area. Findings include: 1. Observation on 5/21/25 at 9:40 a.m. of the nurse supply storage room revealed: *Five of five cases (24 containers in each case) of "Benecalorie" 44 ml (milliliter) packages expired 6/30/24. *Two of two "Mepilex border post-op" bandages	F 761	3. To ensure that the deficient practice does not recur, on 5/23/2025, a full sweep of the nurse supply storage and nurse station was completed by DNS. Administrator and DNS created logs to check for expired medications and supplies. Medications will be checked bi-weekly by night nurses, and supplies will be checked monthly by DNS/HIM or assigned designee. LPNs/RNs were educated by DNS/Administrator on new implementations of logs on 6/16/2025 or before their first shift. 4. Beginning 6/17/2025, the DNS/Administrator or designee will audit the medication expiration log weekly for 4 weeks. After 4 weeks of weekly audits, demonstrating expectations being met, monitoring will reduce to twice monthly for 3 months; audits reports will be reported quarterly to the QAPI committee for 4 months by DNS/Administrator to determine whether process changes need to be reevaluated. QAPI team will determine whether audits need to be continued based on results.	6/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 761	Continued From page 30 expired 3/28/24. *One of three "central line dress change kit" expired 9/24/24. *Five of five "Coloplast interdry moisture wicking fabric" expired 3/17/24. 2. Observation on 5/21/25 at 3:10 p.m. of the nurse's station storage cabinets revealed: *Twenty-seven of twenty-seven "COVID AgCard" Covid tests expired 12/26/24. *Four of four "Covid home test" kits expired 11/17/24. *Eight of eight sterile gloves packages expired 2/1/25. *Two of two "Phazix" pill swallowing gel 500 ml bottles expired 11/30/23. *Approximately 300 "Modudose" 0.9% sodium chloride 5 ml doses expired 11/1/24. *More than 100 "Filter needles" (for drawing up medications) expired 7/31/21. 3. Interview on 5/22/25 at 11:00 a.m. with registered nurse (RN) D revealed: *There was no formal process for removing expired medications and supplies from the facility. *Night shift staff would usually discard expired medications and supplies. 4. Interview on 5/22/25 at 1:55 p.m. with director of nursing (DON) B revealed: *There was no formal process for removing expired medications and supplies from the facility. *It was her expectation that expired medications and supplies would be removed and discarded. 5. Interview on 5/22/25 at 4:13 p.m. with administrator A revealed it was her expectation that expired or outdated medications and supplies would be removed and discarded and would not	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 761	Continued From page 31 have been kept for use in the facility. Review of the provider's 03/2025 Medications: Acquisition Receiving Dispensing and Storage policy revealed "The location will routinely check for expired medications and necessary disposal will be done in accordance with state/pharmacy regulations."	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to follow standard food safety practices for: *Two of two observed cooks (I and P) who had not changed their gloves or washed their hands while serving resident food items to prevent	F 812	1. Individuals identified Cooks I and P were immediately educated by administrator on proper hand hygiene on 6/9/2025. 2. All residents have the potential to be affected by the deficient practice. 3. Education was provided to all staff by the Clinical Lead Development Specialist on 6/16/2025, or before their first shift, on proper handwashing during meals, when serving residents and proper glove use to prevent potential contamination. Hand sanitizer will be readily available to staff by the handwashing sink in the dining room, to be restocked and monitored by the Dietary Manager/Administrator/DNS. 4. Beginning 6/17/2025, Dietary Manager/Administrator/DNS will audit 5 meals weekly for proper hand washing and glove use in the kitchen for dietary aides, cooks, and CNAs for 3 meals weekly for 4 weeks, then 3 meals monthly for 2 months. DM/Administrator/designee will be responsible for bringing audit reports to the QAPI committee for 4 months to determine whether process changes need to be reevaluated. QAPI team will determine whether audits need to be continued based on results.	