STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435087	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society Canistota	700 West Main St Canistota, SD 57012

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (7) with risk for developing skin wounds caused by prolonged pressure and expressed discomfort in areas of irritated skin around her suprapubic catheter (a flexible tubing surgically placed through the abdomen into the bladder to drain urine) insertion site and in her abdominal fold was assessed for irritation and her physician was notified of those skin conditions to determine and order treatment to promote healing and prevent those areas from worsening or developing into pressure wounds. Findings include:1. Observation and interview on 03/17/26 at 11:04 a.m. with resident 7 revealed she was in her room, seated in her wheelchair. There was catheter tubing that extended from her shorts, connected to the catheter bag (a device used to collect urine), and was clipped to her wheelchair. She stated that she had problems with her catheter and that it bleeds every day. She indicated, It is bad down here (pointed to her groin area). 2. Review of resident 7's electronic medical record (EMR) revealed her admission to the facility was on 11/8/21. Her 2/19/26 Brief Interview of Mental Status assessment score was a 15, which indicated her cognition was intact.Her diagnoses included: neuromuscular dysfunction of the bladder (caused by nerve damage that interrupts signals between the brain and bladder, leading to poor bladder control); Type 2 diabetes with chronic kidney disease; Cystostomy status (a surgical opening into the bladder to allow for urinary drainage); retention of urine, (inability to fully empty the bladder); dermatitis (skin inflammation); and morbid obesity (excessive weight that significantly impacts health and well-being).Her 1/6/26 skin observation assessment indicated she had a moist/pink abdominal fold, and her groin area was pink and moist. The treatment indicated for those areas was Nystatin External Powder and was last documented as administered on 12/31/25.Her skin observation assessments indicated that on 1/13/26, her skin observation assessment indicated her groin was pink [and] moist. On 1/20/26, abdomen had s/p [status post] pink area and scattered bruising [due to] insulin injections. On 1/27/26, her abdomen had pink skin under abdominal fold and her groin was pink [and] moist skin. On 2/3/26, her abdomen had pink and moist under abdominal folds and her groin was pink moist. On 2/17/26, her abdomen had irritation under abdominal fold, and the listed treatment of Nystatin External Powder was last documented as administered on 12/31/25. On 2/24/26, her abdomen was pink, moist under abdominal folds [and] scattered bruising from insulin administration. On 3/3/26, the assessment indicated her Skin check was completed - no skin conditions observed/skin condition resolved and no new skin issues noted. There were no medications or treatments listed.Resident 7's skin observation assessments completed on 1/13/26, 1/20/26, 1/27/26, 2/3/26, and 2/24/26, indicated there were no treatments that will or are being done on the skin conditions. Resident 7's 3/17/26 skin assessment indicated she had an abdominal fold with intermittent serous drainage, pink in color, and the only intervention identified was to clean the area.Her 3/24/26 nurse's progress note indicated her skin was warm, dry, and the color was within normal limits. There was a skin condition labeled 001 located on her perineum (the skin between the genitals and anus) that had not been evaluated, was classified as moisture-associated skin damage (MASD), and was acquired in the facility. She had a second skin condition that the staff were monitoring, labeled 002 located on her abdomen, classified as MASD, and was acquired in the facility. (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 0684 Level of Harm - Actual harm Residents Affected - Few	There were no measurements for these skin conditions documented. Resident 7's physician was notified of these skin conditions.Her physician's orders included a 6/8/24 order for catheter care BID [twice a day], and a 5/28/25 order to change her suprapubic sponge each day. The physician order to change her suprapubic sponge each day was discontinued in October 2025.Her physician's orders included an order on 4/30/25 for InterDry to be applied to the affected area as needed for MASD. On 9/17/26, this order was put on hold, resumed on 9/29/25, put on hold on 2/7/26 as she was admitted to the hospital, and was resumed again on 2/10/26.She had a 1/5/26, physician's order to Change catheter every month and PRN [as needed] if dislodged or plugged and unable to clear with irrigation.3. Observation and interview on 3/23/26 at 3:56 p.m. with resident 7 revealed she had a nighttime catheter bag clipped onto her bed frame that held a moderate amount of clear yellow urine. She indicated she had a suprapubic catheter, that the insertion site was sore and sometimes had blood. Resident 7 stated the staff did not use a sponge or ointment when they cleaned that site and wished they would use a sponge.Resident 7 pulled up her shirt and separated her abdominal fold where her suprapubic catheter site was, which revealed a pink, shiny area that appeared moist, without a split sponge (pre-cut sterile dressing designed to fit snugly around catheters, used to absorb