STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435044	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society Luther Manor	1500 W 38th St Sioux Falls, SD 57105

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, record review, interview, and policy review, the provider failed to report incidents to the SD DOH within the required time frame, for one of one sampled resident (10) who fell on the floor while being transferred with a sit-to-stand mechanical lift (a mechanical lift used to assist from a seated to a standing position) by certified nursing assistant (CNA) N without the assistance of another staff member, one of one sampled resident (49) related to allegations of having been verbally abused by CNA K, and one of one sampled resident (44) related to allegations of having been verbally abused by CNA E. Findings include:1.Review of the provider's 12/1/25 submitted FRI regarding resident 10 revealed: *On 12/1/25, the provider completed a review of a fall incident for resident 10 that had occurred on 11/28/25 at 11:30 a.m. *Resident 10 was assisted to the restroom and back to his wheelchair by CNA N with the use of a sit-to-stand mechanical lift. *During the transfer, resident 10 slipped and slid from the sling to the floor onto his bottom and then rolled onto his right side. *CNA N called for assistance and licensed practical nurse (LPN) HH immediately came to the room. *Resident 10 was assessed by the nurse and was not injured as a result of the fall. *The investigation revealed CNA N failed to follow resident 10's care plan, which stated he was to be transferred with the use of a sit-to-stand mechanical lift and the assistance of two staff members. *CNA N was immediately re-educated by director of nursing (DON) B after the incident to ensure she checked a resident's care plan before she provided resident care. *The incident was not reported to the SD DOH until 12/1/25, which was past the 24-hour required timeline. 2. Review of the provider's 2/26/26 submitted FRI regarding resident 49 revealed: *On 2/20/26 at 8:15 p.m. DON B was notified that CNA D left her scheduled 2/20/26 shift 30 minutes after reporting to work. *CNA D stated she did not feel comfortable working until she spoke with the scheduler and DON B on Monday (2/21/26). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*CNA D called DON B and texted the scheduler, which prompted administrator A and DON B to investigate CNA D's report of quality of care concerns. *On 2/20/26 administrator A and DON B went to the facility and interviewed residents and staff. *Resident 49 reported that CNA K told her not to sing and to shut up and Sit Up or I am not going to help you. -Resident 49 could not provide a date or time when CNA K had said that to her. *During resident interviews there were two other residents who stated CNA K made rude and inappropriate comments such as, You would not have these issues if you went out to the dining room and Don't be Cocky. *No resident had reported feeling unsafe or having received poor care from the staff during those resident interviews. *CNA K denied having made rude or inappropriate comments to residents. *The FRI was reported to the SD DOH on 2/26/26 at 1:06 p.m., six days after DON B was notified of the allegations of verbal abuse. *DON B indicated in the report, This report is late as the Administrator felt that with all residents stating they do not feel abused, no care issues of abuse were raised, and all residents interviewed stated they felt safe we did not feel [it] would require reporting. After speaking with [the] Regional Nurse consultant and explaining the details of the investigation she stated that both [investigations involving residents 44 and 49] needed to be reported.We have learned that any and all allegations of verbal, psychological, physical, or emotional abuse will be reported first and investigated second. 3. Review of the provider's FRI on 2/27/26 at 12:46 p.m. regarding resident 44 revealed: *On 2/20/26 at 8:15 p.m. director of nursing (DON) B was notified that CNA D left her scheduled 2/20/26 shift 30 minutes after reporting to work. *CNA D stated she did not feel comfortable working until she spoke with the scheduler and DON B on Monday (2/21/26). *CNA D called DON B and texted the scheduler, which prompted administrator A and DON B to investigate CNA D's report of quality of care concerns. *CNA E reported that resident 44 had used her call light several times during the night on 2/19/26 regarding leg pain and needed to be repositioned. *CNA E reported to the charge nurse that resident 44 could not get comfortable. The nurse assessed resident 44 and provided care and medications ordered by her doctor. *CNA E stated she did not use profanity toward residents or while providing them care, but she did use profanity at times when talking with other staff members about a resident, as an expression of how she felt, not towards the resident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*CNA E was assigned the following training: Abuse and Neglect of Vulnerable Adult Abuse, Neglect and Exploitation, and Creating a Restraint – Free Environment, which was to be completed by 3/4/26. 4. Interview on 3/5/26 at 5:43 p.m. with DON B revealed: *The reports of resident abuse and neglect were to be reported to the SD DOH within two hours of being reported to herself or another staff member. *All other reportable events were to be reported to the SD DOH within 24 hours. *DON B acknowledged she did not report the allegations of verbal abuse, related to residents 44 and 49, within the required two-hour time frame to the SD DOH. *DON B stated she did not recall the 12/1/25 FRI regarding the 11/28/25 incident that involved resident 10's fall from a mechanical lift or that it was not reported within the required 24-hour time frame. 5. Review of the provider's 4/7/25 Abuse and Neglect policy revealed: *If there is an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident/client property, and/or there is serious bodily injury, then it will be reported immediately, but not later than two hours after the allegation is made. *If there is an allegation that does not involve abuse and there is no serious bodily injury, then it will be reported no later than 24 hours after the allegation is made.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, policy review, South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, and staffs' training records review, the provider failed to ensure the residents were protected from risk of injury or harm by staff members failing to safely use lift devices and to provide supervision for:*One of one sampled resident (100) who sustained a skin injury to his buttocks after a total body lift (a mechanical lift and sling used to lift a person's full body) was pulled out from under him by registered nurse (RN)/former director of nursing (DON) DD.*One of one sampled resident (36) identified as unable to safely operate a lift recliner chair and sustained a skin laceration to his head when he fell from that chair onto the floor after being left unsupervised.*One of one sampled resident (10) identified as needing to be transferred by two members with the use of a sit-to-stand lift (a mechanical device used to assist from a seated to a standing position) and fell after certified nursing assistant (CNA) (N) transferred the resident with that lift, without the assistance of another staff member.