6/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 812	Continued From page 32 potential contamination. *One of one observed dietary aide (DA) (H) who had not performed hand hygiene (hand washing) while serving resident food items to prevent potential contamination. Findings include: 1. Observation on 5/19/25 at 5:17 p.m. with DA H in the main dining room revealed she served a plate of food to a resident, touched the items on the table to make room to set the plate down, wiped her right hand on her right leg, returned to the serving area, touched the meal tickets, touched a tray on the counter, touched dirty tongs that were used to retrieve cookies from a container, and without completing hand hygiene she served another meal plate to another resident. 2. Observation on 5/19/25 at 5:23 p.m. with cook I while serving resident meals revealed he: *Wore a pair of disposable gloves. While wearing those gloves he: -Wiped his hand on a white cloth on the edge of the serving line. -Touched the menu slips on the counter. -Touched the top surfaces of plates as he placed food on them. -Wiped his gloved hands on his white apron. -Went into the kitchen, opened the microwave, heated a bowl of soup, rested those gloved hands on the counter, and with those same gloved hands, he returned to the serving line and continued to prepare plates of food for residents. *Was not observed to have changed his gloves or to have washed his hands. 3. Observation on 5/19/25 at 5:34 p.m. of the hand-washing sink in the dining room revealed:	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 812	Continued From page 33 *There was a handwashing sink next to a beverage machine behind the serving line. *A pump container of Thick-It (a food-safe thickening agent) was to the right of that beverage machine. *A meal service tray that contained several discarded used paper towels, straw wrappers, used plastic cup lids, a plastic container that held metal knives and forks, tea bag wrappers, and other waste items was located directly under the spout of the Thick-It pump. *Staff who washed their hands placed their discarded paper towels on that tray. *There was no trash receptacle observed near that hand-washing sink for staff to discard their used paper towels. 4. Observation on 5/19/25 at 5:37 p.m. with cook I revealed he retrieved a cup of ice cream from the kitchen, delivered that to a resident and had not used hand hygiene prior to placing gloves on his hands and serving other residents' food. 5. Observation on 5/19/25 at 5:45 p.m. of the dining room revealed: *One bottle of hand sanitizer on the counter next to the menu slips. *One container of Sani Wipes "sanitizing hand wipes" on the counter in front of the food serving line. *One hand sanitizer dispenser on the wall in the back room of the dining room. 6. Observation on 5/20/25 at 12:16 p.m. with cook P while serving residents meals revealed: *She retrieved a clean ladle from the kitchen with the same gloved hands that she was observed wearing while previously serving food to residents.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 812	Continued From page 34 *She returned to the serving line and touched a clean plate and a baked potato with those same gloved hands. *Wearing those same gloves, she retrieved a clean knife from the kitchen, returned to the serving line, and then continued touching clean plates and food for other residents. *She was not observed to have changed her gloves or to have washed her hands. *She went to kitchen, opened the microwave, heated a bowl of soup, touched the menu slips that were on the counter, and with those same gloved hands, she returned to the serving line and continued to prepare plates of food for residents. *A resident's visitor requested a menu to order a meal for herself, cook P touched a menu slip handing it to the visitor and then returned to serving plates of food with those same gloved hands. 7. Interview and observation on 5/20/25 at 3:09 p.m. with certified nursing assistant (CNA) E revealed she: *Had not used hand hygiene while assisting residents eating. *Should had used hand sanitizer in between assisting residents in the dining room but did not due to not having any sanitizer readily available to use. 8. Interview on 5/22/25 at 12:30 p.m. with director of nursing (DON) B and registered nurse (RN)/ Infection Preventionist (IP) D revealed they expected staff to complete hand hygiene in between assisting residents with eating in the dining room. 9. Interview on 5/22/25 with administrator A	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 812	Continued From page 35	F 812		