drainage). She stated the staff would clean the insertion site by wiping it in the morning and at night with a wet wipe.4. Interview on 3/23/26 at 4:05 p.m. with medication assistant (MA) G revealed that resident 7 had her catheter flushed twice a day. The nurse would cleanse the catheter insertion site, and the certified nursing assistants (CNAs) and medication aides MAs would also cleanse the insertion site if they were providing resident care and saw drainage from the site. She was not aware of any gauze or creams being applied to resident 7's catheter insertion site.5. Interview on 3/23/26 at 4:10 p.m. with CNA/environmental services supervisor (ESS) J, who was scheduled to work the evening of 3/23/26 as a CNA, revealed she was not aware of any blood in resident 7's urine or bleeding at her catheter insertion site.6. Observation and interview on 3/23/26 at 4:15 p.m. with registered nurse (RN) F regarding resident 7's suprapubic catheter revealed there was no known history of blood in her urine. Sometimes there was serous (clear watery fluid) drainage at her suprapubic insertion site, which was in an abdominal fold, and she believed it was related to friction and from being tugged on. RN F often would see resident 7 in the morning when resident 7 woke up. RN F would flush her catheter at that time; otherwise, she did not see the serous drainage. When CNAs completed catheter care for resident 7, they would wipe the drainage at the catheter insertion site and cleanse the area each morning and night, as needed.RN F stated there were no physician-ordered creams for resident 7, as the abdominal fold area was open. She would apply a split sponge, as needed, if she had one. She indicated she had none with her that morning (3/23/26) and was not able to get back to resident 7's room to apply one to her abdominal fold. She confirmed there was no physician order for a split sponge.RN F examined resident 7's abdominal fold, which had a split in the skin and granulation (new, connective tissue and microscopic blood vessels that form on the surfaces of a wound during the healing process) tissue with a small opening. RN F stated the doctor was aware of the site and skin issue. She indicated that resident 7 reported pain when she was asked about it. She indicated that the CNAs and bath aides reported residents' skin concerns to the nurses. She stated that the residents' skin assessments were completed for residents with a Braden Scale (a tool used to assess the risk for developing skin ulcers caused by prolonged pressure) score greater than 18, and resident 7 had a physician order for nurse skin assessments.7. Observation and interview on 3/24/26 at 10:18 a.m. with resident 7 revealed that her right-side abdominal fold was pink with a reddened area. The catheter insertion site was red, the skin was granulating (developing new connective tissue and microscopic blood vessels) on each side of the catheter tube at the insertion site, and the area appeared moist. There was no gauze, dressing, or split sponge at the supra-pubic catheter site. Resident 7 reported that it hurt, and she felt pain across her abdomen in the fold. She stated when gauze was placed in the fold, they [staff members] didn't change it, and it [the gauze] was yellow and green. She had, in the past, refused the powder to be placed in the abdominal (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	fold and stated she did not like it. She explained the powder as an irritation too. Resident 7 stated she told various staff members and CNAs that she wanted gauze placed in her abdominal fold, and they said they had to talk to the nurse about that.8. Interview on 3/24/26 at 10:29 a.m. with CNA N regarding resident 7 revealed she cleansed around the suprapubic catheter insertion site, that sometimes had leakage there with blood, and she used a wipe and cleaner to cleanse the area. CNA N indicated resident 7's skin was a little bit red, and that the resident complained that her skin was irritated and itched. CNA N applied a barrier cream to resident 7's skin every time she assisted resident 7 with her catheter care. She stated the area in resident 7's abdominal fold was moist a lot, she had bladder spasms, and CNA N stated she feels urine is leaking into the abdominal fold. Resident 7 did not ask for gauze, and just asks for the cream to be applied in her abdominal fold. CNA N had not seen a split gauze or any other dressing in resident 7's abdominal fold. She indicated the nurse completed the suprapubic catheter insertion site treatment.9. Interview and review of resident 7's EMR on 3/24/26 at 10:47 a.m. with RN E, revealed resident 7's suprapubic catheter care included flushing the catheter twice a day, cleansing the area around her catheter insertion site, and in her abdominal fold with a wipe. When she completed the treatment in the morning, there was extra moisture and serous drainage at the suprapubic catheter insertion site. She indicated she only saw the bloody drainage in the mornings. RN E indicated that resident 7 had bladder spasms and urine leakage at the suprapubic catheter insertion site. She offered to resident 7 to get a physician's order for powder to keep the area dry, but resident 7 refused. Resident 7 had not asked her for gauze to be placed in the abdominal fold or to have a split sponge at the catheter insertion site. Resident 7's suprapubic catheter care treatment order did not include catheter insertion