*One of one sampled resident (93) identified at risk for elopement (leaving the facility without staff knowledge) who eloped and remained outside unsupervised for about five minutes on 9/12/25. Findings include:1. Interview on 3/4/26 at 1:59 p.m. with certified nurse assistant (CNA) X revealed: *Resident 100 had a wound on his right buttocks area that had healed, then it opened back up. *He thought he was repositioned every 2 hours (hrs) and his incontinence brief was changed every hour. 2. Interview on 3/4/26 at 2:06 p.m. with CNA W regarding resident 100's wound revealed: *He stated he had wound on his buttock that had a wound vac (a device that uses negative pressure to remove excess fluid and debris from a wound to promote wound healing). *He stated that resident 100 developed the wound while he was on the rehab unit. *He stated that resident 100 had a mechanical lift sling placed underneath him for a transfer, and it scraped him when they removed it. CNA W stated the sling caused a rash, then it opened. *He thought that the wound was avoidable. 3. Interview on 3/5/26 at 9:17 a.m. with RN J regarding resident 100 revealed: *She had finished checking his wound, which involved making sure the wound vac was working, monitoring for redness, swelling, warmth, and that the dressing was secure. *She stated wound care was completed by the wound care clinic on Mondays, Wednesdays, and Fridays, and the floor nurses checked it daily. *She stated that he had the wound when he was admitted , and he had no other wounds. 4. Interview on 3/5/26 at 11:58 with assistant director of nursing (ADON) G regarding resident 100's wound revealed: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*Resident 100 had an abscess (confined pocket of pus, bacteria, and dead tissue) while he was in the hospital, which had opened. *He stated that the wound was not from a sling while he was in the rehab unit. 5. Interview on 3/5/26 at 2:00 p.m. with minimum data set (MDS)/wound nurse RN F regarding resident 100's wound revealed: *She was the wound nurse. *She was present in the residents room when he acquired the wound to his right buttock. *She stated registered nurse (RN)/former director of nursing (DON) DD attempted to pull a mechanical lift sling from under the resident and caused that wound. *She stated the wound was not from pressure, it was from shearing, and the wound was avoidable. *She stated he was sent to the hospital for an unrelated issue and the staff discovered the resident was septic. She stated that after further investigation and scans they discovered the wound was deeper than they thought and was tunneling (wound that extends from the skin surface into deeper tissue layers, forming narrow channels or passageways). *She stated the resident returned from the hospital with a wound vac. 6. Review of resident 100's electronic medical record (EMAR) revealed: *He was readmitted to the facility on [DATE]. *He did not have a Brief Interview of Mental Status (BIMS) assessment score completed and he was nonverbal. *His diagnoses included: -Quadriplegia (paralysis of all four limbs and he torso), Unspecified open wound of right Buttock sequela. *His care plan revealed he had a focus area of impairment to skin integrity related to a shearing injury to the right buttock that was initiated on 8/12/25. *His care plan interventions regarding his right buttock were identify potential causative factors and eliminate/resolve where possible, turn and reposition him in bed every two to three hours, weekly skin observations by a licensed nurse, provide a pressure-relieving/reducing mattress on his bed and/or cushion in his wheelchair. *His 8/8/25 wound assessment indicated that the wound was caused by friction/shearing. It was an open area that measured 0.9 cm (centimeters) in length by 0.2 cm in width by 0.1 cm in depth, and it was not present on admission/readmission to the facility. The physician was notified, and the wound was cleansed, and a barrier cream was applied to it. The assessment was signed as completed on 8/10/25 by RN Z. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	7. Interview on 3/5/26 at 2:00 p.m. with DON B regarding resident 100's wound revealed: *She was not aware that the wound was caused by shearing related to the removal of the mechanical lift sling from under the resident. *She was not sure what policy would address accident hazards regarding that incident. 8. Interview on 3/5/26 at 4:15 p.m. with administrator A regarding resident 100's wound revealed: *He did not have an accident hazards policy regarding mechanical lift slings. *He was not aware that resident 100 had a facility acquired wound from a mechanical lift sling. 9. Review of the provider's 12/12/25 Safe Resident Handling Program (SRHP) Overview revealed: *Good Samaritan's goal is to maintain a safe living and working environment for residents and employees. The Safe Resident Handling Program (SRHP) supports this goal. Each location will follow SRHP practices when performing mobilization and other care tasks that require employee assistance. 10. Interview on 3/4/26 at 3:14p.m. with resident 36's family member revealed: *He was informed resident 36 was transferred to his lift chair (recliner) by the staff after they completed his personal cares. After the staff left the room the chair control somehow activated and lifted him all the way up, and he fell on the floor, and had hit his head. 11. Interview on 3/5/26 at 10:32 a.m. with occupational therapist registered and licensed (OTR-L) AA, revealed: *She would have completed resident 36's lift chair safety assessment, but she did not work for the provider at that time. She stated that the nursing staff also completed lift chair assessments. *She was not aware of a resident's fall that involved a lift chair. 12. Interview on 3/5/26 at 9:17 a.m. with RN J revealed: *Resident 36 had one fall in the last two months. *She thought that he may have slipped out of his wheelchair, but he had no injuries. 13. Interview on 3/5/26 at 2:30 p.m. with DON B revealed: *She stated that resident 36 did not have any falls regarding the requested fall information. *She stated that she would look further when this surveyor verbalized that he had fallen, and one fall involved a lift chair. *She stated that resident 36 had one lift chair safety assessment completed 12/27/25. 14. Review of resident 36's (EMR) revealed: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*He was admitted to the facility on [DATE]. *His diagnoses included dementia (a group of symptoms affecting memory, thinking, and social abilities) and Parkinson's Disease without Dyskinesia (a movement disorder characterized by erratic and uncontrollable muscle movements). *He had a BIMS assessment score of 3, which indicated his cognition was severely impaired. *His care plan indicated on 9/27/24 that he had an activities of daily living (ADL) self-care performance deficit related to Parkinson's Disease, pain, shortness of breath, and dementia. His interventions indicated that a lift chair assessment was completed on 10/1/25 and 12/27/25, which indicated he was unable to demonstrate the safe use of the lift chair/remote, and that the remote was to be placed out of his reach. *His 12/27/25 lift chair assessment revealed he was unable to demonstrate safe use of the lift chair and needed his wife or son to operate it for him. 15. His 9/22/25 progress indicated: Resident 36 was found lying on his right side on the floor. He had a cut on his skin above his right eyebrow that measured 2 cm in length by 0.2 cm in width, and was bleeding. He was conscious, alert, able to move all four limbs, denied having pain, and answered the staff's questions. The staff checked his vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate), which were not documented, and his neurological evaluation (assessment of nerve function, reflexes, coordination, motor skills, sensation, and mental status) was completed. RN Y placed a bandage on his cut above his right eyebrow and notified the resident's family and physician of his fall. Before his fall, resident 36 was sitting in his recliner and had the remote tucked over the recliner. 