STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435124	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society Miller	421 East 4th St Miller, SD 57362

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and policy review, the provider failed to monitor and implement pressure ulcer (skin and/or underlying tissue injury due to prolonged pressure) healing and prevention interventions for one of one sampled resident (5) identified at risk for developing pressure ulcers and developed a stage II (2; open wound or blister with partial-thickness skin loss) pressure ulcer to his coccyx (tailbone). Findings include:1. Observation and interview on 2/17/26 at 3:53 p.m. with resident 5 in his room revealed:*He had a cushion in his wheelchair and an air mattress (a specialized mattress filled with air used for pressure reduction) on his bed.*He did not know why he had the air mattress or cushion in his wheelchair.*He did not know if he had a skin wound.2. Review of resident 5's electronic medical record (EMR) revealed:*He was admitted to the facility on [DATE].*His 12/22/25 Brief Interview for Mental Status (BIMS) assessment score was 8, which indicated he had moderate cognitive impairment.*His diagnoses included stage II pressure ulcer of sacral region (bone directly above the tailbone), diabetes (a condition involving disruptions in how the body regulates blood sugar), weakness, and dementia (a group of symptoms affecting memory, thinking, and social abilities).*Resident 5's 12/16/25 Braden Scale for Predicting Pressure Sore Risk (a tool used to assess the risk of developing pressure ulcers) assessment score was 16, which indicated he had a mild risk for the development of a pressure ulcer.-The interventions recommended for mild risk were, Frequent Turning (e.g., q [every] 2 hours), Maximal Remobilization, Pressure-Reduction Support Surfaces if Bed- or Chair-Bound, Protect Heels, Manage Moisture, Manage Nutrition, Manage Friction and Shear*If other major risk factors are present (advanced age, poor dietary intake of protein, diastolic pressure below 60, hemodynamic instability), advance to next level of risk.*His 2/18/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) had a focus area that indicated The resident has potential impairment to skin integrity initiated on 12/17/26 with interventions of High risk for skin injury - use caution during transfers and bed mobility and Keep skin clean and dry. Apply protective barrier cream to peri/rectal [skin between the anus and genitals] area following incontinent [involuntary urine or bowel leakage] episodes and prn [as needed].*His 2/18/26 care plan had a focus area that indicated The resident has hx [history] of Stage 2 pressure ulcer that was initiated on 12/23/26 and revised on 2/18/26 with interventions that indicated Educate resident/family as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning, Inform resident/family of any new are of skin breakdown, and Notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care.-It did not include his wheelchair cushion or an air mattress.*His 12/22/25 wound assessment documentation indicated that resident 5 had a stage II pressure ulcer to his coccyx that measured 1 cm (centimeter) in length by 0.5 cm in width by 0 cm in depth. The evaluation of the ulcer was documented as a Pink open area. First layer of skin gone.-Resident 5's physician was notified.--There was no documentation on the wound assessment that indicated when resident 5's physician was notified.-The wound was cleansed and a Duoderm dressing was applied.*His 12/23/25 wound assessment documentation indicated resident 5's pressure ulcer on his coccyx measured 1 cm (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	by 0.5 cm by 0.1 cm.*Resident 5's 12/24/25 Braden Scale for Predicting Pressure Sore Risk (a tool used to assess the risk of developing pressure ulcers) assessment score was 17, which indicated he had a mild risk for the development of a pressure ulcer.-12/24/25 was after the stage II pressure ulcer had been identified on resident 5's coccyx on 12/22/25.*Hia 12/26/25 wound assessment documentation indicated resident 5's pressure ulcer on his coccyx measured 2.2 cm by 2 cm by 0 cm.-There was no documentation that resident 5's physician was notified of the increased wound size or if the treatments or interventions changed.*His 12/27/25 wound assessment documentation indicated resident 5's pressure ulcer on his coccyx measured 2 cm by 1.5 cm by 0.1 cm.*His 12/30/25 wound assessment documentation indicated resident 5's pressure ulcer on his coccyx measured 0.5 cm by 0.5 cm by 0.1 cm.*His 1/05/26 wound assessment documentation indicated resident 5's pressure ulcer on his coccyx measured 2.5 cm by 1.5 cm by 0.1 cm.-There was no documentation that resident 5's physician was notified of the increased wound size or if the treatments or interventions changed.