site care or to apply a split sponge. There was a 5/28/25 order from her urologist that included an order for a split sponge. RN E confirmed the split sponge was discontinued in October 2025.RN E confirmed resident 7 had bladder spasms and that her urine back flowed at the suprapubic catheter insertion site, into the abdominal fold, and on to her skin. She reported that resident 7 had not reported or complained to her about her skin being irritated or pain in her abdominal fold. RN E described the skin in resident 7's abdominal fold as being intact, light pink, and moist. She confirmed this description was documented on the 3/17/26 nurse skin assessment and that the resident's weekly skin assessment was due today (3/24/26), but she had not completed it. RN E would clean the skin in the abdominal fold with wipes; resident 7 refused powders, and the CNAs applied barrier cream to her abdominal fold.10. Observation and interview on 3/24/26 at 11:10 a.m. of RN E completing resident 7's weekly skin assessment revealed that resident 7 grimaced and voiced ouch throughout RN E cleansing the area with wipes. She stated ouch and touched her right abdominal area with her hand. Her abdominal fold had a white ointment in it and was observed as being moist. Resident 7 stated the white ointment was not helping her skin heal.The skin in resident 7's abdominal fold was reddened and excoriated (worn off). There was an approximately 6-inch-long by 0.25-inch-wide red streak on the right side of her abdomen in the abdominal fold. There was an approximately one centimeter (cm) area on each side of the supra pubic catheter insertion site that was red, excoriated, and appeared to have new granulation of the skin. The catheter tubing had serous drainage on it, which RN E wiped off with a wipe. RN E spent approximately five minutes using four or more wipes to cleanse resident 7's abdominal fold and the suprapubic site and tubing. Resident 7 continued to wince and voice ouch throughout RN E's cleansing of the area. RN E stated to resident 7 that she was trying to clean her up. RN E then stated she would remove the two tubes of DynaShield skin protectant cream from the bedside so the CNAs would not use it on her abdominal fold.RN E removed her gloves, performed hand hygiene (wash or sanitize hands), and stated she was going to the medication room to get supplies and would be back. She returned to resident 7's room approximately 5 minutes later with wound cleanser spray, a split drain sponge, gauze, and InterDry sheets (specialized, antimicrobial, moisture-wicking textiles designed to manage skin folds and skin-to-skin contact areas). She cleansed the suprapubic catheter insertion site wound with the spray and gauze, placed a split drain sponge around the suprapubic catheter (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	insertion site, and laid the InterDry sheets into the abdominal fold. RN E stated she had not seen the resident's red, newly granulated area around the supra pubic insertion site, and the red excoriated skin in the abdominal fold there before. She stated there was a PRN (as needed) order for the InterDry sheets. She did not use them before but was aware that other nurses had used them for under resident 7's breasts in the summer. She was not certain when the the CNAs started applying the cream in resident 7's abdominal fold and indicated no CNAs had reported to her resident 7's current skin conditions that she first saw during today's (3/24/26) skin assessment.11. Interview and record review on 3/24/26 at 2:20 p.m. with RN F, director of nursing (DON) B, and RN/Minimum Data Set (MDS) nurse C revealed resident 7 had her suprapubic catheter surgically placed on 4/23/25. In October 2025, at the request of the nurses, her provider discontinued the order for the split drain sponge at the suprapubic catheter insertion site because that area was healed. They were aware that resident 7's abdominal fold was moist but were not aware that the suprapubic catheter insertion site was red, appeared excoriated, and had new granulation tissue present.DON B stated the nurses did not use a split sponge at the insertion site, as the physician had discontinued it. Resident 7's physician had ordered InterDry sheets PRN, on 4/30/25 to reduce the moisture in her skin folds. DON B would expect the nurses to use the InterDry sheets in resident 7's abdominal folds to reduce the moisture and to prevent excoriation. Nurse skin assessments were done weekly, and there was no expectation for the nurses to measure the pink area in her folds.12. Review of the provider's 12/8/25 Skin Assessment Pressure Ulcer Prevention and Documentation Requirements policy revealed Assessment and Documentation of Bruises/Contusions/Skin Tears/Abrasions[.] An abrasion is a wound caused by superficial damage to the skin, no deeper than the epidermis. If a bruise/contusion/skin tear/abrasion is observed on a resident, this should be reported to the nurse immediately. The bruise/contusion/skin tear/abrasion should be monitored weekly and any changes and/or progress toward healing should be documented on the Skin Observation UDA [user defined assessment] and on the resident's care plan.13. Review of the provider's 3/2/26 Catheter: Care, Insertion and Removal, Drainage Bags, Irrigation, Specimen policy revealed, It is important to keep the dressing dry and cleanse the suprapubic skin insertions site using clean technique every day and as necessary. Catheter Care - Indwelling Catheter Catheter care will be completed with morning and bedtime cares and as needed. Observe meatus and surrounding tissue for inflammation, encrustations, swelling, or discharge, ask the resident if burning or discomfort is present.