STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society Sioux Falls Center	401 West Second Street Sioux Falls, SD 57104

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), record review, interview, and policy review, the provider failed to report a known serious bodily injury within the required time frame for one of one sampled resident (6) who fell and sustained a hip fracture. Findings include:1. Review of the provider's 11/11/25 SD DOH FRI (a required reporting of unexpected or adverse events) report revealed:*Resident 6 slipped out of her wheelchair, landed on her left hip, and reported left hip pain on 11/10/25 at 2:20 p.m.*Resident 6's physician ordered an X-ray of her left hip.*Administrator A and director of nursing (DON) B were notified of the fall.*The X-ray results showed resident 6 had a left intertrochanteric fracture of the femur (a common type of broken hip occurring in the upper part of the thigh bone [femur]), and the resident's daughter-in-law wanted to talk to the rest of the family before transferring the resident to the emergency department (ED).*On 11/11/25 at 7:30 a.m., resident 6's daughter-in-law informed clinical care leader (CCL) E that the family decided they wanted resident 6 sent to the ED.*Resident 6 was transferred to the ED on 11/11/25 at 7:55 a.m., was admitted to the hospital, and later passed away.*The FRI report was reported to the SD DOH by administrator A on 11/11/25 at 12:54 p.m. 2. Review of resident 6's electronic medical record (EMR) revealed that on 11/10/25 at 6:45 p.m., a progress note written by RN L stated resident 6's X-ray results indicated she sustained a left hip fracture, and the results were faxed to her physician. 3. Interview on 2/3/26 at 4:43 p.m. with CCL E revealed a portable X-ray technician came to the facility to complete resident 6's X-ray. 4. Interview on 2/4/26 at 11:35 a.m. with DON B revealed:*Administrator A and she completed incident reporting to the SD DOH.*Reporting to the SD DOH was to be completed within 24 hours after outside medical attention was provided.*A confirmed hip fracture, even when an X-ray technician came to the facility to take it, would need to be reported to the SD DOH within two hours. 5. Interview on 2/4/26 at 12:40 p.m. with administrator A revealed:*He thought that since resident 6 did not receive outside medical attention immediately after her fall, in which she sustained a hip fracture, the incident would need to be reported to the SD DOH within 24 hours.*He considered a hip fracture a serious bodily injury and would need to follow their policy regarding when to report the incident to the SD DOH. 6. Review of the provider's 4/7/25 Abuse and Neglect policy revealed:*Designated agencies will be notified in accordance with state law, including the State Survey and Certification Agency.*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 not later than 24 hours after the allegation is made.

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.

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

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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 South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, observation, record review, and policy review, the provider failed to ensure the safety and staff supervision of seven of seven sampled residents (1, 2, 3, 4, 5, 7, and 8) identified as needing supervision while smoking to prevent physical injury or harm, and specifically one of one sampled resident (1) who subsequently sustained a burn to his face. Findings include:1. Review of the 12/11/25 SD DOH FRI revealed:*On 12/11/25 at 10:20 p.m., resident 1 informed registered nurse (RN) M that he went outside into the facility's enclosed courtyard to smoke. When resident 1 lit his cigarette, an ember began to smolder in his winter hat. He removed his hat and placed it in the snow.*Resident 1 knew the door code to the locked exit door and did not inform any staff members before going out into the enclosed courtyard.*The camera footage review completed by administrator A revealed:-Resident 1 and resident 2 entered the courtyard at 10:20 p.m. At 10:21 p.m., resident 1 tilted his head downward while wearing a brimmed hat, and the brim of the hat began smoldering when the hat touched the lit cigarette. Resident 1's beard was singed near his ear.-Resident 2 assisted resident 1 to put out the smoldering hat.-Both residents remained in the courtyard to finish their cigarettes and entered the facility at 10:26 p.m. and told RN M what had occurred.*RN M completed a skin assessment of resident 1, which revealed a reddened area to the top of his head by his hairline, his beard area on the left side of his face near his ear, and on his left cheekbone, with skin remaining intact. Resident 1 denied pain. RN M applied a cold washcloth to those areas for comfort.*RN M completed a skin assessment of resident 2, and no injury was identified.*Resident 2 stated he knew the door code and, without notifying any staff members, he entered the door code, which deactivated the door alarm, so that he and resident 1 could enter the courtyard to smoke.*Resident 1 and resident 2 were educated on the facility's smoking protocol. Tobacco Use Assessments were completed on all residents who smoked at the facility, and a resident smoking council meeting was held on 12/17/25.