*His 1/12/26 wound assessment documentation indicated resident 5's pressure ulcer on his coccyx measured 0.5 cm by 0.5 cm by 0.1 cm.*His 1/15/26 wound assessment documentation indicated resident 5's pressure ulcer on his coccyx measured 0.7 cm by 0.4 cm.-There was no documentation of the depth of the pressure ulcer.*His 1/16/26 wound assessment documentation indicated resident 5's pressure ulcer on his coccyx measured 0.5 cm by 0.2 cm by 0.2 cm and was documented has having improved as evidence by the wound measurements were smaller.*His 1/17/26 wound assessment documentation indicated resident 5's pressure ulcer on his coccyx measured 0.5 cm by 0.5 cm by 0.1 cm.*The 1/24/26 wound assessment documented resident 5's pressure ulcer on his coccyx measured 0.5 cm by 0.5 cm by 0.7 cm.-There was no documentation that resident 5's physician was notified of the increased wound depth or that the treatments or interventions had changed.*On 1/30/26 resident 5's pressure ulcer on his coccyx was documented as healed.3. Interview on 2/19/26 at 10:32 a.m. with certified nursing assistant (CNA) H revealed:*She did not know when the cushion was placed in resident 5's wheelchair.*She stated that his wheelchair cushion was missing, but it was replaced about two weeks ago.-CNA H did not know how long it was missing.4. Interview on 2/19/26 at 12:28 with administrator A revealed:*He stated the Minimum Data Set (MDS) nurse had entered barrier cream to be applied following incontinent episodes in resident 4's care plan on 12/17/25 but did not trigger the task in the point of care (POC), a portion of a resident's EMR that includes the types and frequency of care needed, there was no documentation to support that the CNAs had applied barrier cream to resident 5 after his incontinent episodes.*The MDS nurse had not triggered the daily skin inspection task in resident 5's POC so there was no documentation that the CNAs completed daily skin inspections.*There was no documentation to support that resident 5's physician was notified that his pressure ulcer had increased in size.*There was no documentation when the cushion was placed in resident 5's wheelchair.5. Interview on 2/20/26 at 9:20 a.m. with CNA/unlicensed assistive personnel (UAP) I revealed:*She was aware resident 5 previously had a pressure ulcer on his coccyx.*She stated that prior to him developing the pressure ulcer, the staff helped him transfer between his bed and wheelchair to offload the pressure on his buttocks.*She stated he was able to reposition himself in his wheelchair.*She stated if barrier cream was being applied on resident 5 it would have been documented in his POC tasks in his EMR.*She did not know when the cushion was placed in his wheelchair.6. Interview on 2/20/26 at 10:28 a.m. with registered nurse (RN) K revealed she would expect a resident's physician to be notified if the size of the resident's pressure ulcer increased from the previous assessment.7. Interview on 2/20/26 at 12:53 with director of nursing (DON) B revealed:*The provider did not have a designated wound nurse.*All licensed nursing staff were responsible for completing the resdients' wound documentation and treatments.*She expected every resident to have a skin assessment completed upon admission to the facility by a licensed nurse.*If a resident was incontinent barrier cream was to be added to the CNA POC tasks in the resident's EMR.*DON B stated the barrier cream task and the daily skin check task were not added into resident 5's POC tasks when he was admitted . She stated she added it to the (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	CNAs POC tasks on 2/20/26.*She acknowledged there was no documentation to support when resident 5's cushion was placed in his wheelchair.*She stated the air mattress was put on resident 5's bed after he had developed the pressure ulcer on his coccyx.*She acknowledged resident 1's air mattress, wheelchair cushion, and repositioning that were indicated as interventions for his pressure ulcer on the wound assessments were not on his care plan.*She expected the physician to be notified when a pressure ulcer was identified, if there was no improvement in the pressure ulcer from week to week, and if the pressure ulcer worsened in size or characteristics to determine if there needed to be a change in the treatment of the resident's pressure ulcer.*DON B acknowledged that resident 5's physician had not been notified when his pressure ulcer increased in size and there was no change in treatment to the pressure ulcer.*She was not aware that the size of resident 5's pressure ulcer had increased in size between his weekly skin assessments.