revealed:
*She was the acting dietary manager (DM).
-It is her expectation that "Employees follow our policy on hand hygiene."

10. Review of the provider's revised 6/13/24 Sanford Policy Enterprise: Rehab/Skilled & Long Term Care: Hand Washing and Glove Use-Food Nutrition Services policy revealed:
"Purpose: To provide guidelines regarding hand hygiene and glove use to reduce risk of cross-contamination when serving highly susceptible population."
Procedure:
Hand Washing: When to wash hands:
*"Before, between and after resident contact."
*"After touching any contaminated object (face, hair, body or clothing; garbage or dirty utensils, dirty dishes, phone, linen or money.)"
*"Before and after use of gloves."
Proper Use of Gloves:
*"Hands are washed thoroughly before putting gloves on and after taking gloves off. Note: The use of gloves does not eliminate the need for proper hand washing or good hygiene."
*"Gloves are worn when the employee: Is handling ready-to-eat foods and completing a single task."
*"Gloves are changed as follows:'
*"Before handling ready-to-eat foods."
*"When coming in contact with something that may be contaminated, such as handling pots/pans/tray/utensils, opening a trash can or touching a doorknob or faucet."
*"Whenever [an] employee changes an activity, the type of food being worked with or whenever he or she leaves the workstation."
*"After touching hair, skin or clothing."
*"Do not use food contact gloves for non-food

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 812	Continued From page 36 tasks such as handling money, garbage removal, sanitizing surfaces, dish or ware washing, etc."	F 812	1. On 6/9/2025, maintenance and environmental services cleaned the hopper and the surrounding areas. Uncleanable paper was removed, and splash shields were visibly provided to staff on the wall next to the hopper. CNA E was educated by Administrator on where the splash shield was located and who was responsible for cleaning the hopper. 2. Education was provided by Administrator and DNS to all staff on 6/16/2025, or before their first shift, on hopper procedures/policies and who was responsible for the cleanliness. 3. Administrator/DNS implemented a new log to be kept in the hopper room for documentation of cleaning to be filled out by environmental services weekly. Administrator/DNS/Maintenance or designee will audit cleaning procedures and proper PPE for the use of hopper for 3X weekly for 4 weeks, then 2X weekly for 4 weeks, then 1X month for 2 months. Administrato/DNS/designee will be responsible for bringing audit reports to the QAPI committee for 4 months to determine whether process changes need to be reevaluated. QAPI team will determine whether audits need to be continued based on results.	
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: (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;	F 880	1. On 5/21/2025, immediate education was provided by DNS to LPN G on proper personal protective equipment (PPE) when providing direct care to a resident with Enhanced Barrier Precautions (EBP) by DNS. 2. Any resident who has an EBP has the potential to be affected by deficient practice. 3. Education was provided to all staff by the CLDS and DNS on 6/16/2025, or before their first shift, on policies and procedures related to EBP and PPE when providing direct resident care. EPB signs are on all appropriate doors and PPE supplies are readily available outside of rooms. 4. DNS/IP will conduct random 3 residents audits weekly on proper PPE when providing direct care on a resident with EBP for 4 months. Administrator/DNS/designee will be responsible for bringing audit reports to the QAPI committee for 4 months to determine whether process changes need to be reevaluated. QAPI team will determine whether audits need to be continued based on results.	6/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 880	Continued From page 37 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure proper infection control practices were followed: *For the cleaning of one of one soiled utility rooms. *To ensure enhanced barrier precautions (EBP) were used according to the provider's policy for	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 880	Continued From page 38 one of one sampled resident (16) on EBP by not wearing a gown and gloves when providing direct care. Findings include: 1. Observation and interview on 5/20/25 at 8:53 a.m. with certified nursing assistant (CNA) E in the soiled utility room between the 200 and 300-hallways revealed: *A hopper (a specialized sink flushing device used to rinse soiled items and linens of bodily fluids) did not have a spray shield. -The inner edges were soiled with a brown, unidentified material. -The floor under the hopper was splattered with what appeared to be a mineral buildup. -The pipes behind the hopper were rusted. -There was white splatter on the wall behind the hopper and areas of peeling paint. *A paper sign with rolled edges, that read "Disinfectant Wipes and Spray Bottles inside," was taped to the white cabinet and was an uncleanable surface; it did not contain gowns or face shields. *CNA E wore gloves and used that hopper to rinse soiled linen without putting on a gown or face shield. *CNA E stated she did not know if there should have been a splash shield on the hopper and confirmed that it was dirty. -She did not know who was responsible for cleaning the hopper. 2. Observation on 5/21/25 at 5:00 p.m. of licensed practical nurse (LPN) G while administering medications to resident 16 revealed: *Resident 16 was on EBP, which required personal protective equipment (PPE)(gown and	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 880	Continued From page 39	F 880		