*Education was provided to all staff members to ensure the door code remains unknown to the residents.*Resident 1's family provided smokeless/vaping alternatives for resident 1 to prevent future incidents from occurring.*The facility purchased fire-resistant beard covering for resident 1 to wear while vaping in the courtyard.*Maintenance supervisor P evaluated the door, alarms, and magnetic locks to ensure all were functioning, and changed the code to the door leading to the courtyard. 2. Observation and review of the provider's sign-out book on 2/3/26 at 8:00 a.m., revealed:*Resident 3 was outside the front door of the facility in his power wheelchair, picking up cigarette butts off the ground with his reacher stick (a device used to increase a person's reach to grab objects).*He did not sign out in the sign-out book located on the windowsill of the closed receptionist's window at the front door. 3. Review of resident 1's Electronic Medical Record (EMR) revealed:*He was admitted to the facility on [DATE].*His 12/11/25 Brief Interview of Mental Status (BIMS) assessment score was 11, which indicated his cognition was moderately impaired.*His diagnoses included Multiple Sclerosis (a chronic, often disabling autoimmune disease of the central nervous system), paraplegia (the inability to voluntarily move the lower parts of the body), intellectual disability, and tobacco use.*His 4/26/25 Tobacco Use Evaluation indicated it was related to: Smoking/Vaping.- Has the resident had any incidents of dropping a cigarette, falling asleep while smoking, burning self, furniture or clothing, or other unacceptable tobacco-related behavior in the past? was marked yes and resident with previous incident- new safety implementations placed.--It did not indicate what those safety implementations included.-Resident 1 needed supervision during smoking times for safety reasons, was sometimes able to light his own cigarette, and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	required a smoking apron and supervision.*There was no documentation that a Tobacco Use Evaluation was completed quarterly in July or in November 2025. *A 12/11/25 incident report indicated resident 1 reported to his nurse that he went outside to smoke and his lighter ignited his hat.-The nurse's assessment revealed a minor burn to the frontal hairline, beard area, and left cheekbone.-Resident did not inform staff prior to going outside.*His 12/11/25 Tobacco Use Evaluation indicated it was related to: Smoking/Vaping.-Resident 1 had dexterity problems that affected his ability to smoke/vape, needed assistance opening doors, and his cognition was moderately impaired. He had a previous incident of burning clothing and needed supervision during smoking times for safety reasons. He was sometimes able to light his own cigarette and safely operate his e-cigarette device, and required a smoking apron and supervision.*His care plan indicated:-A 3/24/24 Focus area that The resident has a history of elopement R/T [related to] disregard for signing himself out and neglecting to advise staff that he was leaving the building, with a goal that the resident will not leave the facility unattended except for planned community outings.-A 3/24/24 Focus area that The resident uses tobacco products E/B [evidenced by] use of cigarettes/e-cig. Interventions included. remind resident to utilize smoking safety equipment including smoking apron, fire retardant jacket and flame retardant beard protector.- Resident must have staff accompany him when he smokes.- Resident allowed to have cigarettes in [his] room. Encourage resident [1] to keep [his] lighter at [the] nurse's station. Resident [1] routinely refuses to return [his] lighter. Continue to provide education of risks associated with the lighter in the room.*There was no documentation that resident 1 vaped or where his vape was stored. 4. Review of resident 2's EMR revealed:*He was admitted to the facility on [DATE].*His 11/20/25 BIMS assessment score was 15, which indicated his cognition was intact.*His 9/16/24 Tobacco Use Evaluation indicated Resident able to use cigarettes independently, however, facility protocol states residents to be supervised while smoking, and he required a smoking apron and supervision.*There was no documentation that a Tobacco Use Evaluation was completed quarterly or annually between 9/16/24 and 12/16/25.*His 12/16/25 Tobacco Use Evaluation indicated he required a smoking apron and supervision.*His care plan had an 11/27/25 goal that Resident [2] will safely use tobacco products in designated areas. Interventions included, Facility protocol states that all residents are to be supervised while smoking. Resident [2 is] known to go out to the courtyard on [his] own. He was provided with and expected to follow designated smoking times, to wear a smoking apron, and to store his lighter at the nurse's station. Resident [was] known to refuse to give up [his] lighter. 5. Review of resident 3's EMR revealed:*He was admitted to the facility on [DATE].*His 11/28/25 BIMS assessment score was 15, which indicated his cognition was intact.*His 12/16/25 Tobacco Use Evaluation indicated he required a smoking apron and supervision.