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	09/05/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, record review, and policy review, the provider failed to follow standard food safety practices to ensure:*A clean and sanitary environment was maintained to store, prepare, and serve food to residents in one of one kitchen, one of one kitchenette, one of one dining room serving counters, and two of two dining rooms. *Proper hand-washing and glove use by any observed kitchen staff during the preparation and serving of residents' food items.*Food temperatures were monitored and documented to ensure meals were served at a safe serving temperature to prevent the spread of food-borne illness. *Two of two kitchen personnel (cook H and food service worker X) wore beard nets according to the provider's policy. Findings include: 1. Observation on 9/2/25 at 1:15 p.m. of the main dining room revealed: *More than half of the tables had dirty dishes from lunch on them. *There were approximately 35 residents at tables getting ready for an activity, although there were still dirty dishes on those tables. Observation on 9/2/25 at 1:50 p.m. of the kitchen revealed: *The hand-washing sink in the kitchen lacked paper towels. *The hand-washing sink in the dish room had food stains and debris in the bowl and on the sides of the sink. *The walk-in freezer contained opened boxes with the plastic liner pulled down over the outside of the box that exposed hamburger patties, mixed vegetables, uncooked chicken pieces, breaded chicken patties, garlic bread, and cookie dough. *Grease buildup was observed on the light bulbs above the flat top grill and fryer. *Cobwebs extended from the lights to the front of the stove hood above the flat top grill and fryer. *Grime was present on the floor around the three-compartment sink and on the cleanout box. *Food particles were visible on the floor and the tile grout throughout the kitchen. *The clean plate rack had numerous food particles in the bottom where plates rested. *The lower shelf and legs of the prep table were unclean. (continued on next page)

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*Dried liquid spills and food debris were present on the clean plate shelf under the steam table. *Breadcrumbs were observed on the counter around the toaster and in the catch tray. *Brown liquid was pooled on the dish room floor below the clean dish counter. *The wall behind the prep table was greasy and sticky to the touch. *The wall behind the flat top grill and stove was greasy and sticky to the touch. *The oven handles were sticky and greasy. Observation and interview on 9/2/25 at 2:00 p.m. in the kitchen with director of dietary services (DDS) G revealed: *The food was prepared at and would arrive from the central kitchen shortly after 4:00 p.m. *Temperatures of the food items were taken and recorded on arrival, and those foods would be heated or cooled as appropriate for serving. *No additional food temperatures were taken after that initial check. Observation and interview on 9/2/25 at 4:00 p.m. in the kitchen with DDS G revealed the residents' supper meal food items had already arrived and consisted of all cold items so it didn't need to be temped [temperature checked]. Observation on 9/2/25 at 4:00 p.m. in the kitchen of food service worker (FSW) X revealed: *He placed a clean pair of gloves and his phone on the counter next to the hand-washing sink. *He washed his hands. *He proceeded to the dish room, where he moved some empty dishwasher racks and a serving cart. *He returned and put on the pair of gloves that were on the counter. *With those gloved hands, he picked up his phone and put it in his pocket. *He did not have his two-inch-long goatee hair covered. Observation on 9/2/25 at 4:00 p.m. in the kitchen of the handling of resident menu cards revealed: *The resident menu cards were a half sheet of paper in a plastic sleeve. *They listed the residents' diet orders, assistive device needs, allergies, and food preferences. *Certified nursing assistants (CNAs) handed the menu card to DDS G or cook H when the resident arrived at the dining room. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*The menu cards were: -Handled by DDS G and cook H with and without gloved hands. -Dropped and picked up from the floor multiple times. *Placed on the resident's meal tray for the CNA to take to the table. *The CNA then returned the menu card to a container on the dining room serving counter. Observation on 9/2/24 at 4:08 p.m. in the kitchen of cook H revealed: *He wore a small chef beanie that did not cover any hair below his ears. *He did not have his full beard covered. *Placed frozen raw hamburger patties on the flat top grill. *Pushed a serving cart to another area of the kitchen. *Used a spatula to turn and remove burgers from the grill. *Tore off aluminum foil, covered a pan of cooked hamburgers, and took the pan to the prep table. *Pushed open the kitchen door and went to the dining room. *He wore the same pair of gloves during all of the above observations. Observation on 9/2/25 at 5:04 p.m. in the kitchen of cook H revealed that with his gloved hands, he: *Leaned and touched both of his hands on the counter. *Opened a drawer and removed a food serving scoop from the drawer. *Returned that scoop to the drawer and retrieved another one from a different drawer. *Removed buns from a bag with those same gloved hands and placed them on plates. *Carried the plates with the buns to the prep table. *Opened the kitchen refrigerator and retrieved a sleeve of cheese slices. *Removed individual cheese slices from that package and placed them on the buns. *Pulled the sleeve wrapper around the remaining cheese and returned it to the refrigerator. *Removed his gloves and without washing his hands, he put on a new pair of gloves. *He continued preparing residents' supper meal trays. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 9/2/25 at 5:13 p.m. in the kitchen of FSW X revealed that with his gloved hands, he: *Pulled the silverware cart by the handle. *Touched individual pieces of silverware while rolling them up in a napkin. *Pushed open the kitchen door and delivered the rolled silverware to residents at tables. *Re-entered the kitchen by pushing open the door. *Repeated that same process of handling silverware, opening the kitchen door, and delivering the silverware to the residents. *Placed bowls of fruit on residents' trays. *Opened soup cans and slapped the bottoms to remove contents. *Touched the microwave door and buttons. *Served bowls with his thumb on the inside rim of the bowl. *He used those same gloved hands during all of the observations above. Observation on 9/2/25 in the kitchen beginning at 5:15 p.m. of dinner meal service revealed: *Plate covers were placed on plated meals on a tray and delivered to the residents. *The plate covers were stacked on a serving tray and reused. *Approximately 10 plate covers were reused throughout the meal service. Observation on 9/2/25 at 5:21 p.m. in the kitchen of DDS G revealed that with his gloved hands, he: *Touched the menu cards in a plastic sleeve that a CNA handed to him. *Picked up a sandwich and placed it on a plate for a resident. *Touched several menu cards that had been handed to him by CNAs. *Opened the refrigerator door. *Touched several menu cards again. *Picked up and plated four ready-to-eat sandwiches for residents with those same gloved hands. *Removed toast from the toaster with those same gloved hands and put it on a plate. *DDS G used the same gloved hands during all of the above observations. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 9/2/25 at 5:22 p.m. in the kitchen of cook H revealed that with his gloved hands, he: *Opened the refrigerator. *Touched unwrapped, ready-to-eat sandwiches and put them on plates. *Touched menu cards between handling sandwiches and plates. *Repeated that process of serving the sandwiches with those same gloved hands. *Removed a grilled cheese sandwich from the refrigerator and placed it on a clean plate. *Touched the microwave door and control buttons to heat the sandwich. *Touched several resident menu cards again. *Removed a hamburger bun from a bag. *He wore the same gloves during all of those observations. Observation on 9/2/25 at 5:34 p.m. of FSW GG in the kitchen revealed: *While wearing the same pair of gloves he had used for serving residents' meals, he lifted the top piece of bread from a sandwich. *He removed the cheese and placed that piece of bread back on top of the sandwich. *He then returned to his serving position. *A CNA at the window told him he needed to wash his hands. *He then washed his hands and put on a clean pair of gloves. Observation and interview on 9/2/25 at 5:45 p.m. in the main dining room with CNA K revealed: *She was observed asking for corrections to several resident meal trays. *The CNAs who were serving residents' meals had frequently experienced issues with the kitchen staff following the residents' diet requirements and fulfilling the residents' specific meal requests. *As a result, they knew to check the menu cards and meal tray closely before serving the residents' meals to them. Interview on 9/2/25 at 5:45 p.m. with cook H in the kitchen revealed: *He was expected to wear gloves at all times while he was in the kitchen. *He was unable to describe when gloves should be removed or when handwashing was required. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 9/3/25 at 4:55 p.m. of the main dining room and kitchen floors revealed: *The main dining room was approximately 80 percent full of residents. *The floor was soiled with debris from previous meals. *The kitchen floor appeared to be soiled with the same debris as observed the previous day (9/2/25). Observation on 9/3/25 at 5:02 p.m. in the kitchen of FSW Y revealed that while wearing the same pair of gloves, she thumbed through menu cards, scooped ice into glasses from the ice well, and poured milk from a jug into glasses, which were served to the residents. Observation on 9/4/25 at 8:00 a.m. of the kitchen revealed: *Additional grime from previous observations was present below the three-compartment sink, around the cleanout box, and along the wall behind it. *Food debris was present in the sink's drain, which appeared to be ravioli from the previous evening's meal. *The walls behind the prep table were visibly dirty and sticky to the touch. *The prep table was soiled with food debris and had a soiled wet towel and a food processor on it. The food processor had drips and food particles on its base and cord. *The shelf above the prep table had substantial amounts of food particles, flour, and unknown debris on it, which could fall onto the food below it. *Food debris was present on the clean bin shelf below the prep table. Observation and interview on 9/4/25 at 10:18 a.m. in the kitchen with DDS G revealed: *Cook H used the same gloved hands to touch the refrigerator handle, cheese packaging, remove ready-to-eat cheese, and retrieve bread from a bag. *DDS G did not respond when asked if that observation demonstrated safe food handling practices, nor did he address those observations with cook H at that time. Observations and interview on 9/4/25 at 3:08 p.m. with DDS G in the kitchen revealed he: *Agreed the oven was dirty with charred food and built-up grease on the sides, bottom, inside the door, on top of the door, and on the door handle. *Agreed that the Robo Coupe food processor had built up food grime on the rim, base, and cord. *Agreed that the top edge and sides of an ingredient cart holding clean cups had food and dirty handprints on it. *Agreed that the clean plate rack had many different food particles on the bottom where the plates (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*Recorded food temperatures were: -Scrambled eggs: 103 degrees Fahrenheit (F). -Gravy in pool on plate: 103 degrees F. -Gravy on top of biscuit: 100 degrees F. -Milk: 47 degrees F. -Coffee: 146 degrees F. Observation on 9/5/25 at 11:00 a.m. of the dining room and kitchen revealed that all the unclean surfaces previously observed and noted on 9/2/25, 9/3/25, and 9/4/25 remained uncleaned. 2. Observation on 9/2/25 at 2:56 p.m. in the rehab unit dining room revealed: *There was food on the table in at least two place settings, and a circular, ring-shaped sticky spot in three areas. *What appeared to be diced carrots and other unidentified food crumbs were scattered on the floor under three tables. *There were small pieces of white paper and plastic wrappers on the floor near the serving window and in several places throughout the dining room. *A cabinet with a coffee maker on the counter had a significant amount of coffee spills on the top of the counter, in the drawer of that cabinet, down the front of the cabinet, and on the carpet around that cabinet. Observation and interview on 9/2/25 at 5:32 p.m. in the rehab unit dining room revealed: *Those same tables observed above had the same food items and sticky spots on them, but now also had utensils, wrapped in napkins, and a cup at each place setting. *The food, paper, and plastic remained on the floor. *The cabinet and the counter with the coffee maker remained dirty. *Resident 95 stated that the spot where she and resident 94 were seated had food on it and pointed to two other spots on the table that were dirty. *Resident 94 stated that the table where she was seated to eat her dinner was sticky and that it had been that way at lunchtime. Observation and interview on 9/2/25 at 5:46 p.m. with CNA R in the rehab unit dining room revealed: *Resident 95 stated that the tables were dirty, and she began to clean those tables. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 9/3/25 at 4:00 p.m. with DDS G about complaints made by residents to surveyors about meal substitutions or omissions revealed: *There was ham on the breakfast menu for Monday, but sausage patties were served. *There was bacon on the breakfast menu for Wednesday, but sausage patties were served. *He stated that the kitchen lacked the equipment to prepare ham or bacon in quantities sufficient for all residents. *He explained that the sausage patties were easier to cook and hold at temperature. *He agreed that the food served to the residents did not match the menu. *Substitutions did not require approval if they were considered like items, such as substituting one meat for another or toast for a muffin. *Residents were not notified of substitutions of like items. Interview on 9/4/25 at 9:05 a.m. with infection prevention specialist (IPS) I revealed she: *Expected the kitchen staff to follow hand washing and glove use practices according to their facility's policy and food safety training. *Had limited oversight of the kitchen as food service was provided by a contracted company, with DDS G responsible for kitchen operations. *Had discussed clean versus unclean practices with DDS G, including touching clothing and the face. *Expressed uncertainty regarding the effectiveness of those conversations. Interview on 9/4/25 at 1:00 p.m. with DDS G revealed: *The steam tables in the kitchen and rehab unit kitchenette were to be drained and cleaned every night. *DDS G agreed that the rehab unit kitchenette steam table was not clean and had dirty water and kernels of corn in the water from a meal served five days earlier. *The kitchen staff were responsible for cleaning the tables in the rehab unit dining room. *He agreed that kitchen staff should not have set the tables for supper without wiping them down after lunch, especially while food debris remained. *He was unaware that the rehab unit kitchen counters were soiled with food debris and were not cleaned after lunch. *He was unaware that the food temperature log in the rehab unit kitchenette had not been completed. (continued on next page)

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Good Samaritan Society Sioux Falls Center	401 West Second Street Sioux Falls, SD 57104