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the provider failed to ensure the code status (emergent treatment a person wishes to receive if their heart or breathing would stop) for thirteen of sixteen sampled residents (1, 3, 5, 6, 9, 23, 26, 40,42, 44, 46, 51, and 58) wishes were determined and accurately documented in the residents' electronic medical records (EMR) at the time of their admission to the facility and one of one sampled resident (46) with discrepancies in his documented code status. Findings include:1. Review of resident 46's EMR revealed that he was admitted to the facility on [DATE]. His [DATE] Brief Interview for Mental Status (BIMS) assessment score was 3, which indicated his cognition was severely impaired. A banner displayed in his EMR indicated that he wanted to receive (cardiopulmonary resuscitation), an emergency procedure to provide chest compressions and often rescue breathing to preserve brain function and maintain blood circulation (CPR), if his heart or breathing stopped. His care plan had a [DATE] initiated code status focus area that indicated I have a DNR [do not resuscitate] order. A [DATE] physician's order indicated he had a DNR code status. There was no documentation in resident 46's EMR that indicated his code status wishes were for CPR. 2. Review of resident 1, 3, 5, 6, 9, 23, 26, 40, 42, 44, 46, 51, and 58's electronic medical records (EMR) revealed: -Resident 5 was admitted to the facility on [DATE]. No documentation in the resident's EMR indicated his code status wishes. -Resident 23 was admitted to the facility on [DATE]. No documentation in the resident's EMR indicated her code status wishes. -Resident 26 was admitted to the facility on [DATE]. No documentation in the resident's EMR indicated her code status wishes. -Resident 51 was admitted to the facility on [DATE]. No documentation in the resident's EMR indicated his code status wishes -Resident 3 was admitted to the facility on [DATE]. No documentation in the resident's EMR indicated his code status wishes. -Resident 9 was admitted to the facility on [DATE]. No documentation in the resident's EMR indicated her code status wishes. -Resident 42 was admitted to the facility on [DATE]. No documentation in the resident's EMR indicated his code status wishes. -Resident 46 was admitted to the facility on [DATE]. No documentation in the resident's EMR indicated his code status wishes. (continued on next page)

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	435087	A. Building B. Wing	03/24/2026

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident 58 was admitted to the facility on [DATE]. No documentation in the resident's EMR indicated his code status wishes. -Resident 1 was admitted to the facility on [DATE]. No documentation in the resident's EMR indicated his code status wishes. -Resident 6 was admitted to the facility on [DATE]. No documentation in the resident's EMR indicated her code status wishes. -Resident 40 was admitted to the facility on [DATE]. No documentation in the resident's EMR indicated her code status wishes. -Resident 44 was admitted to the facility on [DATE]. No documentation in the resident's EMR indicated her code status wishes. 3. Interview on [DATE] at 10:42 a.m. with administrator A regarding resident's code status revealed the provider did not have a form for the residents or their representatives to sign to indicate the resident's code status wishes. She provided a form that included a signed physician admission standing order with a DNR code status that was used if the resident did not have a formal advanced directive. 4. Interview on [DATE] at 4:16 p.m., with social worker (SW) D, regarding the facility's admission process for obtaining and documenting a residents' code status wishes revealed that the facility reviews their residents' advance directives with the residents during their admission to the facility. She stated the facility did not review the resident's code status wishes with residents when they were admitted to the facility. The facility does not utilize a form for the residents or their representatives to document those wishes. SW D indicated that she would ask residents to verbally state their preferences for their code status at the time of admission. For residents who were admitted from a hospital, their code status was determined based on their hospital discharge documentation. The facility did not have documentation to indicate a resident's code status preference at the time of their admission to the facility. SW D stated the facility followed standing orders from the medical director regarding code status at the time of a resident's admission to the facility. She documented the resident's or their family's preference regarding code status in an admission progress note in the resident's EMR and communicated that information to the nursing staff. The nursing staff would then document that preference in the resident's EMR. 5. Centers for Medicaid and Medicare Services (CMS) State Operations Manual Appendix PP (Guidance to Surveyors for Long Term Care Facilities) definition of code status Do Not Resuscitate (DNR) Order refers to a medical order issued by a physician or other authorized non-physician practitioner that directs healthcare providers not to administer CPR in the event of cardiac or respiratory arrest. The existence of an advance directive does not imply that a resident has a DNR order. The medical record should show evidence of documented discussions leading to a DNR order.