*She acknowledged that ensuring the barrier cream was applied after his incontinent episodes, the CNAs were made aware through his care plan to assist resident 5 with repositioning, and the cushion was placed in his wheelchair upon his admission to the facility could have potentially prevented resident 5 from developing the pressure ulcer.8. Review of the provider's 2/17/25 Pressure Ulcers policy revealed Based on the resident's comprehensive assessment, the location will use prevention and assessment interventions to assure that a resident entering the location without pressure ulcers does not develop a pressure ulcer unless the individual's clinical condition demonstrates that this was unavoidable.9. Review of the provider's 12/8/25 Skin Assessment Pressure Ulcer Prevention and Documentation policy revealed:* Any resident at risk [for developing a pressure ulcer] will be placed on a pressure redistribution surface as determined appropriate.* When a pressure ulcer is present, complete the Wound Data Collection UDA [user defined assessment] daily, documentation should include the following:-An evaluation of the ulcer, if no dressing is present .-The presence of possible complications, such as signs of increasing area of ulceration or soft tissue infection.* If the pressure ulcer is not determined to be clinically unavoidable, the ulcer should show signs of improvement within two to four weeks. Signs of improvement might include decrease in size of the wound (length times width), decrease in the amount of exudate [drainage] and improvement in the tissue type.* Observations of the ulcer's characteristics may be documented by a licensed nurse and should include at least the following:-Measurements - length, width, depth-Characteristics of the ulcer - including wound bed, undermining, and tunneling, exudate, surrounding skin, etc.-Presence of pain-Current treatments.

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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 record review, interview, and policy review, the provider failed to ensure the resident's baseline care plan (personalized plan that addresses a resident's care needs, goals, and interventions) was reviewed with, and a copy was provided to the resident and the resident's representative according to the provider's policy within 48 hours of the resident's admission to the facility for four of five newly admitted sampled residents (2, 5, 19, and 24). Findings include: 1. Review of resident 19's electronic medical record (EMR) revealed: *She admitted to the facility on [DATE] and the development of her baseline care plan was initiated. *Her baseline care plan was reviewed with her on 1/13/25, four days after she admitted to the facility. *There was no documentation that a copy of resident 19's baseline care plan was provided to her and her representative. 2. Review of resident 2's EMR revealed: *He admitted to the facility on [DATE], and the development of his baseline care plan was initiated. *His baseline care plan was not reviewed and acknowledged by resident 2 or his representative until his 11/5/25 care conference meeting, 20 days after he was admitted to the facility. 3. Review of resident 5's EMR revealed: *He admitted to the facility on [DATE]. *His baseline care plan was initiated on 12/17/25. *His baseline care plan was emailed to his representative on 12/31/25, 15 days after he admitted to the facility. *There was no documentation that resident 5 BCP was provided a copy of his baseline care plan. 4. Interview on 2/17/26 at 4:00 p.m. with resident 24 revealed: *She admitted to the facility about a month ago. *She did not remember anyone talking to her about her personal care needs or her individual goals when she admitted to the facility. *She did not remember being offered a copy of her baseline care plan when she admitted to the facility. 5. Review of resident 24's EMR revealed: (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She admitted to the facility on [DATE]. *Her 1/26/26 Brief Interview for Mental Status (BIMS) assessment score was 10, which indicated she had moderate cognitive impairment. *Her baseline care plan was initiated on 1/21/26. *Her baseline care plan was provided to her representatives on 1/27/26, seven days after she admitted to the facility. *There was no documentation that resident 24 was provided a copy of her baseline care plan. 6. Interview and review of the residents' baseline care plans on 2/20/26 at 12:53 p.m. with administrator A and director of nursing (DON) B revealed: *The nurse who admitted the resident would initiate the resident's baseline care plan. *The admitting nurse or the interdisciplinary team (nursing, activities, social services, and dietary staff) was responsible for editing the resident's baseline care plan to reflect that resident's individual care needs and goals. *DON B stated the baseline care plan was to be completed within 48 hours of the resident's admission to the facility. *Neither administrator A or DON B were aware that the resident's baseline care plan was required to be reviewed with, and a copy offered to the resident or the resident's representative within 48 hours of admission to the facility. *They acknowledged the baseline care plans for residents 2,5,19, and 24 were not reviewed with, and a copy offered to the resident or resident's representative within 48 hours of admission to the facility. 