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*He had not verified that the cleaning was completed in the kitchen, dining room, or rehab unit dining room. *He thought the dirty meal dishes sometimes remained on the tables in the main dining room when activities started because some residents were still eating. *Lunch was to be served from 11:45 a.m. to 12:45 p.m. *He reported that the kitchen staff had a large onboarding manual to read before their first shift. *He did not provide additional kitchen staff training on-site. *He agreed that the menu cards, used in the main dining room, listed important information, including diet textures and allergies, which were critical to the residents' safe consumption of meals served. *He was unaware that the diet cards used in the rehab unit dining room did not contain that same information. *He acknowledged that plate covers are reused multiple times during the meal service, but did not believe this posed a cross-contamination risk. *He did not acknowledge or respond when asked whether kitchen staff using gloved hands to touch phones, refrigerator handles, menu cards, reused plate covers, and ready-to-eat foods demonstrated safe food handling. *He believed the chef's beanie provided adequate hair coverage. *He believed facial hair only needed to be covered when it reached a certain length. *When asked if he was aware of the facility policy regarding hair covering, he stated he was not. Interview on 9/4/25 at 3:00 p.m. with FSW X revealed he: *Had been employed and worked in the kitchen for approximately five months. *Had not received training when he started, as he claimed prior kitchen experience. *Was unable to describe a process for handwashing or glove-changing. *Acknowledged he had touched his phone with gloved hands while preparing residents' food and admitted that this likely occurred frequently. *Asked whether his gloves could be washed after touching contaminated surfaces. *Had not been instructed to cover his facial hair. Interview on 9/4/25 at 3:05 p.m. with DDS G revealed: *He agreed that kitchen staff should ensure dining trays and meals served reflected correct resident (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	preferences, diets, and adaptive equipment. *He was solely responsible for adding diet orders to menu cards. *He thought CNAs were responsible for managing resident preferences. *He was the only kitchen staff member with ServSafe for Food Manager's training. *There were no plans in place to have another current employee complete the ServSafe training. Interview on 9/5/25 at 8:30 a.m. with dietitian BB revealed: *She was the dietitian for the contracted food service responsible for preparing lunch and supper meals at the central kitchen. *She approved all menus for meals prepared at the central kitchen and served at the facility. *The oversight of the facility dining service was designated as the responsibility of DDS G. *Breakfast was to be prepared based on the menus she approved. *The substitution of like items, such as a meat for a meat or toast for a muffin, did not require her approval, but she expected the menu to be followed as closely as possible. *She agreed that the documented temperatures of the scrambled eggs, biscuit and gravy, or milk on the sample tray were not within safe food serving ranges. Interview on 9/5/25 at 9:40 a.m. with DDS G regarding breakfast tray temperatures revealed: *He did respond when asked if the temperatures were within safe food serving guidelines. *When questioned about the unsafe temperatures on the sample breakfast tray, he said the biscuit was still okay. *He confirmed that food temperatures were not checked during or after meal services. Interview on 9/5/25 at 9:50 a.m. with administrator A regarding glove use, hand washing, and food temperatures revealed: *He expected that the kitchen staff would follow the facility's policy for hand washing and glove use. *His expectations for food temperature documentation were that the staff would follow the policy and document temperatures for each meal. *He agreed that it was not being done. Interview on 9/5/25 at 10:00 a.m. with FSW Y revealed: *She had been employed at the facility for approximately two and a half weeks. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*Her onboarding training primarily consisted of extensive reading. *She reported difficulty retaining the information due to the volume of content. *She was unable to describe the proper procedure for handwashing and glove use. *She stated she followed the practices of her coworkers. *She had not received on-site training on kitchen processes and procedures beyond the initial onboarding reading. Interview on 9/5/25 at 10:15 a.m. with administrator A revealed: *He expected kitchen staff to: -Adhere to facility policies regarding hair and facial hair coverings, hand washing and glove use, kitchen cleaning, food temperature monitoring, and hygiene. -Follow physician diet orders, address allergies, accommodate assistive device needs, and honor food preferences. -Be responsive to food council suggestions and resident choices to the extent possible. *He expected DDS G and all kitchen staff to comply with food safety guidelines. *He agreed that the breakfast sample tray items did not meet safe food serving temperature standards. *He was aware of complaints about hot food being served cold and the frequent serving of cold food items such as sandwiches. *He stated the process for gathering feedback on food choices was through the resident food council, and conducting informal audits of five residents at a time about food taste, food temperature, and choice. Interview on 9/5/25 at 11:20 a.m. with administrator A revealed he: *Thought that contract dietitian FF or DDS G met with residents when they were admitted to the facility to discuss resident choices. *Was not aware that contract dietitian FF was not meeting with residents about preferences. 4. Review of the provider's 12/16/24 revised Food Temperature Monitoring policy revealed: *Food is cooked, reheated or cooled to ensure proper holding temperatures before each meal service. *Food temperatures are taken and recorded before each meal service. Review of provider's hand washing and glove use – food nutrition services policy dated 6/6/25 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	revealed: *The purpose was to provide guidelines regarding hand hygiene and glove use to reduce the risk of cross-contamination when serving highly susceptible populations. *Highly susceptible populations were defined as persons who are more likely than other people in the general population to experience foodborne disease, including: -Older adults. -Obtaining food at a nursing home. *Acceptable food barriers were defined as utensils, deli papers, and appropriately used disposable gloves (single task, uncontaminated). Hand washing and hand sanitizer are not

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to complete a baseline care plan and provide a written summary of the baseline care plan to the resident within 48 hours of their admission to the facility for four of six newly admitted sampled residents (14, 64, 67, and 85) reviewed who admitted to the facility in August 2025.Findings include:1. Observation and interview on 9/2/25 at 2:50 p.m. with resident 14 in his room revealed he:*Was frustrated about the communication he had received about his care since he had been admitted to the facility. He felt that the nursing staff had not given him enough information about his wound care and his positioning needs.*Felt that the dietary staff had not provided him with the correct diet or with the foods he preferred to eat.*Had not received a list of his medications or a copy of his baseline care plan when he was admitted to the facility approximately two weeks ago.*Pointed to an admission packet and stated that was the information he had received when he was admitted to the facility. That information did not contain a baseline care plan. Review of resident 14's electronic medical record (EMR) revealed:*He was admitted on [DATE].*His 8/25/25 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact.*There was no documentation that indicated the resident's baseline care plan was developed and reviewed with him, or that he had been provided or offered a copy of his baseline care plan within 48 hours of his admission. 