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

PRINTED: 11/22/2022 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & I					(X3) DATE SURVEY			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		G	co	C		
CAD L FUN OI		A. Boile			[
		435106	B. WING			11/10/2022		
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE			
		OMED	515 W HWY 46					
GOOD SA	MARITAN SOCIETY WA	SNEK		WAGNER, SD 57380				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X COMPL DA			
E 000	Initial Comments		E 0	00				
	Part 482, Subpart B, Emergency Prepared Term Care Facilities	or compliance with 42 CFR Subsection 483.73, Iness, requirements for Long was conducted on 11/10/22. ciety Wagner was found in						
		RIGIJON JED DEDDESENTATIVE'S SIGNATI	URF	TITLE		(X6) DATE		
LABORATOR'	Y DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNATU				4.4/00/0000		

ABURATURY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTA

Administrator

11/30/2022

Any deficiency statement entire 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

V 2 9 2022 Event ID: 8ZEF2

Facility ID: 0081

If continuation sheet Page 1 of 1

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

PRINTED: 11/22/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDIG 01		(X3) DATE SURVEY COMPLETED		
		435106	B. WING			11/10/2022	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY WAGNER				51	TREET ADDRESS, CITY, STATE, ZIP CODE 15 W HWY 46 IAGNER, SD 57380		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ATE	(X5) COMPLETION DATE
K 000	A complaint survey for Safety Code (LSC) (2 occupancy) was conducted Samaritan Society W	or compliance with the Life 2012 existing health care ducted on 11/10/22. Good agner was found in CFR 483.70 (a) requirements	K	0000	DEFICIENCY)		
ABORATORY	DIRECTOR'S OR PROVIDER	VSYPPLIER REPRESENTATIVE'S SIGNATUF	RE		TITLE		(X6) DATE

Whitney Podzimek

Administrator

11/30/2022

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.

POLC

FORM CMS-2567(02-99) Previous Versions Obsolete NOV 2 9 2022 Event ID 8ZEF21

Facility ID: 0081