7. Review of the provider's 12/1/25 Care Plan policy revealed: *Baseline care plan – Includes instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. *Person-centered care – A focus on the resident as the locus of control and supporting the resident in making his or her own choices and having control over their daily life. *A baseline care plan will be developed upon admission according to federal and state regulations. The location must provide the resident and resident representative with a written summary of the baseline care plan.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and policy review, the provider failed to ensure the staff followed professional standards of practice related to respiratory care for:*Cleaning and storing nebulizer equipment (a device used when using a nebulizer machine that converts liquid medication into an inhalable mist) for three of three sampled residents (13, 19, and 28) who used nebulizer machines.*Cleaning the Continuous Positive Airway Pressure (CPAP) machine (a device that uses air pressure to keep breathing airways open) for one of one sampled resident (13) who used a CPAP machine.*Cleaning and storing oxygen equipment for four of four sampled residents (13, 19, 28, and 29) who used oxygen.Findings included:1. Observation on 2/17/26 at 12:38 p.m. of resident 29's room revealed: *She had an oxygen concentrator (a device that filters room air into purified oxygen) beside her bed. *Her nasal cannula (flexible tubing with prongs that delivers oxygen through the nose) was draped over that concentrator. *That nasal cannula was not dated with the date it had been replaced. *The oxygen concentrator filters and the covers that hold the filters in place were missing on both sides of the concentrator. Observation on 2/18/26 at 3:17 p.m. of resident 29's room revealed: *Resident 29 was lying in her bed. *She was wearing an undated nasal cannula that was attached to the concentrator beside her bed. *There was an undated nasal cannula hanging on the handle of her wheelchair that was attached to a portable oxygen tank. Review of resident 29's electronic medical record (EMR) revealed: *She admitted to the facility on [DATE]. *Her 1/22/26 Brief Interview for Mental Status (BIMS) assessment score was 7, which indicated she had severe cognitive impairment. *She had a 12/29/25 physician's order for Oxygen at 3 LPM [liters per minute] continuously per nasal cannula. *There was no order for her nasal cannula to be replaced and dated, which would indicate to the nursing staff when to change the nasal cannula. *There was no documentation that supported when her nasal cannula was replaced in her EMR. 2. Observation and interview on 2/17/26 at 1:52 p.m. with resident 13 in his room revealed: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Resident 13 was sitting in his wheelchair and independently wheeling himself to his door. *Resident 13 had an oxygen concentrator beside his bed. *Resident 13's CPAP and nebulizer machines were stored on top of his three-drawer wood dresser beside his bed. *A black mesh bag was taped to the top drawer of the wood dresser, dated 1/26. *His oxygen tubing, CPAP hose, and mask attached to the concentrator machine were dated 12/1/25. -The CPAP mask was stored in the black mesh bag. *His nebulizer mask was dated 2/9/26. *The nebulizer mask and tubing were stored in the black mesh bag. Observation on 2/18/2026 at 4:57 p.m. in resident 13's room revealed: *His CPAP mask, dated 12/1/25, was hanging over the top drawer of the wood dresser next to his bed. *Resident 13's CPAP mask and connection hose were secured with clear medical tape at their connection point and the tape was wrapped down the hose approximately six inches. -The tape was coming loose in areas and was visibly soiled with small fibers, debris, and dust that adhered to its sticky side. -The non-sticky side of the tape was discolored and light brown in color. *The filter on his concentrator machine contained dust fibers and lint. *Resident 13's assembled nebulizer mask was lying on his bed with clear liquid in the medicine chamber of the nebulizer mask. Review of resident 13's EMR revealed: *He admitted to the facility on [DATE]. *His 12/23/25 BIMS assessment score was 11, which indicated he had moderate cognitive impairment. *Resident 13 had a 7/2/25 physician's order to Change O2 [oxygen] and neb mask weekly on Monday one time a day. *Resident 13 had a 7/2/25 physician's order to Clean CPAP every morning one time a day. *There was no order for his nebulizer mask to be cleaned daily. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*There was no order for his concentrator filter to be cleaned or replaced. *There was no documentation of the nebulizer mask being cleaned in his EMR. *There was no documentation of the concentrator filter being cleaned or replaced in his EMR. Observation and interview on 2/18/26 at 5:21 p.m. with director of nursing (DON) B in resident 13's room revealed: *She stated, It does not appear that his c-pap mask is getting removed and cleaned daily. *She acknowledged that clear medical tape had been used to secure the hose and mask together and that the tape was visibly soiled. *She acknowledged that resident 13's oxygen tubing and CPAP mask had a date of 12/1/25, had no staff initials written on it, and was not stored in the black mesh bag. *She acknowledged that resident 13's concentrator filter was visibly soiled with dust fibers and lint. *She acknowledged that resident 13's CPAP mask was hanging over the top drawer of the wood dresser and contained a clear liquid in the cup of the nebulizer mask. *She acknowledged that the staff had not cleaned the nebulizer mask after his scheduled nebulizer treatment at 4:00 p.m. and that the nebulizer mask was not stored in the black mesh bag. 3. Observation on 2/17/26 at 1:53 p.m. of resident 19's room revealed: *Resident 19 was lying in her bed. *She was wearing a nasal cannula attached to an oxygen concentrator beside her bed. *There was a nebulizer machine on her bedside table with an assembled nebulizer mask lying on top of the machine. *There were drops of clear liquid in the cup of the nebulizer mask. Observation on 2/17/26 at 2:37 p.m. of resident 19's room revealed an undated nasal cannula lying on the floor beside resident 19's bed. Observation on 2/18/26 at 3:22 p.m. of resident 19's room revealed an undated nasal cannula hanging on the side rail of her bed. Observation and interview on 2/20/26 at 9:15 a.m. with resident 19 in her room revealed: *Her nasal cannula and nebulizer mask were stored in a black bag attached to her bedside table. *Resident 19 stated she did not have a bag to store her nasal cannula in until yesterday (2/19/26). Review of resident 19's EMR revealed: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She admitted to the facility on [DATE]. *Her 12/29/25 BIMS assessment score was 13, which indicated her cognition was intact. *She had a 1/9/25 physician's order to Change label date oxygen tubing and neb tubing weekly every evening shift every Mon [Monday]. 4. Observation on 2/17/26 at 1:58 p.m. of resident 28's room revealed: *Resident 28 had a nebulizer machine with an assembled nebulizer mouthpiece and tubing lying on his bedside table. *His nebulizer tubing was not dated, and the mouthpiece was dated 1/3/26. *The nebulizer machine was visibly dusty. Observation and interview on 2/18/26 at 10:32 a.m. in resident 28's room revealed: *Resident 28 was sitting on the edge of his bed. *The nebulizer machine with the same assembled nebulizer tubing and mouthpiece remained on his bedside table. *Resident 28 did not know how often the nebulizer tubing and mouthpiece should be replaced. *Resident 28 said he did not use the nebulizer with the mouthpiece for a few weeks and only used it when needed. *Resident 28 said he did not have a storage bag for the nebulizer tubing and mouthpiece to store it in when it was not in use. Review of resident 28's EMR revealed: *He admitted to the facility on [DATE]. *His 12/20/25 BIMS assessment score was 15, which indicated his cognition was intact. *Resident 28 had a 12/30/25 physician's order to administer Albuterol Sulfate Inhalation Nebulization Solution - one inhalation orally every four hours as needed for cough/congestion. *There was no order for his nebulizer tubing and mouthpiece to be cleaned or replaced. *There was no documentation of the replacement of his nebulizer tubing and mouthpiece in his EMR. Interview on 2/18/26 at 5:13 p.m. with DON B in resident 28's room revealed: *She stated that resident 28's nebulizer tubing and mouthpiece were packaged together as one unit. *She said that the nebulizer tubing and mouthpiece unit was supposed to have one date and staff (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	initials written on it when it was replaced. *She acknowledged that resident 28's nebulizer tubing and mouthpiece unit was dated 1/3/26 and had no staff initials written on it. *She acknowledged that resident 28's nebulizer machine was visibly dusty, and his nebulizer tubing and mouthpiece unit were not stored in a storage bag. 5. Interview on 2/19/26 at 10:29 a.m. with certified nursing assistant (CNA) H revealed: *Resident 29 required staff assistance to put on, remove, and store her nasal cannulas. *Nasal cannulas that were not being used were to be stored in a bag in the resident's room. *Resident 19 was able to apply, remove, and store her nasal cannula and nebulizer equipment independently. *CNA H acknowledged that resident 19 would not be able to store her nasal cannula or nebulizer equipment in a bag if there was not a bag provided for her in her room. 6. Interview on 2/19/26 at 2:17 p.m. with CNA/UAP I revealed: *She said UAP's were responsible for cleaning the resident's nebulizer mask after each use. *She stated that the mask or mouthpiece was to be rinsed with water and then placed on a clean paper towel to air dry after each use. *She said nebulizer tubing and masks were to be replaced every week on Mondays and dated. 