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and policy review, the provider failed to ensure the staff followed standard food safety and sanitation practices in the kitchen and food storage areas where residents' food was stored, prepared, and served.Findings include: 1. Observation on 3/17/26 at 8:20 a.m. of the provider's dry food storage room, canned goods rack, revealed a # (number) 10 can (holds 12-13 cups) of applesauce and a #10 can of dill pickles that both had severe dents at the sealed seam that could cause cracks and entry of bacteria.On the ceiling, a yellow conduit tube had what appeared to be a dust-like substance on it. That substance was approximately two inches long and hanging from various areas of the conduit tube.2. Observation on 3/17/26 at 8:46 a.m. of the dishwashing area revealed a tan-colored residue that covered the top of the dishwasher, and by the far edge, the residue was one-half inch thick. That same residue was on the wall next to the dishwasher. Behind the dishwasher was what appeared to be yellow insulation wrapped around a pipe with a silver covering that was peeling off the yellow insulation. One area of the silver covering was peeled back and measured approximately 2 feet by 5 inches. A second area of peeling was approximately 8 inches long.There was an oscillating table-top fan attached to the wall between the cupboard and the dishwasher that had dust build-up on the fan blades and the front grille. That fan was turned slightly upward and was blowing air into the clean dishwashing area where clean dishes were present.3. Observation at 11:58 a.m. of food service assistant (FSA) M revealed she held a clean Cambro (plastic food storage container) against her apron. After putting the Cambro container in the cupboard, she went to the freezer and took out eight single-serve containers of frozen dessert. She used both of her hands to hold the desserts against her apron, entered the dining room, and served those desserts to various residents.4. Observation on 3/17/26 at 12:19 p.m. of FSA M, in the kitchen, revealed she performed hand hygiene (wash or sanitize hands) at the hand-washing sink, dried her hands on a paper towel, then used one of her clean hands to open the lid of the trash can, and placed the paper towel she dried her hands with in the trash can. That trash can had a step-on pedal to open the lid without touching it.5. Interview on 3/24/26 at 5:25 p.m. with certified dietary manager (CDM) L and administrator A regarding dietary processes revealed, that CDM L was not aware there were dented cans in the dry storage room, and stated they should not be available for use. She was not aware of the accumulated dust on the yellow conduit tube in the storage room, or that the oscillating fan was blowing into the clean dishwashing area while it had dust on the blades and grille.CDM L expected FSA M not to carry clean dishes or food products against her apron and should have used a cart to transport the products. CDM L confirmed there was a foot pedal to open the trash can, and FSA M should not have used her hand to open the trash can.Administrator A acknowledged the above deficient practices and stated, They [dietary staff] have had training [by CDM L).6. Observation and interview on 3/24/26 at 5:35 p.m. with CDM L in the kitchen revealed she was aware of the tan-colored residue that covered the top of the dishwasher and on the wall next to the dishwasher. She stated that it was cleaned after each meal service. She agreed the amount of food particle residue on the dishwasher could not have accumulated after one missed cleaning.CDM L stated the silver covering over the yellow insulation around the pipe behind the dishwasher was for protection and that it was that way for a while, and should have been replaced.7. Review of the provider's 3/13/26 Food Supply Storage policy revealed there was no guidance regarding the storage of canned goods.8. Review of the provider's 2/1/3/26 Warewashing (the cleaning and sanitizing of utensils and food-contact surfaces of equipment) Mechanical and Manual policy revealed that the warewashing machine was to be cleaned before use, and at a frequency to prevent recontamination of equipment and utensils to ensure that the equipment performed its intended function.9. Review of the provider's 12/3/25 Cleaning Schedule-Food and Nutrition Services policy revealed, Keep fans/grills in unit clean, Ceilings: Check daily for cobwebs, dust and dirt or condensation so it cannot fall from the (continued on next page)

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	435087	A. Building B. Wing	03/24/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ceiling, and Fans: clean weekly or as needed.10. Review of the provider's 6/27/25 General Sanitation - Food and Nutrition policy revealed, The location stores, prepares, distributes and serves food under sanitary conditions at all times. and The location's food preparation, kitchen, serving areas and dry storage are cleaned and sanitized on a regular basis to limit contamination and prevent food-borne illness.

