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

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**X1** PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:
435101

**X2** MULTIPLE CONSTRUCTION
A. BUILDING ________________
B. WING ________________

**X3** DATE SURVEY COMPLETED
C 01/31/2017

**NAME OF PROVIDER OR SUPPLIER**
GOOD SAMARITAN SOCIETY CANTON

**STREET ADDRESS, CITY, STATE, ZIP CODE**
1022 NORTH DAKOTA AVENUE
CANTON, SD 57013

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Surveyor: 183825
A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted on 1/31/2017. Areas surveyed included nursing services. Good Samaritan Society Canton was found in compliance.

**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE**

**TITLE**

**DATE** 2/1/17

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 discloseable 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 discloseable 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.