gloves) while providing direct care to the resident.
*LPN G entered resident 16's room without putting on a gown or gloves.
*LPN G administered resident 16's nebulizer (breathing medication) treatment.
-During the nebulizer treatment, LPN G used her stethoscope to listen to resident 16's lungs from the resident's right side.
-LPN G was in direct contact with resident 16.
-LPN G then leaned over the resident to listen to his lungs on his left side. Her chest came in direct contact with the resident's chest.

3. Interview on 5/22/25 at 12:18 p.m. with registered nurse (RN)/infection preventionist D revealed:
*She had been the facility infection preventionist for the past several years.
*She expected staff to wear appropriate personal protective equipment (PPE) while providing cares for a resident on EBP.
*LPN G should have worn a gown and gloves while providing cares for resident 16.

4. Interview on 5/22/25 at 12:30 with DON B revealed she expected LPN G to wear a gown and gloves while providing cares for resident 16.

Review of the provider's 4/2025 Standard, Enhanced Barrier, and Transmission-Based Precautions, All Services Lines-Enterprise policy revealed:
*"Enhanced barrier precautions expand the use of personal protective equipment beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multidrug-resistant organisms (MDROs) to staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 880	Continued From page 40 hands and clothing." Review of the provider's 12/2/24 Infection Prevention and Control Program policy revealed: *"Purpose- To 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 infection." *"The facility utilizes standard precautions for all residents, regardless of suspected or confirmed diagnosis or presumed infection status. Standard precautions may include, but is not limited to: a. Hand hygiene; b. Proper selection of personal productive equipment ..."	F 880		

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
	10614	A. BUILDING: _____ B. WING _____	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVE NW DE SMET, SD 57231

(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 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 5/19/25 through 5/22/25. Good Samaritan Society De Smet was found in compliance.	S 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. the plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purpose 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.	
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 5/19/25 through 5/22/25. Good Samaritan Society De Smet was found not in compliance with the following requirements: S206 and S296.	S 000		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. All healthcare personnel must complete the orientation program within thirty days of hire and the ongoing education program annually thereafter. The orientation program and ongoing education program must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and	S 206	1. Incidents and diseases training, to include mandatory reporting and the facility's reporting mechanism, as well as advanced directives, will be provided during general orientation for newly hired employees and annually by the business office manager/DNS/Administrator starting 6/16/2025. Employees (E, I, J, and L) completed their missing required education on 6/16/2025, or before their next scheduled shift. 2. New hires for the past 12 months have been reviewed by Administrator/CLDS, and other concerns noted have been addressed/corrected. 3. Required training completion will be added to the General Orientation checklist to prompt documentation when completed. Administrator/department leaders/business office manager will be responsible for completing the General Orientation checklist. 4. Administrator/DNS/department leaders will audit training being completed within 30 days of hire for all new hires for 4 months. Administrator/DNS/department leaders will be responsible for bringing audit reports to the QAPI committee for 4 months to determine whether process changes need to be reevaluated. QAPI team will determine whether audits need to be continued based on results.	6/27/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brittany Smith — TITLE: Administrator — (X6) DATE: 6·25·25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10614	A. BUILDING: _____ B. WING _____	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVE NW DE SMET, SD 57231

(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 206	Continued From page 1 hydration needs of residents; (11) Abuse and neglect; and (12) Advanced directives. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section. The facility shall provide additional personnel education based on the facility's identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee personnel records review, training transcript review, and interview, the provider failed to ensure the required training was completed on topics of: *Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms for four of the four employees (E, I, J, and L) reviewed within 30 days of hire. *Advance directives for three of four employees (E, I, and L) reviewed within 30 days of hire. *Infection prevention and control and proper restraint use for one of five employees (I) reviewed within 30 days of hire. Findings Include: 1. Review of employee personnel records revealed: *Employee E was hired on 3/11/25. *Employee I was hired on 12/10/24. *Employee J was hired on 4/20/25. *Employee L was hired on 5/8/24. 2. Review of employee training records and online training transcripts revealed: *There was no documentation that employees E,	S 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10614	A. BUILDING. _____ B. WING _____	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVE NW DE SMET, SD 57231