2. Interview on 9/4/25 at 1:15 p.m. with resident 67 in his room revealed he: *Had not received a list of his medications or a copy of his baseline care plan when he was first admitted to the facility.*Felt that there was miscommunication between his therapy team and the nursing staff regarding his discharge goals. Review of resident 67's EMR revealed:*He was admitted [DATE].*His 8/17/25 BIMS assessment score was 15, which indicated his cognition was intact.*There was no documentation that indicated the resident's baseline care plan was developed and reviewed with him, or that he had been provided or offered a copy of his baseline care plan within 48 hours of his admission. 3. Interview on 9/2/25 at 2:20 p.m. with resident 64 in her room revealed she did not recall having received a baseline care plan when she was first admitted to the facility. Review of resident 64's EMR revealed:*She was admitted on [DATE].*Her 8/21/25 BIMS assessment score was 15, which indicated her cognition was intact.*There was no documentation that indicated the resident's baseline care plan was developed and reviewed with her or that she had been provided or offered a copy of her baseline care plan within 48 hours of her admission to the facility. 4. Review of resident 85's EMR revealed:*She was admitted on [DATE].*Her 8/11/25 BIMS assessment score was 15, which indicated her cognition was intact.*There was no documentation that indicated the resident's baseline care plan was developed and reviewed with her or that she had been provided or offered a copy of her baseline care plan within 48 hours of her admission to the facility. A request was made on 9/4/25 at 7:43 a.m. to administrator A for documentation that baseline care plans had been developed and the resident or their representative was offered a copy within 48 hours of their admission to the facility for newly admitted residents 14, 64, 67, and 85. No further documentation was provided. Interview on 9/4/25 at 12:54 p.m. with director of nursing (DON) B revealed:*Baseline care plans had been completed, but had not been provided to residents 14, 64, 67, and 85.*DON B expected that the resident's baseline care plans would be completed within 48 hours of their admission to the facility, and a copy would be provided to the resident.*Baseline care plans for residents 14, 64, 67, and 85 were to be completed by the Minimum Data Set (MDS)/registered nurse (RN) U. Interview on 9/4/25 at 1:20 p.m. with MDS/RN U revealed she:*Would initiate the comprehensive care plan in the EMR on the day that the resident was admitted to the facility.*Completed all the sections of the care plan, printed that care plan, and provided a copy of it to the resident. She would document in the EMR when she had completed the baseline care plan and had provided the care plan to the resident.*Had been on leave from the facility (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for approximately three weeks. Residents 14, 64, 67, and 85 were admitted to the facility while she was on leave.*Stated that residents' 14, 64, 67, and 85's baseline care plans had been completed by MDS/RN T, but had not been provided to them or documented as having been completed. Review of the provider's 12/2/24 Care Plan policy revealed:*Baseline care plan- Includes instructions needed to provide effective and person-centered care to the resident that meet professional standards of quality care.*A baseline care plan will be developed upon admission according to federal and state regulations. The location must provide the resident and the resident representative with a written summary of the baseline care plan. Use the PN Care Conference Note . to document that the meeting occurred with the resident and representative and any significant discussion that occurred.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation and interview, the facility failed to ensure that three of three residents (44, 81, 82) were provided with a nourishing, palatable, well-balanced diet that met their daily nutritional and dietary needs. 1. Interview on 9/3/25 at 8:50 a.m. with resident 81 revealed:*Hot food is frequently served cold.*She would sometimes not eat an item if it was not at an acceptable serving temperature because it was unpleasant to her.*The previous evening, they were served a cold sandwich and a cold bean salad. *No fruit or dessert was provided. 2. Interview on 9/3/25 at 8:50 a.m. with resident 44 revealed:*They are served cold sandwiches for three to four suppers every week.*She would prefer something warm in the evenings.*When she asked for something warm, she was not given a choice but provided mashed potatoes and gravy.*She dislikes hot dogs and doesn't like it when they are served.*She is not aware of other food choices. 3. Interview on 9/3/25 at 9:15 a.m. with resident 82 revealed:*The food is frequently very dry and hard for her to eat due to her lack of teeth.*Foods that should be served hot are more often cold than they are hot. 4. Interview on 9/3/25 at 4:00 p.m. with director of dietary services (DDS) G about resident menu complaints revealed:*There was ham on the breakfast menu for Monday, but sausage patties were served. *There was bacon on the breakfast menu for Wednesday, but sausage patties were served.*He did not feel they had the equipment to prepare ham or bacon for the number of residents they served.*It was easiest to cook and hold the temperature of the sausage patties.*He agreed that the menu did not match the food served.*They were not required to get a substitution approved if it was a like item such as a meat substituted for a meat or toast substituted for a muffin. *He attributed complaints about cold food were due to the certified nursing assistants (CNAs) taking too long to deliver room meal trays. *He did not believe that hot food served in the dining room was cold. *Cold sandwiches were served for many suppers were because they were on the summer menu. 5. Interview on 9/4/25 at 9:30 a.m. with CNA K revealed:*She and other CNAs expressed frustration over frequent corrections needed for the residents' meal trays despite the kitchen staff having access to the same resident menu cards (a card used at each meal that describes the resident's physician-ordered diet, choice from the menu, food preferences, allergies, and dislikes) as the CNAs.*She explained that each resident had a menu card. The nurse managers were to give the residents' diet information to DDS G, who updated the menu cards, and that was considered as the first check that the meal served to the residents was correct. *Cooks and FSWs preparing and plating the meals was considered the second check, and the CNAs serving those meals was considered the third check that the resident was served the correct meal. *Menu cards were frequently not updated by the kitchen staff.*She felt the kitchen staff disregarded residents' diet needs and preferences and failed to provide them with adaptive items some of the residents needed to eat. 6. Interview on 9/4/25 at 1:00 p.m. with DDS G revealed:*He agreed that the menu cards contained important resident information, including food preferences, ordered diets and food textures, and food allergies, which were critical to the residents' safety. Interview on 9/4/25 at 2:00 p.m. with social worker (SW) HH revealed:*She had been an employee at the facility for approximately three weeks.*She had heard three meal-related complaints from residents that included:-They were not receiving meat for breakfast.-They were not receiving the food item that the menu showed.-A complaint regarding the serving of succotash. *She had discussed these complaints with the lead social worker. 7. Interview on 9/4/25 at 2:05 p.m. with lead social worker (LSW) II revealed:*She thought the resident's food complaints occurred in intermittent streaks.*Food complaints were to be discussed during the resident food council meetings.