16. Review of the providers 9/22/25 Fall Scene Huddle Worksheet regarding resident 36 revealed: *Resident 36 was found on the floor. *A CNA had transferred him to his recliner five minutes before his fall. *He had diarrhea that day, and last went to the bathroom at 9:00 a.m. *Resident 36 seemed alert and oriented before and after his fall. *His range of motion (measurement of movement around a joint or body part) was within normal limits, and he had a skin tear above his right eyebrow. 17. Review of the provider's 9/23/25 fall interdisciplinary review for resident 36 revealed: *He had a skin laceration to his right eyebrow. *His fall was not reported to the South Dakota Department of Health. *They were unsure of his last fall occurred. *The staff were to complete a lift chair assessment for resident 36. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	18. Review of the provider's 9/12/25 submitted FRI regarding resident 93 revealed: *On 9/12/25 at 2:00 p.m. resident 93 had eloped from the front door entrance of the facility. *Resident 93 was not observed leaving the facility and was missing approximately five minutes before staff intervened according to the video footage that was reviewed by the facility leadership. *When approached by the staff, resident 93 stated she wanted to go home and refused to come back into the facility. *The resident eventually agreed to go to the hospital for an examination after much encouragement and a phone conversation from her brother. *Resident 93 was examined at the hospital emergency department and discovered to have a urinary tract infection. -She was hospitalized and returned to the facility with her family transporting her back on 9/17/25. *The resident had no prior elopements from the facility. *Resident 93's family planned to move her to a facility in another state to be near her family members by 10/1/25. *Following the incident, the provider immediately provided re-education to the staff who were on duty of the provider's elopement policy and procedure, and planned to re-educate all other staff by 10/2/25. *Weekly elopement drills were to be conducted for one month, bi-weekly for one month, then monthly for four months. *All residents with a WanderGuard (a wearable door alarming device) would be checked for proper function each shift by nursing staff and recorded on the resident's treatment administration record. *DON or designee would audit one resident WanderGuard per week for one month, bi-weekly for one month, then monthly for four months. 19. Review of resident 93's EMR revealed: *She was admitted to the facility on [DATE]. *Her BIMS score was 7, which indicated her cognition was severely impaired. *Her diagnoses included dementia (cognitive communication deficit), anxiety, depression, and a history of a femur and cervical spine level two fractures. *She required the assistance of one staff member for bathing, bed mobility, dressing, and personal hygiene, but was independent with ambulation (walking) around the facility. *She wore a C-collar (a type of brace used to stabilize the neck). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*Resident 93's revised 8/28/25 care plan revealed: -A focus area: The resident has impaired thought processes R/T [related to] cognitive communication deficit/dementia. --Goal: Resident will be safe in their own environment as evidenced by: not eloping, not wandering into other resident rooms, etc. --Identified interventions for that goal included that staff were to ask yes/no questions to determine her needs, cue, reorient, and supervise as needed. A WanderGuard was to be used to alert the staff to her movements and help monitor her, and the staff was to offer her assistance by calling her brothers, helping her shower, or offering her a Diet Coke or candy. 20. Interview on 3/4/25 at 8:40 a.m. with RN C revealed: *She was working in the facility the day of resident 93's elopement. *RN C observed staff sitting, interacting, and attempting to keep resident 93 occupied on 9/12/25 because she made statements that she wanted to leave and to go home. *When resident 93 eloped, the staff stayed with her to ensure that she remained safe. *Education was provided to the staff following the elopement incident on 9/12/25 of the provider's elopement process to follow. *A code yellow is called over the intercom system in the event a door alarm goes off. *The door alarms are loud and easily heard by the staff. *A list of current residents with a WanderGuard was kept at the nurse station in the event a door alarm sounded, which indicated a possible resident elopement. *Nursing would take the lead with giving out resident assignments to the staff. *Each staff completed a head count for the residents on their list, and they reported back to nursing. *All residents needed to be accounted for before the nurse in charge would give an all clear to resume normal activities. *Education was initiated by leadership and provided to all staff members following that elopement incident. -Elopement drills were held to ensure the staff knew the process to follow in the event a door alarmed. -Nurses were to check every shift for the resident's WanderGuards and document them on the resident's treatment administration record (TAR) to ensure each resident's WanderGuard functions properly. The device used to check the WanderGuard functions was kept in the locked medication cabinet. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	21. Interview on 3/4/26 at 1:40 p.m. with RN Nurse Manager R revealed: *She was the nurse manager in charge of the rehabilitation unit. *Resident 93 was admitted to the facility on [DATE] for rehabilitation services. *Her room was located on the long-term care side of the facility and not in the regular rehabilitation services hallway which was not unusual. *An elopement assessment was completed with her admission, and resident 93 was not identified as an elopement risk at that time. *The family had let the facility staff know they were interested in a permanent placement for resident 93, but the resident stated she did not want to stay at the facility long term and wanted to return to her apartment. *After resident 93 became aware of the family plan for her to stay long term, she started to make statements about not wanting to be there and that she wanted to go home. *An updated elopement risk assessment was completed after those statements began and a WanderGuard was added on 8/27/25 as an intervention and added to her care plan. -The family agreed with the proposed WanderGuard intervention, and a physician's order for it was obtained on 8/27/25. *On days resident 93 had made statements about wanting to go home or to leave the facility, the staff were usually able to distract her from those thoughts by offering to call her family or to talk about her dog. *The day that she eloped from the facility she was near the front entrance area and making statements that she did not want to be there. *The staff were keeping a close eye on her due to those statements and interacted with her to help distract her thought process from wanting to leave. *RN nurse manager R was aware that resident 93 eloped that day but was not involved with the incident. *No other resident elopements occurred since resident 93's incident on 9/12/25. 