7. Interview on 2/20/26 at 9:20 a.m. with CNA/unlicensed assistive personnel (UAP) I revealed: *The UAPs were responsible for replacing the residents' nasal cannulas and nebulizer masks weekly on Mondays. *After replacing the nasal cannulas and nebulizer masks she would document those replacements on the resident's TAR. *If the replacement of the resident's nasal cannulas and nebulizer masks were not on the TAR she would replace them but the replacement would not be documented. *She stated the staff know who received oxygen and nebulizer treatments, so they knew who had nasal cannulas and nebulizer masks that needed to be replaced weekly even if it was not on a resident's TAR. 8. Interview on 2/20/26 at 12:53 p.m. with DON B revealed: *The CPAP masks and tubing were to be washed out daily and replaced according to the manufacturer's instructions. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society Miller	421 East 4th St Miller, SD 57362

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Nasal cannulas and nebulizer masks were to be replaced weekly. *The replacement of the nasal cannulas and nebulizer masks was to be documented in that resident's MAR or TAR. *When the residents' nasal cannulas and nebulizer masks were not in use they were to be stored in the black bags in the resident's room. *DON B acknowledged that nasal cannulas were at risk of being contaminated when they were hung on wheelchairs, oxygen concentrators, or bed rails. *Oxygen concentrator filters were to be cleaned at least monthly and placed back on the concentrator. 9. Review of the provider's 7/30/25 Oxygen Administration policy revealed: *All oxygen therapy equipment will be clean, safe and functional. *When oxygen is not in use, store cannula, face mask or face tent and tubing in zip-lock bag/plastic bag secured to the oxygen cylinder or concentrator. *Disposable equipment should be changed weekly or according to manufacturer's instructions and marked with date and initials. *Change filters between resident uses. *Clean filters according to manufacturer's instructions. 10. Review of the 2022 DeVilbiss 5-Liter Oxygen Concentrator Instruction Guide revealed: *A mask or any nasal cannula can be used with continuous flow delivery and may be sized according to our prescription as recommended by your homecare provider who should also give you advice on the proper usage, maintenance and cleaning. *Individual maintenance requirements may vary based upon local operating conditions, regulations, or other circumstances. *Clean and replace the cannula/mask, tubing, and humidifier bottle according to the manufacturer's instructions. *Check to be sure the cabinet air filter (if applicable) and the intake filter are in place. *Inspect the vents periodically, and wipe with a dry cloth as needed to remove dust. *Cleaning: -Outer Cabinet – 7 days -Water, use only a damp cloth. -Filter Door Vents – 7 days – Wipe with dry cloth, or a cloth dampened with water to (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	remove dust. 11. Review of the provider's 12/10/25 Nebulizer policy revealed: *Following medication administration clean nebulizer after each use: . 4. Separate the nebulizer parts (mask/mouthpiece, cup) and wash in warm soapy water and rinse thoroughly. 6. Place mask or mouthpiece and cup on a paper towel and air-dry until the next use. Cover with clean cloth or towel. 12. Review of the undated Power Neb Ultra Compressor Nebulizer Instruction Guide revealed: *Clean After Every Use: -Disassemble mouthpiece or mask from cap. -Wash all items, except tubing, in a hot water/dishwashing detergent solution. Rinse under hot tap water for 30 seconds to remove detergent residue. Allow to air dry. *Disinfect Daily: -Using a clean container or bowl, soak items in three parts hot water to one part white vinegar for 30 minutes OR use a medical bacterial-germicidal disinfectant available through your provider. Be sure to follow manufacturer's instructions carefully. -With clean hands, remove items from disinfectant solution, rinse under hot tap water, and air dry on a clean paper towel. Store in a zip-lock bag. *Do not towel dry nebulizer parts; this could cause contamination. 