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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 interview, observation, and policy review, the provider failed to ensure the staff followed infection prevention practices regarding the disinfection of one of one whirlpool by one of one observed certified nursing assistant (CNA) (I), and the prompt cleaning of two of two sampled residents' (6 and 44) bedroom floors observed with bowel movement (BM) on them.Findings include: 1. Observation, interview, and review of whirlpool cleaning instructions on 3/17/26 at 3:22 p.m. with CNA I cleaning the whirlpool revealed he filled the whirlpool with water and disinfectant to a couple of inches up from the bottom of the whirlpool, he used a scrub brush and thoroughly scrubbed all interior surfaces with the disinfectant solution in the bottom of the tub. He then indicated he would let the disinfectant solution sit for ten minutes, drain the tub, and then rinse the tub's interior. He was not sure how to flush the disinfectant from the whirlpool jets. After reviewing the instructions for cleaning and disinfecting the whirlpool, he stated he did not know where the flush button for the whirlpool jets was.2. Observation on 3/19/26 at 10:38 a.m. of the whirlpool revealed the whirlpool door located on the end of the tub was open, with one-fourth inch of water in the bottom of the tub, and suds in the area between the bottom of the tub's edge and where the door closes. Water was filling the reservoir of the tub, and hair on the drain plug, and wrapped around the chain that attached the drain plug to the tub. There was a dry scrub brush lying on the top of the whirlpool. There was no other scrub brush available in the whirlpool room. 3. Observation on 3/17/26 at 10:54 a.m. of resident 6's room revealed two areas of a dark brown substance, both approximately one and one-half inches round in size, dried onto the floor.4. Observation on 3/18/26 at 8:45 a.m. of resident 6's room revealed a staff member on her knees, scrubbing the dark substance on the floor that was identified on 3/17/26, with a washcloth.5. Observation on 3/18/26 at 8:49 a.m. of resident 44's room revealed she was not in her room. There was a small brown stain on her pillow, a brown streak located on the sheet on the edge of her bed, a two-inch round formed piece of BM on the floor, additional bedding, and a pair of shorts with an incontinent (involuntary urine or bowel leakage) brief inside of them with BM smeared throughout.6. Observation on 3/18/26 at 9:32 a.m., of resident 44's room revealed the same conditions as observed above, and at 11:00 a.m., those areas were clean.7. Interview on 3/24/26 at 1:50 p.m. with director of nursing (DON) B, registered nurse (RN) Minimum Data Set (MDS) C nurse, and environmental services supervisor (ESS) J revealed ESS J stated that resident rooms were to be swept and mopped daily. There were no housekeepers to be scheduled on the weekends, so no sweeping or mopping was completed then. EES J had discovered urine on the floor in resident 44's room, but no BM. DON B stated that anytime there was urine or BM on the floor, someone from the nursing department was to clean that up. She then stated resident 44 would take herself to the bathroom, but is not very good at it, and required staff assistance with cleaning and dressing herself. She expected fluids to be cleaned up immediately and the bed linens to be changed when soiled.DON B stated two CNAs were scheduled to work as bath aides Monday through Friday. DON B indicated she did not complete audits for cleaning the whirlpool. She expected the whirlpool to be cleaned and disinfected after each resident's use. She was not aware that CNA I did not know how to clean the whirlpool jets.8. Review of the provider's undated Whirlpool System Cleaning instructions for rinsing the whirlpool jets revealed Press and hold the Disinfectant Button located on the left side of the tub. As the button is held down, the properly mixed cleaning solutions is running through the air injection system and out all of the air jets. Release the button after you see solution coming out of all the air jets and you have 1 to 1 1/2 [one and a half] gallons of disinfectant solution [disinfectant and water combined] in the foot well of the tub. Using the long handled brush, .thoroughly scrub all interior surfaces of the tub with the solution that remains in the foot well of the tub. Let disinfectant stay on surface for 10 minutes . Remove the plug from the drain. Rinse the tub's interior surfaces thoroughly with the shower sprayer. Press and hold the Rinse button located on the left side of the control panel until clear water runs from all the air jets. Then release the Rinse button. 9. Review of the provider's (continued on next page)

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	435087	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society Canistota	700 West Main St Canistota, SD 57012

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Cleaning Blood and Body Fluid Spill policy revealed the staff were to contain the spill. Block off the area until cleanup and disinfection/sanitization is completed. For hard surfaces body fluids are to be wiped up using a dry cloth or paper towels, then use [a] wet cloth or wipes to remove all visible soil/organic material.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the provider failed to ensure two of two sampled residents'(42 and 46) Minimum Data Set (MDS) (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) assessments were accurately coded regarding Pre-admission Screening and Resident Reviews (PASRR), used to screen residents for serious mental health, intellectual disabilities, or developmental disabilities to ensure appropriate placement and specialized services, and Level I PASRRs. Findings include:1. Review of resident 42's electronic medical record (EMR) revealed:*He admitted to the facility on [DATE].*His diagnoses included schizoaffective disorder (hallucinations, delusions, disorganized speech), bipolar type (episodes of mania, extreme highs, and sometimes major depression), traumatic brain injury (TBI), and epilepsy (recurrent, unprovoked seizures).*His 10/28/25 level I (one) PASRR was coded as Yes to the questions: * Does this individual have a confirmed or suspected serious mental illness diagnosis limited to the following?