22. Interview on 3/4/26 at 2:02 p.m. with administrator A revealed: *He was working inside his office on 9/12/25 at the time resident 93 eloped from the facility. *Resident 93 was making statements earlier in the day that she wanted to go home. *Administrator A believed he was the first staff member to find resident 93 when he saw her outside of his office, which was located next to the front door entrance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*Resident 93 was seated on a bench outside of the building which was next to his office window, and he recognized that she was to have staff supervision. *He thought only a few minutes had passed before her discovery and he had approached her. *While resident 93 was seated on the bench, he attempted to reason with her to come back inside, but she refused. *She then got up and walked away toward a nearby car because she believed it was her personal car and stated she was going to use it to leave and go home. *Resident 93 became angry and suspicious of administrator A at this time because he had tried to talk her out of entering the car. *She refused to go back into the building, but she walked back and sat on the same bench again. *Several other staff members attempted to intervene with resident 93 but were unsuccessful in bringing her back inside. *Resident 93's brother and power of attorney (someone designated on a legal document to act on behalf of a resident) was contacted by telephone and had a conversation with resident 93, but he was also unable to talk her into going back inside the building. *Eventually she agreed with the staff to be evaluated at the emergency department and was transported by a facility vehicle with two staff members. *She was hospitalized with a urinary tract infection and remained at the hospital for treatment and then returned to the facility. *The family decided to discharge resident 93 to another facility near them in Illinois and she was discharged on 10/1/25. *As a result of resident 93's elopement, the provider had implemented door audits to ensure alarms functioned correctly, nursing checked all residents with a WanderGuard for proper function each shift, elopement drills were conducted, and all the staff were re-educated on the provider's elopement policy and procedure. 23. Interview on 3/5/26 at 8:00 a.m. with clinical learning and development specialist S and DON B revealed: *Clinical learning and development specialist S was responsible for training new staff members and ensuring that all the staff were up to date with the required ongoing training. *The majority of the facility training was assigned and provided online. *He could run reports for all the staff to see what training they had to complete. *Each staff member was assigned the required training, and he checked to ensure that their training was completed on time. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society Luther Manor	1500 W 38th St Sioux Falls, SD 57105

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*If a staff member did not complete the training as assigned and it was near the required completion date, he was alerted and would then contact that staff member by email to remind them to do the training before the completion date passed. *If there were continued issues, DON B received alerts and would also contact the staff member with reminders. *The elopement training that was conducted after the 9/12/25 incident was completed in person by the staff with DON B and administrator A. *The staff who were educated had signatures on a sign in sheet to indicate they completed the elopement training. *He was not aware that there were staff who did not attend that training. *He stated administrator A and DON B did not communicate to him that he was to ensure all the staff had completed that training, but he would have if he was informed. 24. Interview and audit review on 3/5/26 at 9:15 a.m. with maintenance supervisor T revealed: *The maintenance department was responsible for conducting the audits for the door alarm function when a resident's WanderGuard was triggered. *The audits were completed weekly after resident 93's 9/12/25 elopement and were currently being done once a month. *The audits included the use of a WanderGuard to ensure that the door alarm triggered appropriately when the WanderGuard was near an exit door. *The surveyor verified that these audits were completed. *No resident had eloped from the facility since the 9/12/25 incident. *He believed he was working the day of the 9/12/25 elopement but was not directly involved. *He stated a staff member stationed at the front desk was assisting the family of a resident who had a WanderGuard on to leave the building for an outing. *When the door alarmed, the staff thought it was due to the resident who was leaving who also had a WanderGuard. -The same staff member did not notice resident 93 near the front door entrance when the family and other resident were leaving the facility. -She turned to reset the alarm and did not notice resident 93 follow the family and resident outside of the building. *Resident 93 was out of the building for a few minutes before she was discovered and the staff had intervened. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	25. Interview on 3/5/26 at 9:20 a.m. with CNA U revealed: *The staff were provided with re-education on the procedure to follow when a resident eloped from the facility. *She had heard about resident 93's elopement but was not involved with the incident. *Elopement drills were being conducted regularly so the staff would be familiar with what to do in the event a door alarmed. *In the event of a suspected resident elopement, a code yellow would be called over the intercom system to alert the staff. *The staff would report to their unit nurse station for instructions and resident assignments. *Once the resident assignments were given, the staff would conduct room-to-room searches ensure every resident was accounted for. *When the resident assignments were completed, the staff would check in at the nurse station. *After all the residents were accounted for, the designated person in charge would give an all clear on the overhead intercom system to resume regular facility activities. *She was not aware of any other resident elopements taking place after the 9/12/25 incident with resident 93. 26. Review of the staff re-education completion sheets regarding the provider's elopement policy and procedure revealed: *The elopement training was completed over several days according to the dates listed next to the staffs' signatures on the completion sheets. *There were ten staff members on the re-education completion sheets who did not receive the required elopement training. 27. Interview on 3/5/26 at 10:30 a.m. with administrator A revealed: *Administrator A and DON B had conducted the elopement policy and procedure re-training for their staff. *The elopement policy and procedure did not change. *He was not aware there were ten staff members who had missed the elopement re-education training but expected all staff to receive the training. *He expected the clinical learning and development specialist to have checked to ensure all staff had received the elopement training, but that did not happen. *He agreed he was responsible for ensuring all staff were trained. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*No further documentation was provided to indicate that those ten employees had received the elopement re-education training. 28. Interview on 3/5/26 at 2:00 p.m. with DON B and administrator A revealed: *The resident WanderGuard audits of the TAR that were to be conducted by the DON or designee as reported in the 12/1/25 FRI submitted for resident 93 were not completed and should have been. *They both agreed the elopement re-education training was not completed for all staff and should have been. *DON A stated administrator A and she had been working on their follow-up of facility incidents. *They did not complete all interventions for resident 93's elopement as they had planned and recognized they had issues with the completion of documentation to ensure that future incidents did not occur. 