13. Review of the undated ResMed AirCurve 10 CPAP User Guide revealed: *You should clean the device weekly as described. *Wash the water tub and air tubing in warm water using only mild detergent. *Rinse the water tub and air tubing thoroughly and allow to dry out of direct sunlight and/or heat. *Wipe the exterior of the device with a dry cloth. *Check the air tubing and replace it if there are any holes, tears or cracks. *Check the air filter and replace it at least every six months. Replace it more often if there are any holes or blockages by dirt or dust. -The air filter is not washable or reusable. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Clean the mask daily by soaking the cushion and frame in warm, soapy water (mild detergent) for 5-10 minutes, then rinse thoroughly and air dry out of direct sunlight. *Hand wash the headgear and any soft sleeves in warm, soapy water, then air dry weekly. *Clean the air tubing in warm soapy water, rinse thoroughly, and hang to dry weekly. *Check the air tubing and mask for cracks, tears, or hardening components weekly and replace as needed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to maintain a system to account for all controlled (medications with risk for abuse, addiction, and potential theft) medications for one of two observed medication carts and for one of one treatment cart in the East hall, and to document medications related to their receipt, counts, administration details, and destruction process. Findings include:1. Review of the February 2026 Controlled Drugs Count Record on the treatment cart revealed: *There were three headings labeled 7-3 Shift, 3-11 Shift, and 11-7 Shift. *Below heading were columns labeled Nurse Off, Nurse On, and Card or prescription count. *The controlled drug count was signed off by one nurse as the on-coming nurse under the 7-3 heading and the off-going nurse under the 11-7 heading on 2/1/26, 2/2/26, 2/4/26, 2/6/26, 2/10/26, 2/11/26, and 2/14/26. *The controlled drug count was not completed the entire day on 2/3/26, 2/12/26, 2/13/26, 2/18/26, and 2/19/26. *The controlled drug count was signed off by one nurse as the 7-3 on-coming nurse and the 3-11 off-going nurse on 2/5/26 with no documentation under the 11-7 heading. *On 2/7/26 the controlled drug count was signed off by one nurse as the on-coming nurse under the 7-3 heading and no other signatures were documented that day. 2. Review of resident 3's Individual Resident Narcotic Record forms from 12/21/25 through 2/19/26 revealed: *From 12/21/25 to 1/18/26 there were three pages labeled as resident 3's alprazolam (a medication used to treat anxiety) Individual Resident's Narcotic Records, one labeled a.m., one labeled noon, and one labeled 8:00 p.m. These forms did not have documented on them the medication form, the method of administration, the medication dosage, the prescription number, or the pharmacy name. -There were no times documented when the alprazolam was removed from locked storage to be administered to resident 3 for any of the dates on the a.m. or noon record. -There was no time documented when the alprazolam was removed from locked storage to be administered to resident 3 on 12/22/25 on the 8:00 p.m. record. -On 12/28/26 there was no documentation of an alprazolam having been removed from locked storage to be administered at 8:00 p.m. *From 1/19/25-2/15/26 there were three pages labeled as resident 3's alprazolam Individual Resident's Narcotic Records, one labeled a.m., one labeled noon, and one labeled p.m. These forms did not have documented on them the medication form, the method of administration, the medication dosage, or the pharmacy name. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There were no times documented when the alprazolam was removed from locked storage to be administered to resident 3 for any of the dates on the a.m. or noon record from 1/19/26 to 2/11/26. - On 1/25/26 and 2/6/26 there was no documentation of an alprazolam having been removed from locked storage to be administered at 8:00 p.m. -On 1/28/26 an alprazolam was documented as having been removed at 7:45 a.m. The a.m. and noon alprazolam Individual Resident's Narcotic Records did not have times documented when the medication was removed from the locked storage for administration to determine if the 8:00 p.m. alprazolam had been removed from the a.m. or noon medication card. -On 1/31/26 on the p.m. alprazolam Individual Resident's Narcotic Record, it was documented that there were 17 remaining. --The next entry was dated 2/2/26 and it was documented that there were 18 on hand, one was administered, and the remaining was documented as 16. --The next entry is dated 2/1/26, there was no number in the amount on hand column, one was administered, and it was documented there were 15 remaining. -On the bottom of Resident 3's p.m. alprazolam Individual Resident's Narcotic Records it was documented that on 2/17/26 three tablets were returned to the retail pharmacy for repackaging. * From 1/19/25-2/15/26 there were three pages labeled as resident 3's alprazolam Individual Resident's Narcotic Records, one labeled a.m., one labeled noon, and one labeled H.S (bedtime). These forms did not have documented on them the medication form, the method of administration, the medication dosage, or the pharmacy name, or resident 3's name or sticker. -There was no time documented when the controlled medication was removed from locked storage to be administered to resident 3 on 2/19/26 on the noon record. 