*His care plan had a 1/6/26 goal that he would safely use tobacco products in designated areas.-Interventions included:-- Resident [3] is independent with tobacco use per assessment; however, per facility protocol, [he] will only smoke in designated areas with supervision at all times. Resident 3 was known to be non-compliant, and education was provided on the importance of his compliance.--Resident 3 was to be supervised at all times and allowed to smoke in the courtyard only.-- Put smoking apron on resident.-- Keep lighter at nurses' station. Resident 3 was known to refuse to hand over [his] lighter. 6. Review of resident 4's EMR revealed:*She was admitted on [DATE].*Her 11/26/25 BIMS assessment score was 15, which indicated her cognition was intact.*Her 3/12/24 Tobacco Use Evaluation indicated that she was educated on smoking/vaping in designated areas. There was no adaptive equipment needed for resident safety. There was no indication of what level of supervision she required.*There was no documentation that a Tobacco Use Evaluation was completed quarterly or annually since 3/12/24.*Her 4/3/24 updated care plan indicated she used tobacco (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	products with a goal that she would safely use tobacco products in [the] designated area. Interventions included that she was able to smoke with supervision in designated smoking areas while on facility property, she was to face the windows if the staff members were unable to be outside with her. She was encouraged to wear two smoking aprons at all times, one across her chest and one across her legs for safety. She often refused the second apron. Continue to encourage. She was allowed to have her cigarettes in her room. Encourage [the] resident to keep [her] lighter at the nurses station. 7. Review of resident 5's EMR revealed:*She was admitted on [DATE].*Her 1/14/26 BIMS assessment score was 15, which indicated her cognition was intact.*Her 12/16/25 Tobacco Use Evaluation indicated that she was needing more help with ADL's [activities of daily living], wore oxygen, was able to remove her oxygen when she smoked, was sometimes able to light her own cigarette, and required a smoking apron and supervision.*Her 9/9/25 updated care plan indicated she used tobacco products with a goal that she would safely use tobacco products in [the] designated area. Interventions included that she was independent with tobacco use. She understood and followed the smoking schedule. Remove the resident's oxygen prior to smoking. put smoking apron on [the] resident, and monitor resident during the use of smoking. 8. Interview on 2/3/26 at 8:41 a.m. with resident 3 in his room revealed:*There were changes made to the smoking policy after resident 1 burned himself while smoking. There were specific times when he was allowed to smoke in the courtyard, and the door code to the courtyard was changed. He was not allowed to know the new door code.*He thought that staff members were required to stay by the courtyard doors when he went out to smoke in the courtyard, but they did not. He was frustrated that there were times he got stuck out there waiting for the staff to answer the doorbell to let him back inside.*He was independent with his power wheelchair for his mobility and preferred to smoke outside the front of the facility building because he was allowed to go out there to smoke anytime.*He kept his cigarettes and his lighter with him and did not need to let staff members know when he went outside the front doors to smoke.*He was told that he needed to sign out in the book on the receptionist's desk when he left the facility and to go across the street or down to the corner of the block to smoke. He smoked outside the facility's front doors when it was cold in the evening or early in the morning. He was not sure if he had signed out in that book when he went outside to smoke that morning (2/3/26).*He used his reacher stick to pick up the cigarette butts on the ground outside the facility's front doors because there was no receptacle for them. He knew that other residents smoked out there, and he didn't want the staff members to have to clean up after them because then the staff members would not let him smoke out there.*The front doors of the facility were not locked during the day and would open automatically for him. He knew the front door code, and he entered and exited the facility through those doors in the evening and on the weekends, when the receptionist was not working. 9. Observation and interview on 2/3/26 at 8:50 a.m. with resident 2 in his room revealed:*He recalled the evening that resident 1's hat caught on fire while he was in the courtyard smoking. He had helped resident 1 remove his hat and had thrown the hat on the ground to put out the fire. He did not think resident 1 was hurt, but was frustrated that the smoking rules changed after that incident.*He was independent with his power wheelchair for his mobility and was allowed to smoke in the courtyard or to leave through the front doors and smoke out front and down a block.*There were no specific times when he smoked. He kept his cigarettes and his lighter with him and went outside through the front doors of the facility to smoke whenever he wanted. He did not need to tell the staff members or sign out in a book.