29. Review of the provider's revised 4/7/25 Elopement policy and procedure revealed: *The SNF [skilled nursing facility] location and each Adult Day Program will be responsible for maintaining a system that clearly defines the mechanisms and procedures for monitoring residents/clients at risk for elopement. These include identifying, evaluating and analyzing environmental hazards and risks; and implementing, monitoring and modifying interventions as needed. All SNF residents will be assessed for risk of elopement through the pre-admission and/or admission process and as needed. All Adult Day clients will be screened for risk of elopement through the intake process and as needed. Each SNF location and Adult Day Program will put measures in place to minimize the risk of elopement that are individualized to resident/client needs and identified on the care plan. When an elopement occurs, immediate efforts to locate the resident/client will be taken. All occurrences will be documented, and follow-up will be completed as required by state and federal regulations. 30. Review of the provider's 12/1/25 FRI regarding resident 10 revealed: *On 12/1/25, a post-fall huddle [when the staff gathered to discuss information available related to a resident's fall] form review was completed by the provider leadership, and it was determined that a report would be submitted to the SD DOH regarding resident 10's fall. -The fall report was not reported to the SD DOH within the required 24-hour reporting window. *On 11/28/25 at 11:30 a.m. CNA N was transferring resident 10 with a sit-to-stand mechanical lift (a mechanical lift used to assist from a seated to a standing position) from the toilet to his wheelchair. *Before the resident was able to be positioned and lowered into the wheelchair, he slipped and slid out of the sling and onto the floor on his bottom, then rolled onto his right side. *The nursing staff came to the room immediately and completed a physical assessment of resident 10. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*The resident indicated he bumped his head and Neurological evaluation (assessment of nerve function, reflexes, coordination, motor skills, sensation, and mental status) (neuros) and vitals were completed and within normal limits. *Notifications were made to the family and resident 10's medical provider. *CNA N was educated regarding the need for a second staff member when completing transfers with the sit-to-stand with resident 10. *The provider's investigation of the fall revealed that the sit-to-stand lift was functioning properly, the correct sling size was used, but CNA N had failed to follow resident 10's care plan, which indicated he was to be transferred using the sit-to-stand mechanical lift with the assistance of two staff members. *The provider planned to implement education to all CNAs regarding resident transfer status and to follow the residents' care plans. *Safe resident handling audits were to be completed by DON B or designee including: -The review of five random residents' care plan per week observing the resident transfers, weekly for eight weeks, biweekly for two months, and monthly for two months. -All resident care plans were to be reviewed by 12/9/25 to ensure their resident transfer status was correct. 31. Review of resident 10's EMR revealed: *He was admitted to the facility on [DATE]. *His Brief Interview of Mental Status (BIMS) assessment score was 00, which indicated he could not be interviewed. -Resident 10 was able to make his needs known by gesturing with his hands and with a head shake or nod. *His diagnoses included aphasia (a language disorder commonly caused by stroke or injury that impairs the ability to speak, understand, read, and write), and hemiparesis (weakness of one side of the body) following cerebral infarction (stroke) affecting the right side. *He required the assistance of one staff member for bed mobility, dressing, oral care and personal hygiene. *He required the use of a sit-to-stand mechanical lift with the assistance of two staff members for transfers. *He was dependent upon the staff to ensure his care plan was implemented and followed. Resident 10's care plan revised on 12/17/25 revealed an identified problem of, The resident has an ADL [activities of daily living] self-care performance deficit R/T [related to] obesity, (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	pain/osteoarthritis, stroke with hemiparesis, expressive and receptive aphasia, OA [osteoarthritis], RUE/RLE [right upper extremity/right lower extremity] paralysis, LICA [left internal carotid artery] and [NAME] [right internal carotid artery] stenosis, low back pain and arthritis, and vitamin D deficiency E/B [evidenced by] assist needed with ADLs. -Identified interventions for that problem area included: Transfer between surfaces: mechanical sit to stand assist of 2 [staff members]. Sling size XL [extra-large], staff to assist right arm on bar. Initiated: 9/15/25. 32. Interview on 3/3/26 at 11:55 a.m. with CNA I revealed: *CNA I had worked at the facility for 13 years and was a CNA for 30 years. *Usually, she was scheduled to work in restorative, but also worked as a CNA when needed. *When the staff were working with the residents, the expectation was that they would consult the Kardex (a report of the resident's care needs and interventions), the whiteboard (a dry erase board used for communication) within the resident room, or use their computer tablets to ensure the residents care plan was followed. There were several resources that were available to the CNAs in each hallway of the facility. *The gait belts and slings for mechanical lift transfers were hung on the backside of the entrance door in each resident room. -Each resident's sling size was indicated in their individual care plan. *There were to be two staff members to assist with all full body lift (a mechanical lift and sling used to lift a person's full body) transfers. *If a sit-to-stand mechanical lift was used, it could either be one or two staff members involved, depending on the resident's needs. *The facility expectation was that CNAs would check the resident's care plan before assisting a resident to ensure their care plan was being followed correctly. *Resident 10 was known to need two staff to assist him with sit-to-stand mechanical lift transfers. 33. Interview on 3/4/25 at 8:40 a.m. with RN C revealed: *She had worked at the facility for 27 years. *Care plans were initiated by the MDS coordinators or the admissions nurse. *When there were care plan updates, the nursing leadership usually made those changes. *She expected the CNAs to ask nursing if there were any questions or concerns about the residents. *The CNAs should check the resident care plans for the correct way to care for and assist the resident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	34. Interview on 3/4/26 at 11:35 a.m. with CNA N regarding resident 10 revealed: *She was a CNA for a year but was hired by the facility on 11/4/25. *During her orientation training at the facility she thought she remembered ot