(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 206	Continued From page 2 I, J, and L had received training on incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms within 30 days of hire. *There was no documentation that employees E, I, and L had received training on advance directives within 30 days of hire. *Employee I was assigned the training topics on infection prevention and control and proper restraint use on 2/1/25 and completed those trainings on 4/3/25. -They were assigned 53 days after he was hired and did not meet the 30-day requirement as they were not completed until 114 days after his hire date. 3. Interview and review of training transcripts on 5/22/25 at 12:12 p.m. and again at 2:26 p.m. with clinical learning development specialist (CLDS) M revealed: *He provided in-person and online employee training and oversaw the nurse aide training program within the facility, but did not complete the new employee orientation. -He thought office manager Q completed the new employee orientation. *He thought the training on incidents and diseases subject to mandatory reporting, and the facility's reporting mechanisms, was included in the abuse and neglect training because the staff were educated that they were mandated reporters. -He thought that diseases subject to mandatory reporting were included in the employee handbook, because it provided the providers "Contagious and Infectious Illness" policy. --That policy covered the employees' responsibilities when they were sick. -He was unable to provide a training transcript that covered the education provided to employees	S 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10614	A. BUILDING: _____ B. WING _____	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVE NW DE SMET, SD 57231

(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 206	Continued From page 3 on incidents and diseases subject to mandatory reporting, and the facility's reporting mechanisms. *He provided a Relias training called "About Advanced Directives," but thought that the topic of advance directives was only required in North Dakota and had not been provided to the staff listed. -He thought that the provider's "Resident Rights" training would have contained that topic. -He was unable to provide a training transcript that covered the education provided to employees on advance directives *Employee J was a contracted travel staff, and the transcript for her education had been provided by her employment agency. -He did not know if her facility orientation or training would have included incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms. *He confirmed employee I was assigned the training topics on infection prevention and control and proper restraint use on 2/1/25 and completed those trainings on 4/3/25. -He did not know why those trainings had been assigned and completed late. 4. Interview and review of employee I's printed training transcript on 5/22/25 at 2:30 p.m. with office manager Q regarding employee training revealed: *New and annual employee trainings were assigned by their corporate learning team. -She did not know what the required training topics included. *She ensured that new employees completed their orientation and their assigned new employee online training before they worked their first shift. *She could not access the employee online training assignments or transcripts and did not know which topics were assigned to which	S 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10614	A. BUILDING: _____ B. WING _____	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVE NW DE SMET, SD 57231

(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 206	Continued From page 4 employee. *The online training system sent an email to the employee's supervisor if an assigned training was not completed by the due date. *She confirmed employee I was assigned the training topics on infection prevention and control and proper restraint use on 2/1/25 and completed those trainings on 4/3/25. -If employee I's required new employee training topics had not been assigned on time by the corporate learning team, it would not have alerted his supervisor that the training had not been completed. 5. Interview on 5/22/25 at 2:38 p.m. with administrator A regarding employee training revealed: *The provider used an online training program for employee-required training. *She expected that the new employees' required training would be completed within 30 days of hire, but most completed it before they were allowed to work their first shift. *She expected that all employees would complete training on the required topics when they were hired and annually. *She stated that she would receive an email if the assigned training had not been completed by the due date and forwarded those emails to the employee's supervisor for follow-up. *She was unaware that training topics of advance directives and incidents, and diseases subject to mandatory reporting had not been included in the assigned employee-required training. *She had been unaware that employee I's training topics of infection prevention and control and proper restraint had been assigned 53 days after he was hired. Review of the provider's 3/28/25 Orientation	S 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10614	A. BUILDING: _____ B. WING _____	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVE NW DE SMET, SD 57231