*He did not smoke in the courtyard very often because there were specific times, he did not know the door code, and he did not like waiting for staff to answer the doorbell to let him back inside when it was cold. He knew the code to the front doors of the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	facility and did not have to wait for staff to help him.*He needed to wear a smoking apron if he smoked in the courtyard, but did not wear one when he smoked out front. 10. Observation on 2/3/26 at 8:59 a.m. of the resident smoking area revealed:*The smoking area was in the courtyard, located outside the activities room. There was a locked door with a keypad.*There were smoking aprons, an umbrella, and a fire blanket near the door.*The sign posted on the door indicated there were five scheduled smoking times. The first scheduled smoking time was half an hour from 6:30 a.m. to 7:00 a.m. The remaining four scheduled times were for one hour, with the last scheduled smoking time scheduled from 6:00 p.m. to 7:00 p.m.*There were several cigarette butts on the ground. There was a large outdoor cigarette receptacle for cigarette butts. What appeared to be a ceramic bowl and a tin can on the table also contained cigarette butts. 11. Interview on 2/3/26 at 9:03 a.m. with certified medication assistant (CMA) F regarding residents who smoked revealed:*She worked on both day and evening shifts.*She knew which residents smoked and if they kept their cigarettes or lighters with them or if those items were stored at the nurses' station, because it was listed in the residents' care plan (personalized plan that addresses a resident's care needs, goals, and interventions).*Residents were care planned to smoke in the courtyard, but she knew at least two residents, resident 2 and resident 3 would go outside the front doors to smoke without staff assistance.*The courtyard door code was recently changed, and there were specific times when residents were allowed to smoke in the courtyard. She thought there were five times during each day and that those times were for approximately half an hour each.*She was aware that a resident was burned while smoking about a month ago. She was not working that day. It was after that incident that the courtyard door code was changed, and the facility began enforcing specific smoking times. Before that incident, residents were constantly wanting to be let in and out of the courtyard doors, and it was chaotic.*During the day, the activities staff members let residents who smoked in and out of the courtyard doors.*When the activities staff members were not working (during the first and last scheduled smoking times and on the weekend), the nursing staff let the residents out into the courtyard to smoke by entering the door code, and then let them back in when they rang the doorbell.*There were no specific nursing staff members assigned to assist or supervise the residents when they smoked during the scheduled times. She felt like all the staff members worked as a team to let the residents outside in the courtyard and to answer the doorbell when the residents wanted to come back in.*Most residents had their own cigarettes and lighters and were able to smoke without staff assistance. She knew that two residents who were not smoking very frequently had their cigarettes and lighters stored at the nurses' station. 12. Interview on 2/3/26 at 9:21 a.m. with CMA D regarding residents who smoked revealed:*Most residents were allowed to keep their cigarettes with them in their rooms, but all resident lighters were to be stored at the nurse's station. He knew that residents 2 and 3 refused to return their lighters and kept them in their rooms.*There was a change in the smoking policy about a month ago, after resident 1 was burned while smoking. The courtyard door code was changed, and residents were no longer allowed to go in and out of the courtyard on their own to smoke. A staff member had to enter the door code to let them out and answer the doorbell when the residents wanted to come back in. 13. Observation and interview on 2/3/26 at 9:27 a.m. of the residents' smoking area with activities director (AD) C revealed:*There were between eight and ten residents who smoked each day outside in the courtyard during the scheduled smoking times.*The new smoking times were scheduled so that the residents' smoking times did not interfere with the activities that were scheduled in the activities room. A schedule of activities was posted on the door to the courtyard to remind residents who smoked of those activity times, because opening and closing the courtyard door allowed the cold air and smoke from outside to drift into (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the activities room.*Activities staff members took turns assisting the residents who smoked by entering the courtyard door code and assisting the residents through the doors during the day, but the nursing staff assisted residents on the weekends and for the first and last scheduled smoking times during the week, when the activities staff were not working.*When it was nice outside, she would sit outside with the residents, but when it was cold, she watched the residents from the window next to the door.