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), observation, interview, record review, and policy review, the provider failed to ensure the staff completed and documented controlled medications (medications at risk for abuse and addiction) supply counts for five of five medication carts (Mystic Ranch, Park View, Focus, East, and [NAME] Lane), failed to prevent the theft of one of one sampled resident's (94) controlled pain medication (oxycodone) by registered nurse (RN) FF, and failed to ensure insulin was administered according to the physician's order for one of one sampled resident (10) who was evaluated at an emergency room after being administered the wrong insulin by licensed practical nurse (LPN) CC.Findings include:1. Review of the provider's 12/18/25 FRI involving resident 10's medication error revealed: *On 12/17/25 at 8:45 p.m. LPN CC administered the incorrect insulin to resident 10. *His insulin medication orders were to inject Novolog) a fast-acting insulin according to the sliding scale: *Novolog sliding scale order indicated if his blood sugar was: -between 60 and 150, to inject zero units. -between 201 and 250, to inject two units. -between 251 and 300, to inject four units. -between 301 and 350, to inject six units. -between 351 and 400, to inject eight units. *The physician was to be notified if his blood sugar level was less than 70. *He was to be given 18 units of Novolog with his breakfast meal and 15 units daily with his noon and evening meals. *He was to receive 38 units of Tresiba (a long -acting insulin) one time a day. *LPN CC noticed she injected the resident with Novolog and not the Tresiba. *The resident's primary provider was called immediately and requested that the resident be sent to the emergency room (ER) for overnight observation. *The resident was alert, non-verbal, and easy to arouse. *The resident's wife was notified of the insulin error. *His blood sugar was 234, and no other vital signs were obtained. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Resident 10's blood sugar levels remained stable in the ER, with the lowest level of 100. *Resident 10 returned to the facility on [DATE] at 4:16 a.m., and he had no adverse effects from that incident. *There were no new physician's orders or orders to hold any of his medications. *The facility's investigation revealed that the resident's insulin pens were stored in one bulk container on the medication cart. *LPN CC stated she did not realize which insulin she had until she was administering the units to the resident. *The insulin medications were now stored in the medication drawer in the medication cart, and every resident had their own container of their insulin medications. *Insulin education was provided to LPN CC and for all nurses by 1/1/26. 2. Observation and Interview on 3/3/26 at 11:24 a.m. with resident 10 revealed: *He was in a wheelchair with headphones on and was watching television (TV). *He took his headphones off, indicated he was non-verbal and shook his head to respond yes or no to questions asked. *He acknowledged that he received good care from the staff, and that he did not have problems with his insulin. *He indicated that he received good care from the staff, and that he did not have problems with his insulin. 3. Review of resident 10's electronic medical record (EMR) revealed: *He was admitted to the facility on [DATE]. *Diagnoses included: hyperglycemia (high blood sugar) and Type 2 Diabetes Mellitus with Diabetic Neuropathy. 4. Interview and observation of the medication care on 3/4/26 at 4:20 p.m. with LPN CC regarding resident 10's incident above and insulin storage revealed: *When she went to administer resident 10 his Tresiba , she took his Tresiba and Novolog insulin pens to his room. *She dialed the insulin dose and while she was injecting him with that insulin, she realized it was the Novolog pen, which was the wrong insulin. *She stated she stopped the injection, but she had already administered the resident a significant amount of the incorrect medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She called director of nursing (DON) B to discuss the error and was directed to call 911. *She explained to resident 10 that she had given him too much insulin and she would send him to the ER. She contacted his wife regarding the medication error. *She stated that resident 10 had done well and returned to the facility within a few hours, but not during her shift. *Before that incident, all residents' insulin pens were stored together in one container in the medication cart. *The insulin pens were stored in the medication cart in separate containers for each resident and were labelled with their names. *She did not remember being educated regarding storing the insulin pens in individual containers, but noticed the resident-specific insulin containers during the next shift she worked. 5. Observation of the medication carts and interview on 3/5/26 at 10:08 a.m. with registered nurse (RN) C revealed: *The medication carts had separate containers in them that were labelled with each resident's name and contained their individual insulin pens. *She stated the new insulin storage containers process was started two to four months ago. She received education to keep the residents' insulin pens stored separately. 6. Interview on 3/5/26 at 2:00 p.m. with DON B regarding the 12/17/25 incident with resident 10 and insulin storage revealed: *She was called right away regarding the insulin error involving resident 10 by LPN CC. *She stated the resident did not have a negative outcome from receiving the wrong insulin and had been monitored in the ER. *She stated LPN CC had been educated regarding medication errors but DON B did not have documentation to support that had occurred. *She stated each resident had a container in the medication cart that was labelled and contained their insulin pens. 7. Review of the provider's 3/3/26 Medication Error policy revealed that medication errors were defined as: *The observed or identified preparation or administration of medications or biologicals which are not in accordance with prescriber's order, manufacturer's specifications (not recommendations) regarding the preparation and administration of the medication or biological or accepted professional standards and principles which apply to professionals providing services. 8. Review of the provider's 9/18/25 FRI regarding resident 94 revealed: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*On 9/17/25 at approximately 6:10 a.m. DON B was notified that the Mystic Ranch hall medication cart had a discrepancy in its controlled drug (medications with risk for abuse and addiction) count. *Resident 94's bottle of oxycodone (a controlled pain medication) 5 milligram (mg) tablets were counted by the on-coming and off-going nurses and was found to have 84 halved tablets, but the Controlled Drug Count Record sheet indicated there was supposed to be 90 halved tablets in the bottle. *DON B removed the bottle of oxycodone from the Mystic Ranch medication cart and initiated an investigation into the oxycodone that could not be accounted for. *The bottle of oxycodone had arrived at the facility from the pharmacy on 9/11/25. *The Individual Resident's Narcotic Record for resident 94 did not have a signature of the nurse who received that bottle of oxycodone and verified the bottle contained the correct amount of oxycodone in it. *DON B identified through her investigation that RN FF had cut the oxycodone 5 mg tablets in half to equal the 2.5 mg dose that was ordered to be given to resident 94 on 9/11/25. *Resident 94's oxycodone tablets were not counted after they were cut by RN FF and put into the locked medication drawer in the medication cart. *The 9/11/26 evening nurse placed a piece of tape over the top of the bottle of oxycodone without counting the pills in that bottle to prevent staff from using that bottle of oxycodone. *That bottle of oxycodone was not counted until 9/17/25, when the discrepancy was found. *On 9/17/25 at 2:33 p.m. DON B and administrator A spoke with RN FF on the telephone. -RN FF denied that she had cut resident 94's oxycodone tablets in half, stating she was allergic to oxycodone. *DON B reviewed the facility's video footage from 9/11/25 at the west nurses' station where she identified RN FF putting a pill in her hand, placing the pill in her mouth, and then she took several drinks of water. *On 9/23/25 at 8:51 a.m. administrator A, DON B, and human resources lead GG called RN FF on the telephone to discuss the events on 9/11/25 when RN FF was on video surveillance cutting resident 94's oxycodone tablet in half. -RN FF stated she had a problem and human resources lead GG ended the phone conversation by telling RN FF she was terminated for theft related to consuming medications that did not belong to her. *DON B determined there were six halved tablets of oxycodone 5 mg that could not be accounted for. *All medication carts were audited for controlled medications and it was determined that there were no other controlled medications that were not accounted for. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*DON B started audits on the controlled drugs in the medication carts and the Controlled Drug Count Record sheets and began educating staff on controlled medication counts and the cutting of medications. 9. Observation on 3/4/26 at 1:32 p.m. of the three-ring binder on the Park View medication cart revealed that on 3/3/26 at 11:00 p.m. the on-coming nurse did not sign the Controlled Drugs Count Record sheet to indicate a count of the controlled medications were completed with no discrepancies. 10. Interview on 3/5/26 at 2:30 p.m. with RN C revealed: *The controlled drugs were to be counted by the on-coming and off-going nurses at the change of each shift, or if the keys to the medication cart are exchanged between nursing staff members and then documented on the Controlled Drugs Count Record. *The off-going nurse was to review the Individual Resident's Narcotic Record while the on-coming nurse counted the medications. *She did not recall being educated on the controlled drug count process. She stated process was the same for years. *The nursing staff was educated during a nurses' meeting to remember to count the controlled medications between each shift and sign the Controlled Drugs Record to indicate the drug count was completed and accurate. 11. Review of the December 2025 Controlled Drugs Count Record sheets on the Mystic Ranch medication cart revealed: *There were three headings labeled 7-3 Shift (7:00 a.m. to 3:00 p.m.), 3-11 Shift (3:00 p.m. to 11:00 p.m.), and 11-7 Shift (11:00 p.m. to 7:00 a.m.). *Below those headings were columns labeled Nurse Off, Nurse On, and Card or prescription count. *The controlled drug count was not signed as completed with no discrepancies by the on-coming nurse under the 7-3 shift heading and the off-going nurse under the 11-7 shift heading on 12/4/25. *The controlled drug count was not signed as completed with no discrepancies by the 7-3 shift off-going nurse and the 3-11 shift on-coming nurse on 12/14/25 and 12/22/25. *The controlled drug count was not signed as completed with no discrepancies by the 3-11 shift off-going nurse and the 11-7 shift on-coming nurse on 12/1/25, 12/3/25, and 12/28/25. 12. Review of the December 2025 Controlled Drugs Count Record sheets on the Focus medication cart revealed: *There were three headings labeled 7-3 Shift (7:00 a.m. to 3:00 p.m.), 3-11 Shift (3:00 p.m. to 11:00 p.m.), and 11-7 Shift (11:00 p.m. to 7:00 a.m.). *Below those headings were columns labeled Nurse Off, Nurse On, and Card or prescription count. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435044	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society Luther Manor	1500 W 38th St Sioux Falls, SD 57105

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The controlled drug count was not signed as completed with no discrepancies by the on-coming nurse under the 7-3 shift heading and the off-going nurse under the 11-7 shift heading on 12/3/25 and 12/31/25. *The controlled drug count was not signed as completed with no discrepancies by the 7-3 shift off-going nurse and the 3-11 shift on-coming nurse on 12/12/25. *The controlled drug count was not signed as completed with no discrepancies by the 3-11 shift off-going nurse and the 11-7 shift on-coming nurse on 12/30/25 and 12/31/25. 13. Review of the December 2025 Controlled Drugs Count Record sheets on the East medication cart revealed: *There were three headings labeled 7-3 Shift (7:00 a.m. to 3:00 p.m.), 3-11 Shift (3:00 p.m. to 11:00 p.m.), and 11-7 Shift (11:00 p.m. to 7:00 a.m.). *Below those headings were columns labeled Nurse Off, Nurse On, and Card or prescription count. *The controlled drug count was not signed as completed with no discrepancies by the on-coming nurse under the 7-3 shift heading and the off-going nurse under the 11-7 shift heading on 12/3/25 and 12/27/25. *The controlled drug count was not signed as completed with no discrepancies by the 3-11 shift off-going nurse and the 11-7 shift on-coming nurse on 12/2/25 and 12/29/25. 14. Review of the December 2025 Controlled Drugs Count Record sheets on the Park View medication cart revealed: *There were three headings labeled 7-3 Shift (7:00 a.m. to 3:00 p.m.), 3-11 Shift (3:00 p.m. to 11:00 p.m.), and 11-7 Shift (11:00 p.m. to 7:00 a.m.). *Below those headings were columns labeled Nurse Off, Nurse On, and Card or prescription count. *The controlled drug count was not signed as completed with no discrepancies by the on-coming nurse under the 7-3 shift heading and the off-going nurse under the 11-7 shift heading on 12/4/25, 12/6/25, 12/15/25, and 12/27/25. *The controlled drug count was not signed as completed with no discrepancies by the 7-3 shift off-going nurse and the 3-11 shift on-coming nurse on 12/14/25, 12/22/25, 12/26/25 and 12/27/25. *The controlled drug count was not signed as completed with no discrepancies by the 3-11 shift off-going nurse and the 11-7 shift on-coming nurse on 12/5/15, 12/14/25, 12/18/25, 12/23/25, 12/24/25, and 12/31/25. 15. Review of the December 2025 Controlled Drugs Count Record sheets on the [NAME] Lane medication cart revealed: *There were three headings labeled 7-3 Shift (7:00 a.m. to 3:00 p.m.), 3-11 Shift (3:00 p.m. to 11:00 p.m.), and 11-7 Shift (11:00 p.m. to 7:00 a.m.). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Below those headings were columns labeled Nurse Off, Nurse On, and Card or prescription count. *The controlled drug count was not signed as completed with no discrepancies by the on-coming nurse under the 7-3 shift heading and the off-going nurse under the 11-7 shift heading on 12/4/25 and 12/27/25. *The controlled drug count was not signed as completed with no discrepancies by the 7-3 shift off-going nurse and the 3-11 shift on-coming nurse on 12/9/25, 12/17/25, and 12/31/25. 16. Review of the January 2026 Controlled Drugs Count Record sheets on the East medication cart revealed: *There were three headings labeled 7-3 Shift (7:00 a.m. to 3:00 p.m.), 3-11 Shift (3:00 p.m. to 11:00 p.m.), and 11-7 Shift (11:00 p.m. to 7:00 a.m.). *Below those headings were columns labeled Nurse Off, Nurse On, and Card or prescription count. *The controlled drug count was not signed as completed with no discrepancies by the 3-11 shift off-going nurse and the 11-7 shift on-coming nurse on 1/6/26 and 1/22/26. 17. Review of the January 2026 Controlled Drugs Count Record sheets on the [NAME] Lane medication cart revealed: *There were three headings labeled 7-3 Shift (7:00 a.m. to 3:00 p.m.), 3-11 Shift (3:00 p.m. to 11:00 p.m.), and 11-7 Shift (11:00 p.m. to 7:00 a.m.). *Below those headings were columns labeled Nurse Off, Nurse On, and Card or prescription count. *The controlled drug count was not signed as completed with no discrepancies by the on-coming nurse under the 7-3 shift heading and the off-going nurse under the 11-7 shift heading on 1/30/26. *The controlled drug count was not signed as completed with no discrepancies by the 3-11 shift off-going nurse and the 11-7 shift on-coming nurse on 1/2/26. 18. Review of the January 2026 Controlled Drugs Count Record sheets on the Park View medication cart revealed: *There were three headings labeled 7-3 Shift (7:00 a.m. to 3:00 p.m.), 3-11 Shift (3:00 p.m. to 11:00 p.m.), and 11-7 Shift (11:00 p.m. to 7:00 a.m.). *Below those headings were columns labeled Nurse Off, Nurse On, and Card or prescription count. *The controlled drug count was not signed as completed with no discrepancies by the on-coming nurse under the 7-3 shift heading and the off-going nurse under the 11-7 shift heading on 1/2/26, 1/14/26, and 1/21/26. *The controlled drug count was not signed as completed with no discrepancies by the 7-3 shift off-going nurse and the 3-11 shift on-coming nurse on 1/14/26 and 1/15/26. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The controlled drug count was not signed as completed with no discrepancies by the 3-11 shift off-going nurse and the 11-7 shift on-coming nurse on 1/1/26 and 1/6/26. 19. Review of the January 2026 Controlled Drugs Count Record sheets on the Mystic Ranch medication cart revealed: *There were three headings labeled 7-3 Shift (7:00 a.m. to 3:00 p.m.), 3-11 Shift (3:00 p.m. to 11:00 p.m.), and 11-7 Shift (11:00 p.m. to 7:00 a.m.). *Below those headings were columns labeled Nurse Off, Nurse On, and Card or prescription count. *The controlled drug count was not signed as completed with no discrepancies by the on-coming nurse under the 7-3 shift heading and the off-going nurse under the 11-7 shift heading on 1/25/26. *The controlled drug count was not signed as completed with no discrepancies by the 7-3 shift off-going nurse and the 3-11 shift on-coming nurse on 1/23/26 and 1/25/26. *The controlled drug count was not signed as completed with no discrepancies by the 3-11 shift off-going nurse and the 11-7 shift on-coming nurse on 1/1/26, 1/2/26, 1/3/26, 1/5/26, 1/21/26, 1/24/26, and 1/28/26. 20. Review of the February 2026 Controlled Drugs Count Record sheets on the Mystic Ranch medication cart revealed: *There were three headings labeled 7-3 Shift (7:00 a.m. to 3:00 p.m.), 3-11 Shift (3:00 p.m. to 11:00 p.m.), and 11-7 Shift (11:00 p.m. to 7:00 a.m.). *Below those headings were columns labeled Nurse Off, Nurse On, and Card or prescription count. *The controlled drug count was not signed as completed with no discrepancies by the on-coming nurse under the 7-3 shift heading and the off-going nurse under the 11-7 shift heading on 2/5/26, 2/7/26, 2/10/26, and 2/19/26. *The controlled drug count was not signed as completed with no discrepancies by the 7-3 shift off-going nurse and the 3-11 shift on-coming nurse on 2/6/26, 2/10/25, 2/20/26, 2/21/26, and 2/22/26. *The controlled drug count was not signed as completed with no discrepancies by the 3-11 shift off-going nurse and the 11-7 shift on-coming nurse on 2/2/26, 2/4/26, 2/18/26, and 2/21/26. 21. Review of the February 2026 Controlled Drugs Count Record sheets on the [NAME] Lane medication cart revealed: *There were three headings labeled 7-3 Shift (7:00 a.m. to 3:00 p.m.), 3-11 Shift (3:00 p.m. to 11:00 p.m.), and 11-7 Shift (11:00 p.m. to 7:00 a.m.). *Below those headings were columns labeled Nurse Off, Nurse On, and Card or prescription count. *The controlled drug count was not signed as completed with no discrepancies by the 7-3 shift (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	off-going nurse and the 3-11 shift on-coming nurse on 2/25/26, and 2/27/26. 22. Review of the February 2026 Controlled Drugs Count Record sheets on the Park View medication cart revealed: *There were three headings labeled 7-3 Shift (7:00 a.m. to 3:00 p.m.), 3-11 Shift (3:00 p.m. to 11:00 p.m.), and 11-7 Shift (11:00 p.m. to 7:00 a.m.). *Below those headings were columns labeled Nurse Off, Nurse On, and Card or prescription count. *The controlled drug count was not signed as completed with no discrepancies by the on-coming nurse under the 7-3 shift heading and the off-going nurse under the 11-7 shift heading on 2/5/26. *The controlled drug count was not signed as completed with no discrepancies by the 3-11 shift off-going nurse and the 11-7 shift on-coming nurse on 2/3/26. 23. Review of the February 2026 Controlled Drugs Count Record sheets on the Mystic Ranch medication cart revealed: *There were three headings labeled 7-3 Shift (7:00 a.m. to 3:00 p.m.), 3-11 Shift (3:00 p.m. to 11:00 p.m.), and 11-7 Shift (11:00 p.m. to 7:00 a.m.). *Below those headings were columns labeled Nurse Off, Nurse On, and Card or prescription count. *The controlled drug count was not signed as completed with no discrepancies by the on-coming nurse under the 7-3 shift heading and the off-going nurse under the 11-7 shift heading on 2/5/26, 2/7/26, 2/10/26, and 2/19/26. *The controlled drug count was not signed as completed with no discrepancies by the 7-3 shift off-going nurse and the 3-11 shift on-coming nurse on 2/6/26, 2/10/25, 2/20/26, 2/21/26, and 2/22/26. *The controlled drug count was not signed as completed with no discrepancies by the 3-11 shift off-going nurse and the 11-7 shift on-coming nurse on 2/2/26, 2/4/26, 2/18/26, and 2/21/26. 24. Review of the February 2026 Controlled Drugs Count Record sheets on the East medication cart revealed: *There were three headings labeled 7-3 Shift (7:00 a.m. to 3:00 p.m.), 3-11 Shift (3:00 p.m. to 11:00 p.m.), and 11-7 Shift (11:00 p.m. to 7:00 a.m.). *Below those headings were columns labeled Nurse Off, Nurse On, and Card or prescription count. *The controlled drug count was not signed as completed with no discrepancies by the 7-3 shift off-going nurse and the 3-11 shift on-coming nurse on 2/27/26. 25. Interview and review of the Controlled Drugs Count Records on 3/5/26 at 5:43 p.m. with DON B revealed: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Education was provided to the nursing staff related to controlled medication counts to ensure all controlled medications were accounted for after resident 94's oxycodone could not be accounted for on 9/17/25. *Resident 94's oxycodone was changed to be supplied by a local pharmacy so it would arrive in half tablets and in a bubble pack to prevent the need to cut the pills and to be easier to count to ensure they were accounted for. *DON B reviewed the Controlled Drugs Count Record sheets intermittently, but she was not auditing them routinely. *She expected the controlled drugs were counted by the on-coming and off-going nurse at each shift change and any time the keys to a medication cart were exchanged. *The signatures on the controlled drug count record indicated that the count was completed and accurate. *She acknowledged there were missing signatures on the Controlled Drug Count Records. 26. Review of the provider's revised 10/20/25 Medication: Missing/Diversion of Medication – R/S, LTC, AL policy revealed: *Upon discovery of a medication that may be missing or diverted, notify the Director of Nursing/AL Nurse. Document the incident in SAFE Event Reporting application. *If controlled medication is discovered missing during perpetual count, consider: Recount, Checking addition and subtraction from previous activity, check the outdated medications. *Nursing employees with access to the medication cart are asked to search the cart, their pockets and surrounding areas for the missing medications. *An investigation of the situation is performed by the investigation team. *Notify the administrator, the state survey and certification agency, law enforcement, and other designated agencies in accordance with state law of a medication diversion. 27. Review of the provider's revised 3/4/25 Medications: Acquisition, Receiving, Dispensing, and Storage – R/S, LTC policy revealed: *It Is preferred that a licensed nurse receive and verify the medications. Once the medications are received, they will be secured in the appropriate storage area (i.e., medication cart or medication room). Licensed nurses and medication aides (when allowed by state law) are responsible for reconciling medications received. *Disposal will be done in accordance with state/pharmacy regulations. *Controlled drugs (Schedule II) and other drugs subject to possible abuse will be stored in separate, locked, permanently fixed compartments, except when a single unit package drug distribution is used. These drugs will be reconciled daily through an appropriate system of records of receipt and disposition established by the licensed pharmacist.