*She thought that since the contracted company provided the food service, communication options were limited beyond the food council meetings, which were a monthly meeting separate from the resident council meeting for residents, facility leadership, and DDS G to talk about the food served at meals.*DDS G attended the resident food council meetings. *Residents had expressed dissatisfaction with the effectiveness of (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the food council recommendations.Observation and interview on 9/4/25 at 3:05 p.m. with DDS G revealed:*He agreed that kitchen staff should ensure the residents' dining meal trays reflected the correct resident preferences, diets, and adaptive equipment.*He was solely responsible for adding the residents' diet orders to the menu cards.*He thought the CNAs were responsible for managing residents' meal preferences. Observation on 9/5/25 at 8:00 a.m. during the breakfast meal service in the dining room revealed the CNAs had requested corrections on 14 of 15 prepared resident meal trays before they could be served to the residents. 8. Interview on 9/5/25 at 8:30 a.m. with dietitian BB revealed: *She was the dietitian for the contracted food service responsible for preparing the residents' lunch and supper meals at the facility's central kitchen.*She approved all of the menus at the central kitchen. *The oversight of the facility's dining service was designated as the responsibility of DDS G.*Breakfast was to be prepared based on the menus she approved.*The substitution of like items such as a meat for a meat or toast for a muffin did not require her approval, but she expected the menu to be followed as closely as possible. *She disagreed with substituting sausage patties for all breakfast meat items solely for ease of preparation.*She agreed that the kitchen staff were responsible for following the residents' menu cards, including the residents' diet orders, allergies, assistive device needs, and preferences.*She agreed that the documented temperatures of the scrambled eggs, biscuit and gravy, or milk on the sample tray did not meet safe food serving temperatures. 9. Interview on 9/5/25 at 10:15 a.m. with administrator A revealed:*He expected kitchen staff to:-Adhere to facility policies regarding hair and facial hair coverings, hand washing and glove use, kitchen cleaning, food temperature monitoring, and hygiene.-Follow physician diet orders, address allergies, accommodate assistive device needs and honor food preferences.-Be responsive to food council suggestions and resident choices to the extent possible.Was aware of complaints about hot food being served cold and the frequent serving of cold food items such as sandwiches. *He stated the process for gathering feedback on food choices was the food council, and they conduct informal audits of five residents at a time about food taste, food temperature, and choice.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the provider failed to provide meals to meet the residents' satisfaction for eight of twenty-five sampled residents (14, 34, 44, 49, 52, 53, 67, and 82) who expressed dissatisfaction with the meal service regarding food quality, temperature, repetition, choices, and not accommodating the residents' food preferences and ordered diets Findings include:1. Observation and interview on 9/2/25 at 2:50 p.m. and again on 9/4/25 at 8:32 a.m. with resident 14 in his room revealed: *He ate his meals in his room and was frustrated about the food that he received. He had filled out a menu with his food choices, but the kitchen had not sent the food that he requested. *He was concerned that the dietary staff had not provided him with the correct diet or with the foods he preferred to eat. *No one had asked him about his meal preferences and the foods he liked to eat, so he often refused the fried food items they served until he requested that his diet be changed to include more protein. He felt that since that change, all he received was meat, usually sausage patties or hamburger patties, eggs, and milk. *He pointed to a sheet of information that he had brought from the hospital regarding Nutrition and Wound Healing and stated that he had hoped to discuss that information with the dietitian so that he received the foods that he preferred to eat. *He would tell the certified nursing assistants (CNAs) what he wanted to eat, but he was unsure if that information was relayed to the kitchen. *He avoided carbohydrates and did not want potatoes or corn, but would have liked broccoli, cauliflower, beans, or peas. He could not recall having been served any vegetables in the last week. *He stated that on 9/3/25, he was served a hamburger patty and two small pieces of chicken with a bone in them. He had been served french fries and breaded shrimp, and he was angry about that because he had told the staff several times that he would not eat fried foods because they mess up his blood sugars. *On 9/4/25, he was served a cheese omelet and milk and had not been provided with bacon or sausage. He thought that bacon had been on the menu that day, and he would have liked to receive that. Review of resident 14's electronic medical record (EMR) and paper medical records revealed: *He was admitted on [DATE]. *His 8/25/25 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact. *His diagnosis included Diabetes Mellitus (a condition involving disruptions in how the body regulates (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	blood sugar), esophageal reflux (a condition where stomach contents flow back into the esophagus causing irritation), and pressure ulcers (skin and/or underlying tissue injury from prolonged pressure). *His 8/20/25 physician's orders indicated he was to be provided with CCHO [Consistent Carbohydrate] diet.All protein diet, and Boost Glucose Control with all meals. *An 8/20/25 Diet Notification Form (a form used by nursing to communicate diet orders to the kitchen) indicated he was to be provided a Consistent Carbohydrate (Diabetic Diet), but it did not indicate his need for a high protein diet, supplements, or his food preferences. *His undated diet card indicated CCHO. The food preferences, dislikes, and supplements sections had not been filled in on that card. A yellow sticky note attached to that card indicated extra protein, no carbs, no desserts. *His 8/20/25 care plan indicated a goal that the resident will express that his/her nutritional needs are being met, and he/she feels supported in dining decisions. His food preferences were not listed in his care plan. *His Amount Eaten by Mouth task documentation since his admission indicated that 33 out of 41 meals had been documented. Of those 41 meals, 16 were marked as Resident Refused, Not Applicable, or that he had eaten 0-25% (percent) of the meal. 2. Interview on 9/2/25 at 5:01 p.m. and again on 9/4/25 at 1:15 p.m. with resident 67 in his room revealed he: *Ate most of his meals in his room and was unhappy with the quality and quantity of food he had been offered. *Stated there was a menu that he filled out with his food choices on Saturdays for the week. He thought that the menu was provided to the kitchen, but was unsure because he did not receive the items he had indicated on that menu. *Recently had gall bladder surgery and had to be careful about what he ate. He avoided processed and spicy foods. He often selected the alternative items, but did not receive them. *Recalled that one night they had a choice of chili dogs or a BLT (bacon, lettuce, tomato) salad. He ordered a double portion of the BLT salad but was told they had run out after serving the residents upstairs. He was offered the chilidog but felt he should not eat that, so he had ordered a sandwich from a restaurant to be delivered. *Stated he had run out of money from ordering food out from restaurants, so a friend had brought him more money and some tuna. *Told the CNAs who delivered his meal tray when he did not like certain foods or could not eat them. The CNAs would then offer to make him a bowl of soup or toast. Review of resident 67's EMR revealed: *He was admitted [DATE]. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*His 8/17/25 BIMS assessment score was 15, which indicated his cognition was intact. *His diagnosis included Diabetes Mellitus, cholecystectomy (removal of the gall bladder), esophageal reflux, and obesity (overweight). *His 8/11/25 physician's orders indicated he was to be provided a Regular diet. *His allergies included corn. *An 8/11/25 Diet Notification Form indicated Regular Diet. It did not include his allergy to corn or his food preferences. *His undated diet card indicated Reg [regular diet]. It did not include his allergy to corn. The food preferences, dislikes, and special instructions sections had not been filled in on that card. *An 8/12/25 care plan goal, Residents will show evidence of adjustment to nursing home by eating meals and dining room. and an intervention, Provide resident with as many choices as possible which give control over [the] resident's environment and care delivery. *His Amount Eaten by Mouth task documentation since his admission indicated that 56 out of 65 meals had been documented. Of those 56 meals, 19 were marked as Resident Refused, or Not Applicable. 3. Interview on 9/2/25 at 5:45 p.m. with cook H in the Sunrise Suites dining room revealed: *All of the residents on the first floor who ate in the dining room or in their rooms were served the same meal, except for one who just received hamburger patties for dinner. *Dinner that night, 9/2/25, was to include a cold sandwich, broccoli salad, and mandarin oranges. Three-bean salad had been on the menu, but he had dropped it on the floor and made a broccoli salad instead. *There was no alternative meal available that day because the [NAME] was not working. *If a resident asked for something else, they could have had soup, a sandwich, or a burger, and sometimes there was salad. 4. Interview on 9/2/25 at 6:01 p.m. with CNA R in the Sunrise Suites dining room revealed she: *Confirmed that for dinner that evening, all but one resident had received the same meal. *Stated that if the residents refused their meal when she brought it to them, she would make them a bowl of soup. 5. Interview on 9/4/25 at 8:58 a.m. with CNA N regarding meal service in the Sunrise Suites dining room revealed: *There was no meal ticket system (where resident meal preferences were recorded) like they used in the upstairs dining room because the residents admitted and discharged more quickly. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*They listed the residents' diet orders, assistive device needs, allergies, and food preferences. *CNAs gave the menu card to director of dietary services (DDS) G or cook H when the resident arrived to the dining room. 12. Interview on 9/2/25 at 4:31 p.m. with DDS G revealed the residents' menu cards are filled out with their food choices on Saturdays for the next week but sometimes the nursing staff did not pick them up and give them to the kitchen. 13. Observation on 9/2/25 at 5:34 p.m. with food service worker (FSW) GG revealed: *A sandwich was returned to him by certified nursing assistant (CNA) K who stated the resident couldn't have cheese. *FSW GG removed the cheese and returned the sandwich to CNA K to serve to the resident. 14. Observation and Interview on 9/2/25 at 5:45 p.m. with CNA K revealed the CNAs who were serving residents' meals had frequently experienced issues with the kitchen staff following the residents' diet requirements and fulfilling the residents' requests correctly, so the CNAs knew to check the menu card closely. 15. Interview on 9/3/25 at 4:00 p.m. with DDS G about resident menu complaints revealed: *There was ham on the breakfast menu for Monday, but sausage patties were served. *There was bacon on the breakfast menu for Wednesday, but sausage patties were served. *It was easiest to cook and hold the temperature of sausage patties. *He agreed that the menu did not match the food served. *They were not required to get a substitution approved if it was a like item, such as a meat substituted for a meat or toast substituted for a muffin. *He felt the residents' complaints about cold food were due to the CNAs taking too long to deliver room trays. *He did not think hot foods served in the dining room was cold. *Cold sandwiches were served for many suppers were because they were on the summer menu. *He did not know when the fall menu would start. *The fryer had been inoperable on 9/1/25 and 9/2/25, but had been fixed today (9/3/25). 16. Interview on 9/4/25 at 9:30 a.m. with CNA K revealed: *She had been trained as a food service worker, and had helped in the kitchen. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She and other CNAs were frustrated with having to ask for many corrections to the meal trays when kitchen staff were seeing the same menu card as the CNAs, and it led to delays serving the residents. *The menu card process is for nurse managers to give the diet to DDS G, who updates the menu card as the first check that the meal being served is correct. *Cooks and FSWs are the second check, and the CNAs serving are the third check that the resident is being served the correct meal. *Menu cards frequently don't get updated by the kitchen with changes. *Kitchen staff disregard resident's likes and dislikes and forget to use adaptive items. *CNAs had to make sure that the residents' meal trays contain the divided plates, covered cups, or assistive silverware that residents need, as those items were frequently missed by the kitchen staff. 17. Interview on 9/4/25 at 2:00 p.m. with social worker (SW) HH revealed: *She had been an employee at the facility for approximately three weeks. *She had heard meal complaints from three residents that included: -They were not receiving meat for breakfast. -They were not receiving the food item that the menu showed. -A complaint about the serving of succotash. *She had discussed those complaints with the lead social worker. 18. Interview on 9/4/25 at 2:05 p.m. with lead social worker (LSW) II revealed: *She thought that residents' food complaints seemed to occur in intermittent streaks. *Food complaints were to be discussed at the resident food council meetings, which were held in addition to the resident council and attended by residents, administration, and DDS G. *She thought that since the contracted company provided the food service, communication options were limited beyond the food council. *Residents had expressed dissatisfaction with the effectiveness of the food council recommendations. 19. Observation on 9/5/25 at 8:00 a.m. of the breakfast service in the dining room revealed: *The CNAs asked the kitchen staff for corrections on 14 of 15 residents' meal trays before they could serve them. *Corrections included telling the kitchen staff they needed a clean plate instead of just removing the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and policy review, the provider failed to ensure proper infection control practices were followed by allowing clean resident lift slings to lay on the floor, failing to properly clean resident lifting devices, and allowing water to leak from ceiling in a storage closet.Findings include:1. Observation on 9/2/25 at 4:45 p.m., of a sit to stand lift (a mechanical lift used to assist from a seated to a standing position) had an unknown substance build-up where residents would place their hands while being lifted. 2. Observations on 9/3/25 at 1:30 p.m., 9/4/25 at 8:50 a.m., and again on 9/5/25 at 11:20 a.m. in the clean storage room on the second floor revealed:*Several lift slings were lying on the floor, and multiple slings that had been hanging on three of the four walls had been touching the floor.*Inside the storage room where the lift slings were stored, a sign was posted above the slings that had a red stop sign it and stated ALL STAFF PLEASE MAKE SURE SLINGS ARE NOT TOUCHING THE GROUND THANK YOU! 3. Interview on 9/4/25 at 9:00 a.m. with certified nursing aide (CNA) J revealed:*CNAs would hang the lift slings up when they were received from laundry.*She was aware that slings should not have been lying on or touching the floor.*She reported that slings were touching the floor all the time.