*Resident 4 and resident 7 were outside smoking, both of whom wore a smoking apron. They were facing away from the window and door. AD C stated that she liked it when the residents faced the door and window, but it was their right to move about outside in the courtyard while they smoked.*She assisted some residents with lighting their cigarettes, and others were able to light their own.*She thought all the residents who currently smoked kept their cigarettes with them in their rooms, and most of the residents had their own lighters.*Residents were allowed to leave the facility grounds to smoke by going directly across the street or down the sidewalk to the end of the facility grounds. 14. Observation and interview on 2/3/26 at 9:43 a.m. at the nurses' station with CMA F revealed:*A basket on the counter contained two lighters and two packs of cigarettes labeled with resident 9's name and one pack of cigarettes labeled with resident 10's name.*CMA F stated that residents 9 and 10 were not allowed to keep their cigarettes or their lighters in their rooms. 15. Observation and interview on 2/3/26 at 11:51 with resident 1 in his room revealed:*He used a power wheelchair for mobility. He sat with his power wheelchair reclined and had a hard time holding his head up when he spoke. He wore a brimmed hat and rested his head downward between each response.*He remembered his hat and beard were burned when he went outside to smoke about a month ago with resident 2.*Resident 2 knew the door code and was able to hold the door open for him. Staff did not go outside with him when he smoked.*His brother provided him with a vape, and he was told he needed to use that now when he wanted to smoke. He kept that vape with him and in his room. 16. Observation on 2/3/26 at 12:32 p.m. of the residents' courtyard smoking area revealed:*Resident 5 arrived at the courtyard door in her power wheelchair and put on a smoking apron.*Activities assistant G entered a code on the keypad and opened the courtyard door for resident 5 to enter the courtyard, then returned to her desk behind the partition wall.*Resident 8 arrived at the courtyard door in his power wheelchair and put on a smoking apron.*Activities assistant G entered a code on the keypad and opened the courtyard door for resident 8 to enter the courtyard, then walked away from the doors.*Resident 4 arrived at the courtyard door with her walker, and resident 7 arrived in her wheelchair. They each put on a smoking apron, and activities assistant G repeated the task of entering the door code to allow them to enter the courtyard.*While residents were in the courtyard, smoking activities assistant G carried items from the cabinets to her desk, assisted a resident who was leaving the dining room, and sat at her desk behind the partition wall. She occasionally looked out the window next to the door.*Resident 3 drove past the courtyard door in his electric wheelchair and told the surveyor he was going to the front of the facility to smoke because he did not like smoking in the courtyard, because he could not get back in.*When residents rang the doorbell, activities assistant G returned to the door and entered the code so the residents could come inside.*Activities assistant G did not provide cigarettes or lighters to any residents, did not assist the residents with lighting their cigarettes, or attempt to collect any cigarettes or lighters when the residents came inside from smoking. 17. Interview on 2/3/26 at 12:56 p.m. with activities assistant G regarding residents smoking revealed:*She confirmed that all residents had come back inside after smoking.*Each resident had their own cigarettes and lighter, and she did not need to assist those residents with lighting their cigarettes. The one resident who needed assistance with lighting his cigarette did not smoke at that time.*Residents did not know (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 0689 Level of Harm - Actual harm Residents Affected - Few	residents' designated smoking area. There were specific times that the residents could smoke, and she expected any staff member who assisted a resident into the courtyard to smoke to be outside with that resident or, when it was cold, to stand at the window to ensure constant supervision.*She expected the residents to sit facing the window so that the staff member supervising could see them.*She confirmed residents 1, 2, 3, 4, 5, 7, and 8 required supervision when they smoked in the courtyard during the designated smoking times.*A staff member who was talking to other residents in the activities room and seated at the desk was not considered supervision.*She was aware that some residents left the facility property to smoke, and she expected them to go to the corner down the block or across the street when they smoked to be off the facility's property.*The Tobacco Use Evaluation addressed residents' smoking on the facility's property, not when they left the facility to smoke.*She felt that residents 2 and 3 were safe leaving the facility property independently to smoke and expected them to tell a staff member and sign out in the sign-out book near the front door. She was unsure if any other residents left the facility property to smoke.*She was unsure if an assessment was completed of residents 2 and 3's ability to leave the facility in their power chairs in the winter on their own, or if residents' care plans indicated they left the facility independently to smoke off the property.