* Does the individual have a confirmed or suspected diagnosis of an intellectual disability (ID) that was prior to the age of 22?*Resident 42 was referred to Maximus for further mental health evaluation and then to the Department of Human Services, Division of Developmental Disabilities (DDD).*His 10/28/25 notice of PASRR Outcome Explanation, indicated The facility should mark yes for question A1500 on the Minimum Data Set' Is the resident currently considered by the state level II [two]PASRR process to have a serious mental illness and/or intellectual disability or a related condition?'*His 11/05/25 comprehensive MDS assessment indicated: *Item A1500 was coded as No to the question, Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition?*Item A1510 was not coded, which would have indicated that resident 42 had a serious mental illness or intellectual disability.*Item A1550, conditions related to intellectual disability (ID) and developmental disability (DD), was coded as None of the above to the question, If the resident is [AGE] years of age or older, complete only if A0310A+01.*His 10/30/25 care plan indicated he received an antipsychotic (medications used to manage psychosis, including delusions, hallucinations, and severe agitation) medication related to his schizoaffective disorder, bipolar type, and anticonvulsant (therapeutic agents that stabilize nerve cell membranes, reducing abnormal electrical activity in the brain to prevent seizures) medication related to epilepsy. 2. Review of resident 46's EMR revealed:*He admitted to the facility on [DATE].*His diagnoses included anxiety, behavior, psychotic, and mood disturbance.*His 1/29/26 level I PASRR was coded as No to the question, Does this individual have a confirmed or suspected serious mental illness diagnosis limited to the following disorders?-The question had indicated that if the diagnoses were checked, then mark Yes.*His 2/9/26 notice of PASRR Outcome Explanation indicated, The facility should mark yes for question A1500 on the Minimum Data Set ?Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition.'*His 2/9/26 comprehensive MDS assessment indicated:*Item A1500 was coded as No to the question: Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition?*Item A1510 was blank. 3. Interview and record review on 3/16/26 at 4:16 p.m. of resident 46's PASRR level 1 screening when he was admitted to the facility with social worker (SW) D revealed:*She was responsible for completing item A1500 on the comprehensive MDS assessments for all residents. 4. Interview and record review on 3/24/26 at 1:47 p.m. with registered nurse (RN)/ Minimum Data Set (MDS) C, regarding completing residents' comprehensive MDS assessments revealed:* SW D completed the PASRR on the residents' comprehensive MDS assessments, and then RN C signed those assessments to indicate that it was accurate?*She confirmed item A1500 on resident 46's 11/05/25 comprehensive MDS assessment for resident 46 should have been coded as yes. 5. Review of Centers for Medicare and Medicaid Services (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 October 2025 revealed section A, item A1500, Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD [intellectual disability/developmental disability] or related condition.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the provider failed to ensure two of two sampled residents (1 and 46) with diagnosed anxiety, behaviors, psychosis, and mood disturbances had a Preadmission Screening and Resident Review (PASRR) reviewed for accuracy to ensure the resident were evaluated for mental health care needs.Findings include:Based on record review, interview, and policy review, the provider failed to ensure two of two sampled residents (1 and 46) with diagnosed anxiety, behaviors, psychosis, and mood disturbances had a Preadmission Screening and Resident Review (PASRR) reviewed for accuracy to ensure the resident were evaluated for mental health care needs. Findings include: 1. Review of resident 46's electronic medical record (EMR) revealed: *He admitted to the facility on [DATE]. *Resident 46's diagnoses included: anxiety, behaviors, psychosis, and mood disturbances. *On 02/03/26, he had a Brief Interview for Mental Status (BIMS) assessment score of 3, which indicated his cognition was severely impaired. *He had a Level I (one) PASRR completed on 01/29/26. - The question, Does this individual have a confirmed or suspected serious mental illness diagnosis limited to the following disorders? was marked No. 2. Review of resident 1's EMR revealed: *He admitted to the facility on [DATE]. *His 8/20/25 care plan had a focus area that indicated The resident has a psychosocial well-being deficit reliving trauma. The care plan did not indicate what the trauma was. *He had a 2/27/26 BIMS assessment score of 15, which indicated his cognition was intact. *His admission diagnoses included: other signs and symptoms involving cognitive functions and awareness; psychosis; traumatic brain injury; personal history of mental and behavioral disorders; major depressive disorder, and anxiety. 3. Interview and record review on 3/16/26 at 4:16 p.m. with social worker (SW) D regarding resident 46's Level I PASARR when he was admitted to the facility revealed: *She reviewed resident 46's Level I PASRR and acknowledged that it had been completed it incorrectly. *She acknowledged that a Level II (two) PASARR request should have been submitted for resident 46. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Interview and review on 3/19/26 at 4:01 p.m. of resident 1's Level 1 PASRR with SW D revealed: *When a resident admitted to the facility, from a hospital, with a Level I PASRR already completed by the hospital, she was responsible for reviewing that PASRR for accuracy and submitting a Level II PASRR to the State Mental Health Agency (SMHA) for additional review when the Level I PASRR was positive (the Level I PASRR has identified a suspected or confirmed serious mental illness (SMI), intellectual disability (ID), or developmental disability (DD). *Resident 1 admitted to the facility from the hospital with a Level I PASRR that was completed by the hospital social worker on 8/15/25. *The Level I PASRR indicated a categorical outcome (an expediated determination made during a Level II evaluation) was being requested and was marked as yes, and the area of IF YES, WHICH ONE? had no areas marked. *SW D reviewed resident 1's 8/15/25 Level I PASRR and did not notice that his mental health diagnoses were not included on that PASRR. *She submitted resident 1's 8/15/25 Level I PASRR to the SMHA on 1/27/26 for Level II PASRR determination. *She indicated a Level II request for resident 1 should have been submitted to the SMHA after he was admitted to the facility on [DATE]. *She did not indicate on Level 1 his additional mental health diagnoses, nor did she complete a new, accurate, Level 1 screen. 