*She stated It's kind of gross regarding using lift slings after they had been on the floor. 4. Interview on 9/4/25 at 10:20 am with certified medication aide (CMA) JJ revealed:*He reported that lift slings were hung up by the laundry staff members after they had been cleaned.*He did not believe that the clean slings should have been touching the floor.*He stated that lift slings were still used to assist the residents even if they were touching the floor. 5. Interview on 9/5/25 at 10:50 a.m. with infection prevention specialist I revealed:*After lift slings had been washed, they were brought to the storage closet by the laundry staff members and put away by the CNAs.*She reported that she had not noticed the slings touching the floor.*She reported it was an infection control problem for them to be used after lying on the floor.*She acknowledged that the slings laying on the floor were considered dirty and should not have been used. 6. Observations on 9/4/25 at 3:00 p.m. and 9/5/25 at 11:25 a.m. in the main level clean storage room next to the conference room revealed a hole in the ceiling with an unknown black speckled substance around it where water was dripping into a plastic bin. 7. Interview with infection prevention specialist I revealed she was aware of the hole in the ceiling and reported that it had been there since around May of 2025.*She reported that maintenance staff had attempted to repair the hole and the leaking water, but was unsuccessful.*She acknowledged that the leaking hole in the ceiling was an infection control concern and needed to be fixed. 8. Review of the provider's 12/2024 Infection Prevention and Control Program policy revealed:*Purpose, To establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

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	09/05/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure bathing was provided and documented for two of two sampled residents (14 and 64) who were dependent on staff assistance with bathing. Findings include:1. Observation and interview on 9/2/25 at 2:50 p.m. and again on 9/4/25 at 8:32 a.m. with resident 14 in his room revealed:*He was told that he could shower, but he had not received a shower since he was admitted to the facility.*He had only received bed baths since he was admitted , but he felt that the bed baths were not very thorough. He wanted his hair washed.*On 9/4/25, a staff member had washed his back in the morning, and he wondered if that was considered his bath for the day. Review of resident 14's electronic medical record (EMR) revealed:*He was admitted on [DATE].*His 8/25/25 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact.*His diagnoses included paraplegia (partial or complete loss of movement and/or sensation in the legs and lower part of the body), multiple sclerosis (a chronic autoimmune disease that causes symptoms, including vision problems, muscle weakness, fatigue, numbness, balance and coordination issues, and cognitive difficulties), and pressure ulcers (injury to skin and underlying tissue from prolonged pressure).*His 8/20/25 care plan indicated Resident requires [the use of a] shower chair, [and] 2 staff assist [assistance of two staff].*An 8/20/25 physician order indicated May shower, do not allow direct water pressure to dressing/incision. Keep dressing clean and dry. No tub until directed.*His 8/25/25 Minimum Data Set (MDS) assessment (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) indicated he felt choosing between a tub bath, shower, bed bath, or sponge bath was Somewhat important.*The bathing task documentation options included shower, tub [bath], whirlpool [bath], sponge bath, shampoo only, unavailable and refused.There was no documentation that resident 14 had received a shower, tub [bath], whirlpool [bath], a sponge bath, a shampoo only, or that he was unavailable or refused bathing, since he was admitted . 2. Interview on 9/2/25 at 2:20 p.m. with resident 64 in her room revealed she: *Had only received one shower since she had been admitted to the facility. She would have liked to have received more showers because her hair felt dirty and her skin felt very dry. *Showered three times a week at home. She thought that she would have received one or two showers each week while at the facility.*Thought that she was not offered showers because she required more assistance than the staff could provide. Review of resident 64's EMR revealed:*She was admitted on [DATE].*Her 8/21/25 BIMS assessment score was 15, which indicated her cognition was intact.*Her 8/15/25 care plan indicated, Resident requires bathing options, shower chair 1 staff assist [assistance of one staff].*Her 8/21/25 MDS assessment indicated she felt choosing between a tub bath, shower, bed bath, or sponge bath was Very important.*Her bathing task documentation indicated she had received a shower on 8/24/25.-There was no documentation that resident 64 had received a tub [bath], whirlpool [bath], a sponge bath, a shampoo only, or that she was unavailable or refused bathing, since she was admitted . 3. Review of the current Sunrise Suites Bath Schedule revealed:*Residents' bathing was assigned by room number.*All [new resident] admits [admissions] [are] to receive a bath the day after [their] admission- this is REQUIRED.*Makeups can be completed on Sunday- openings on Wednesday/Thursday evening for [new] admits.*Resident 14 was scheduled for bathing on Mondays and Thursdays during the evening shift.-Resident 14 had not been provided his scheduled bathing on 8/21/25 (the day after his admission), 8/25/25, 8/28/25, or 9/1/25.*Resident 64 was scheduled for bathing on Mondays and Thursdays during the evening shift.-Resident 64 had not been provided her scheduled bathing on 8/16/25 (the day after her admission), 8/18/25, 8/21/25, 8/25/25, 8/28/25, or 9/1/25. 4. Interview on 9/4/25 at 10:58 a.m. with licensed practical nurse (LPN) O regarding resident 64's bathing revealed:*Resident 64 was allowed to shower if her dialysis port dressing was covered.*She stated (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that certified nursing assistant (CNA) N had assisted resident 64 to shower that morning (9/4/25).*LPN O expected that resident 64's showers provided or refusals to shower would have been documented in the EMR. 5. Observation and interview on 9/4/25 at 11:12 a.m. with CNA N and occupational therapist (OT) S in resident 64's room revealed:*CNA N had just finished assisting resident 64 with showering. This was the first time she had assisted resident 64 to shower.*CNA N documented when she completed a resident's shower in the resident's EMR under bathing tasks.*OT S stated that she had not assisted resident 64 with showering. When therapy provided residents assistance with bathing or showering, they would tell the CNA so that shower would be documented in the residents' EMR. 6. Interview on 9/04/25 at 11:13 a.m. with LPN O regarding resident 14's bathing revealed:*Resident 14 was allowed to shower as long as his wound dressings remained dry. She was unaware of any reason that the resident would not have been provided a shower or a bed bath.*LPN O thought that resident 14 had been refusing to shower and those refusals should have been documented in the EMR.*LPN O was unable to find documentation that resident 14 refused showering.*LPN O stated that resident 14 had been provided bed baths and those bed baths should have been documented in the bathing task section of the EMR. She was unable to find documentation that resident 14 had received bed baths. 7. Interview on 9/5/25 at 9:10 a.m. with director of nursing (DON) B regarding resident 64's bathing revealed:*Resident 64 was allowed to shower if her dialysis port was covered.*DON expected resident 64 to have showers twice a week and expected those showers to have been documented in the EMR. 8. Interview on 9/5/25 at 10:36 a.m. with DON B regarding resident 14's bathing revealed:*There was no documentation that resident 14 had received a bed bath or a shower.*Resident 14 had been refusing to get out of bed or shower.