

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>56129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>08/10/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - CANISTOTA ALC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 WEST MAIN ST CANISTOTA, SD 57012</b>
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(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	<p><b>Compliance Statement</b></p> <p>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers was conducted from 8/7/23 through 8/10/23. Environment and life safety code surveys were completed. Good Samaritan Society Canistota ALC was found in compliance.</p> <p>There were no current or recent residents to review for the licensure health survey.</p>	S 000		

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

Alexis Luke

TITLE

Administrator

(X6) DATE

9/12/23

STATE FORM

6899

BGNS11

If continuation sheet 1 of 1