(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 206	Continued From page 5 -Employee policy revealed: *"Orientation must be completed within 30 days of the employee's start date. As part of GO/NEO [general orientation/new employee orientation], new employees will complete a series of online training modules (tracked in the employee's permanent learning plan). Progress is monitored by Human Resources." A staff training policy was requested on 5/22/25 at 2:06 p.m. from administrator A and was not provided before the end of the survey.	S 206		
S 296	44:73:07:11 Director Of Dietetic Services A facility shall have a full-time dietary manager who is responsible to the administrator and who shall direct the dietetic services. The dietary manager must: (1) Be a certified dietary manager; (2) Be a certified food service manager; (3) Have a similar national certification for food service management and safety from a national certifying body; or (4) Have an associate's or higher degree in food service management or hospitality from an accredited institution of higher learning that has a course of study in food service or restaurant management. Any dietary manager who does not must enroll, within ninety days of the dietary manager's hire date, in programming necessary to achieve one of the qualifications, and achieve the qualifications within eighteen months of hire. The dietary manager and at least one cook shall possess a current certificate from a ServSafe Manager Food Protection Program offered by	S 296	1. On 6/14/2025, the dietary manager enrolled into ServSafe course. Another full-time cook already has the ServeSafe certification to serve as the second required certification. 2. Future DM's and Cooks have the potential to be affected. Residents provided food by staff who have not had the ServSafe course have potential to be affected. No negative resident outcomes were noted to residents. 3. ServSafe certification verification will be added to the General orientation of those required or eligible to complete the course. This will be verified by Administrator/DM. 4. DM/designee will review new dietary employee's orientation checklist to verify ServSafe course is current or those eligible have been enrolled in the course. DM/designee will be responsible for bringing findings to QAPI for the next 4 months. Depending on results will determine if further process changes/audits need to occur.	6/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10614	A. BUILDING: _____ B. WING _____	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVE NW DE SMET, SD 57231

(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 296	Continued From page 6 various retailers, the Certified Food Protection Professional's Sanitation Course offered by the Association of Nutrition and Foodservice Professionals, or an equivalent training program as determined by the department. Individuals seeking ServSafe recertification are only required to take the national examination. The dietary manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each resident are met. If the dietary manager is not a dietitian, the facility must schedule dietitian consultations onsite at least monthly. The dietitian shall approve each menu, assess the nutritional status of each resident with problems identified in the assessment, and review and revise dietetic policies and procedures during scheduled visits. The facility shall have sufficient personnel to meet the dietetic needs of the residents and provide dietetic services for a minimum of twelve hours each day. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure that the dietary manager and at least one cook were ServSafe certified. Findings include: 1. On 5/20/25 at 8:01 a.m. ServSafe certificates for the dietary manager and at least one cook were requested from administrator A. A ServSafe certificate for a person not on the facility employee list and a "Food Safety for Handlers" certificate for cook F were provided. 2. Interview on 5/22/25 with administrator A regarding ServSafe certifications revealed:	S 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10614	A. BUILDING: _____ B. WING _____	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVE NW DE SMET, SD 57231

(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 296	Continued From page 7 *Administrator A was the acting dietary manager (DM) and did not have a ServSafe certification. *The previous DM worked approximately one weekend a month and was not ServSafe certified. *She was unaware that the "Food Safety for Handlers" certificate was not equivalent to the ServSafe certification. *The ServSafe certificate provided was for a new employee who was hired and was scheduled to start working within a week. *There had not been a ServSafe-certified DM or other ServSafe employee since she began her role at the facility as the administrator on 12/30/24. The provider's 12/16/24 Director of Food and Nutrition Services Job Orientation And Training policy did not include the required ServSafe training. A food service manager training and a ServeSafe policy was requested on 5/22/25 at 2:06 p.m. from administrator A and was not provided before the end of the survey.	S 296		

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

PRINTED: 06/09/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING _____ B. WING _____	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 5/21/25. Good Samaritan Society De Smet was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brittany Smith — TITLE: Administrator — (X6) DATE: 6.18.25

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.

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

PRINTED: 06/09/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW DE SMET, SD 57231

(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 5/21/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Good Samaritan Society De Smet was found in compliance.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brittny Smith — TITLE: Administrator — (X6) DATE: 6.18.25

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.