*DON B expected those refusals to shower to have been documented.*She thought that resident 14 was provided with a bed bath when he refused to shower and expected those bed baths to have been documented.*If a resident was unavailable or refused a shower or a bed bath, she expected the CNA to have offered the resident a shower or a bed bath on another day, and any bathing activity to have been documented in the EMR. Review of the provider's 8/29/25 Bathing policy revealed:*Purpose- To promote cleanliness and general hygiene, To promote comfort, relaxation, and well-being, To observe [the] resident's condition, To assist [the] resident with personal care.*Perform.document[ion] where/when appropriate.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, record review, and policy review, the provider failed to ensure an air mattress safely fit the resident's bed frame and did not impede the use of assist bars for one of one sampled resident (44) who had an air mattress to relieve pressure from a pressure ulcer and used assist bars for mobility and positioning while in bed, which may have put the resident at risk for accidents and injury. Findings include:Based on observation, interview, record review, and policy review, the provider failed to ensure that the air mattress for one of one sampled resident (44) was safely fitted to the bed frame and did not present an accident hazard. 1. Observation and interview on 9/3/25 at 8:50 a.m. with resident 44 revealed:*Her bed had an air mattress on it that extended approximately five inches over the open side of the bed frame.*The air mattress was covered with a smooth nylon cover and designed to be used without a bottom sheet.*She had been using the air mattress for several months because she had a pressure ulcer (skin and/or underlying tissue injury from prolonged pressure).*There were assist bars (bed/side rails) attached to both sides of the bed frame but she was only able to use the one on the wall side of the bed.*She used the assist bar on the bed's wall side to help turn over.*She previously used the assist bar on the open side for assistance with turning and getting up from the bed.*The assist bar on the open side of the bed was no longer able to be used due to the air mattress being larger than the bed frame.*The nursing staff would place the long side of her bedside table against the bed at night to remind her not to get too close to the edge.*She was afraid of falling out of bed, and she felt it disturbed her sleep. 2. Interview on 9/4/25 at 9:45 a.m. with director of nursing (DON) B revealed:*She had created the work order for an air mattress to be placed on resident 44's bed.*Maintenance staff would install an air mattress when there is a work order for one.*She was not aware of an issue with the air mattress size or that the assist bar on the open side of the bed could not be used.*She agreed that an air mattress that was larger than the bed frame would be an accident hazard. 3. Interview and observation on 9/4/25 at 9:50 a.m. with maintenance mechanic (MM) Z and maintenance technician (MT) C revealed:*They agreed that resident 44's mattress did not fit properly and was not safe.*The air mattress being too large for the bed frame was an accident hazard.*Resident 44 could slide out of bed and onto the floor.*The bed rail on the open side of the bed could not be raised.*MM Z did not know who had installed the air mattress on resident 44's bed. 4. Review of work order #2822 revealed:*The request to add an air mattress to resident 44's bed was created by DON B on 6/10/25.*It was assigned to MM Z on 6/11/25 at 8:53 a.m. and marked set to: completed on the same date and time by LMM AA. 5. Review of the 6/13/25 bed and side rail inspection log completed by MM Z revealed the areas:*Inspect mattress gap between side rails/assist bars.*Verify side rail[s] are fully functional and free of obstructions. 6. Interview on 9/4/25 at 12:30 p.m. with lead maintenance mechanic (LMM) AA revealed:*Resident 44's bed frame was not an acceptable size for that air mattress.*They had bed frames that were the appropriate size for the air mattress.*It would not be acceptable for the bed rails not to be used.*The bed and side rail inspection log completed by MM Z on 6/13/25 was not accurate.*Agreed that it was an unsafe environment for the resident. Review of resident 44's electronic medical record (EMR) revealed:*Resident 44 had a Brief Interview for Mental Status (BIMS) Assessment score of 15, which indicated that her cognitive function was considered normal and not impaired. *A 6/5/25 physician's order to provide an air mattress for resident 44 due to a stage II (2; open wound or blister with partial-thickness skin loss) pressure ulcer.*Her current care plan had a 6/4/25 initiated focus area of an ADL self-care performance deficit related to her deconditioning post hospital stay, with interventions that indicated she:-Used assist/grab bars to position up in bed, turn side to side, move from lying to sitting, and to move from sitting to lying, which were initiated on 6/5/25.-Was able to utilize assist/grab bars appropriately, which was initiated on 6/5/25.*Had an air mattress for pressure relieving, which was initiated on 6/5/25 and revised on 9/4/25.*Her current (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care plan had a 6/5/25 initiated focus area that indicated the resident was at risk for falls related to new onset atrial fibrillation and her deconditioning post hospital stay.-An intervention for that focus area indicated that staff members were to educate the resident and her family about safety reminders. 5. Interview on 9/5/25 at 9:50 a.m. with minimum data set (MDS)/registered nurse (RN) revealed:*She had completed the education with resident 44 as indicated on the physical device and restraint evaluation on 8/24/25.*She pushed the air mattress out of the way with her shoulder to be able to raise the rail.*Resident 44 would not have been able to raise the rail herself.*She recognized that the air mattress was too big for resident 44's bed frame and had meant to let nursing or maintenance know.*She had not notified anyone about the air mattress being too big for the resident's bed frame. 6. Interview on 9/5/25 at 10:15 a.m. with administrator A revealed:*An assessment would be required to ensure the proper fit of the mattress to the bed frame and ensure the safety of the resident.*The air mattress assessment completed by MM Z was not accurate. Review of the physical device and/or restraint evaluation and review for resident 44 revealed:*It was signed as completed by Minimum Data Set/Registered Nurse (MDS/RN) T on 8/24/25.*It indicated a recommendation for the use of an assist rail (quarter rail used for turning and mobility).*It indicated that informed consent had been obtained for use of the assist rail.*It indicated that general device education was provided and specifically that she showed the resident how to use/remove the assist rail. Review of the provider's 2/2/24 reviewed/revised bed safety and side rail entrapment resource policy revealed:- Hazards refer to elements of the resident environment that have the potential to cause injury or illness.- Free of accident hazards as possible refers to being free of accident hazards over which the facility has control.* F689 [federal regulation] states: The facility must ensure that the resident's environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents.* A resident's bed should be a place of comfort and relaxation, a safe place. When the bed system does not fit correctly . the resident's bed is no longer a safe place.*The bed system includes the bed frame and mattress as well as any side rails or assistive devices.*Review manufacturer's guidance for use of the various types of mattresses such as air mattresses.*It is important to remember that not all rails and mattresses fit all bed frames.-Inspect the bed system for proper fit of mattress in the bed frame.The air mattress manufacturer's instructions were requested from the provider but not received prior to survey exit on 9/5/25.