*On 12/11/25, residents 1 and 2 went into the courtyard without notifying staff members, and resident 1 was burned by his cigarette.*Resident 1 was unable to leave the facility or open the door independently. Resident 2 opened the door and assisted resident 1 out into the courtyard and back inside that day.*She agreed that it was cold in December and there were risks of residents being outside smoking without staff knowledge, related to the cold and getting burned.*After resident 1 was burned, his brother provided vapes for him. His Tobacco Use Evaluation did not differentiate between smoking and vaping, and resident 1 was not assessed as unsafe to smoke, but it was strongly encouraged that he vaped because there was no active flame.*She was unaware that resident 1 bummed cigarettes from other residents, but felt that he was safe to smoke outside while he was supervised by a staff member. 21. Observation and interview on 2/4/26 at 8:55 a.m. with resident 5 in her room revealed:*She used a power wheelchair and wore oxygen. She stated she removed her oxygen when she smoked.*She was allowed to keep her cigarettes and her lighter in her room with her.*Sometimes she smoked in the courtyard during the designated times, and other times she went downstairs and smoked in front of the facility. She knew the door code to open the front door, but she did not know the door code for the courtyard door.*There was a smokers' meeting recently, and they were told they needed to sign out in the book at the front door and leave the facility's property when they wanted to smoke outside of the designated smoking times in the courtyard. 22. Observation on 2/4/26 at 9:00 a.m. of the residents' courtyard smoking area revealed:*Resident 4 walked to the courtyard door holding her lighter and a cigarette in her hand. Activities assistant H entered the door code and opened the door for resident 4 to go out into the courtyard. Activities assistant H then stood about eight feet from the door and read a book.*While resident 4 was outside smoking, activities assistant H walked over to the desk behind the partition wall. AD C told activities assistant H to stand next to the door, and she returned to the door.*A few moments later, activities assistant H walked away from the door and assisted a resident as they left the dining room by wiping her face. Administrator A told activities assistant H to stand next to the door, and she returned to the door.*Activities assistant H stood at the door, read her book, and glanced out the window occasionally. When resident 4 rang the doorbell, activities assistant H opened the door and she did not collect resident 4's lighter. 23. Interview on 2/4/26 at 9:10 a.m. with resident 4 in her room revealed:*She kept her cigarettes and her lighter in her room.*She usually smoked in the courtyard during the day when the staff members would (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society Sioux Falls Center	401 West Second Street Sioux Falls, SD 57104

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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 0689 Level of Harm - Actual harm Residents Affected - Few	enter the door code and open the door for her.*She sat on her walker outside the front doors of the facility to smoke in the evening because the staff members were not available to open the courtyard door past 7:00 p.m.*She knew the door code to the front door of the facility and smoked whenever she wanted. She did not need to tell the staff members or sign out in a book. 24. Interview on 2/4/26 at 9:25 a.m. with activities assistant H regarding residents smoking revealed:*She assisted residents by entering the door code to let them out into the courtyard to smoke and answered the doorbell when they were done and ready to come back in.*She stayed in the activities room and checked on the residents when they were outside smoking, but she did not need to watch them the whole time.*Most of the residents were independent with smoking and kept their own cigarettes and lighters.*There was only one resident she needed to help light his cigarette, but she was unsure if he still smoked. 25. Interview on 2/4/26 at 10:10 a.m. with administrator A regarding residents' smoking revealed:*He held a smokers' resident council on 12/17/25 to educate the residents on the facility's smoking policy after resident 1 was burned while smoking.*The door code to the courtyard door was changed, and he expected residents to smoke in the courtyard during the designated times.*He expected the staff members to stand by the window and watch the residents outside while they smoked. He confirmed that activities assistant H did not supervise resident 4 the entire time she was outside smoking.*Some residents left the facility property to smoke, and he expected them to let a staff member know when they were leaving or to sign out in the book near the front door.*He was unaware that residents knew the front door code and that they went out those doors in the evening to smoke.*Residents who smoked had a Tobacco Use Evaluation completed, and he expected that the staff members and residents followed the recommendations made in that evaluation.*He was unsu