5. Interview and record review on 3/24/26 at 1:47 p.m. with registered nurse (RN)/ Minimum Data Set (MDS) C revealed: *She expected each resident's Level I PASRR to be completed and accurate. *She indicated that SW D completed the PASRR on the residents' comprehensive MDS assessments, and then RN/MDS C signed the assessments to indicate that they were completed accurately. *She agreed that resident 46's PASRR on his comprehensive MDS assessment was coded incorrectly and should have been coded as yes. 6. Review of the provider's 5/14/25 Preadmission Screening and Resident Review (PASRR) policy revealed: *The Preadmission Screening and Resident Review (PASRR) is a federal requirement to ensure [the] nursing facility residents with serious mental illness (MI) or intellectual and developmental disability (ID/DD) are: -Identified and evaluated; -Placed in the most appropriate and least restrictive setting available; (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Transitioned to an appropriate community setting when they no longer meet criteria for nursing facility placement; -Provided with the MI/ID/DD services they need, including specialized services. *A negative Level I screen permits admission to proceed and ends the pre-screening process unless possible serious mental disorder or intellectual disability arises later. A positive Level I screen necessitates an in-depth evaluation of the individual, by the state-designated authority, known as Level II PASRR, which must be conducted prior to admission to the facility. *Failure to pre-screen residents prior to admission to the facility may result in the failure to identify residents who have or may have MD, ID, or a related condition. A record of the prescreening should be retained in the resident's medical record. *Individuals who have or are suspected to have MD, ID, or a related condition (as indicated by a positive Level I screen) may not be admitted to a Medicaid-certified nursing facility unless approved based on Level II PASRR evaluation and determination. Exemptions to this requirement are specified in 483.20 (k)(2) and may be exercised at the discretion of the State, as specified in the State's PASRR process.

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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 the safe use of devices by two of two certified nursing assistants (CNA) (H and K) observed transferring a resident to and from her wheelchair and her mattress without a gait belt (a waist strap gripped as support for safe mobility and transfers) for one of one sampled resident (11) with Huntington's disease (a progressive genetic disorder that causes the breakdown of nerve cells in the brain and involuntary movements) who needed to be transferred with the assistance of two staff members and the use of a gait belt. That failure put the resident at risk for falling and injury. 1. Observation and Interview on 3/17/26 at 3:33 p.m. with CNAs K and CNA H while assisting resident 11 to stand up from her wheelchair in her room revealed the CNAs were positioned on each side of resident 11 and they had one hand under each of the resident's arms while their other hands held the waistband of the resident's pants. each of her arms and held the back of her pants. The CNA's prompted resident 11 to step forward onto her mattress, and turn, and then the CNAs lowered her to a lying position on her mattress. The CNA's changed her incontinence brief (absorbent, protective garments designed to manage bladder or bowel leakage), then prompted her to stand. Resident 11 pulled herself up to a standing position by holding the CNA's hands while the CNAs held on to the back of her pants. Resident 11 was then prompted to turn and sit down on her wheelchair. CNA K stated that resident 11 could not use a mechanical lift (a device used to safely transfer individuals with limited mobility between beds, chairs, and bathrooms) because she had previously thrown herself out of the lift. 2. Review of resident 11's electronic medical record (EMR) revealed her care plan indicated she was able to transfer to and from her mattress on the floor and her wheelchair with hand-held assistance from two CNAs and the use of a gait belt. The resident could hold the hands of CNAs for transfers. 3. Interview on 3/24/26 at 11:39 with CNA K revealed she was not concerned regarding resident 11's transfers because she held onto the resident's pants. She acknowledged she did not use a gait belt to transfer resident 11 on 3/17/26 and stated that she probably should have. 4. Interview on 3/23/26 at 12:06 p.m. with registered nurse (RN) F revealed that resident 11 was not safe to be transferred with a mechanical lift due to her uncontrolled movements. She expected the CNAs to use a gait belt when transferring resident 11. 5. Interview on 3/24/26 at 8:54 a.m. with director of nursing (DON) B revealed that the CNAs would refer to the residents' care plan (personalized plan that addresses a resident's care needs, goals, and interventions), daily report (information shared between CNAs at a shift change regarding the care of residents) to know how to care for the residents. She expected the CNAs to use a gait belt when they transferred resident 11. 6. Review of the provider's 12/1/25 Care Plan policy revealed, Residents will receive and be provided with the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. The policy did not address the implementation of interventions. 7. Review of the provider's 12/12/25 Safe Resident Handling Program policy revealed, Good Samaritan's goal is to maintain a safe living and working environment for residents and employees.