3. Observation and interview on 2/17/26 at 1:09 p.m. with resident 3 in his room revealed: *He had a feeding tube (a tube surgically placed through the abdomen into the stomach to administer liquid nutrition, fluids and medications). *He waved when surveyor entered the room. *He gave a thumbs up when asked how he was doing. *His verbalizations were grunting noises. 4. Review of resident 3's electronic medical record (EMR) revealed: *He was admitted on [DATE]. *His diagnoses included depression, anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), diabetes (a condition involving disruptions in how the body regulates blood sugar), traumatic brain injury without return to (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pre-existing conscious level (damage to the brain resulting from an external force resulting in permanent impairment in cognitive, physical, and emotional function), and post traumatic seizures. *Review of resident 3's January 2026 and February 2026 medication administration record (MAR) revealed: -DuoNeb Solution (a medication used to open the airways and reduce mucous) four times daily by nebulizer (a device that converts liquid medication into an inhalable mist) for aspiration and was not documented as having been administered on 2/4/26, 2/7/26, and 2/18/26 at 4:00 a.m., 2/4/26, and 2/15/26 at 12:00 p.m., 2/8/26 at 4:0 p.m., and 1/14/26, 1/22/26, 2/7/26, 2/9/26, and 2/12/26 at 8:00 p.m. -Reglan (a medication used to treat heartburn) 10 mg (milligrams) before meals and at bedtime was not documented as having been administered on 2/15/26 at 11:00 a.m., 2/8/26 at 4:00 p.m., and 1/22/26 and 2/9/26 at 9:00 p.m. -Tylenol 1000 mg three times daily for pain was not documented as having been administered on 2/15/26 at 12:00 p.m. and 1/22/26 and 2/9/26 at 8:00 p.m. -Alprazolam 0.25 mg three times daily was not documented as having been administered on 2/15/26 at 12:00 p.m., and 1/22/26, 1/26/26, 2/6/26, and 2/9/26 at 8:00 p.m. --On 1/22/26, 1/26/26, and 2/9/26 resident 3's 8:00 p.m. dose of alprazolam and on 2/15/26 resident 3's 12:00 p.m. dose of alprazolam was documented as having been removed from the locked storage for controlled medication but not documented as having been administered on resident 3's MAR. --On 1/25/26 at 8:00 p.m. resident 3's alprazolam was documented as having been administered on his MAR but was not documented as having been removed from the locked storage for controlled medications. --On 2/6/26 at 8:00 p.m. resident 3's alprazolam was not documented as having been removed from the locked storage for controlled medications to be administered and was not documented as having been administered to him in his MAR. -Simethicone (a medication used to treat gas and bloating) 80 mg three times daily was not documented as having been administered on 2/15/26 at 12:00 p.m. and 1/22/29 and 2/9/26 at 8:00 p.m. -Topamax (a medication to treat seizures and headaches) 50 mg two times daily was not documented as having been administered on 1/22/26 and 2/9/26 at 8:00 p.m. -Valproic acid (a medication for seizure prevention) 250 mg/ml (milligrams per milliliter) give 25 ml two times per day was not documented as having been administer on 1/22/26 and 2/9/26 at 8:00 p.m. -Lispro insulin (a fast-acting insulin used to lower blood sugars) sliding scale (the dose depends on the person's blood sugar level) two times daily was not documented as having been administered on 2/4/26, 2/7/26, 2/10/26, and 2/18/26 at 4:00 a.m. and on 1/27/26, 2/8/26, and 2/12/26 at 4:00 p.m. --Resident 1's blood sugar was not documented as having been taken on 1/27/26 at 4:00 p.m., 2/4/26 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 4:00 a.m. or 4:00 p.m., 2/7/26 at 4:00 a.m., 2/8/26 at 4:00 a.m. or 4:00 p.m., 2/10/26 at 4:00 a.m., 2/12/26 at 4:00 p.m., and on 2/18/26 at 4:00 a.m. -Levetiracetam (a medication for seizure prevention) 100 mg/ml give 15 ml two times daily was not documented as having been administered on 1/22/26 and 2/9/26 at 8:00 p.m. -Guaifenesin (a medication for cough and congestion) 200 mg/5ml give 10 ml two times daily was not documented as having been administered on 1/22/26 and 2/9/26 at 8:00 p.m. -Augmentin (an antibiotic) 400-57 mg/ml give 10 ml two times daily for 10 days was not documented as having been administered on 1/28/26 during the PM medication pass. -Melatonin (a medication used to aid sleep) 6mg one time daily was not documented as having been administered on 1/22/26 and 2/9/26 at 8:00 p.m. -Mirtazapine (a medication used to treat depression) 20 mg one time daily was not documented as having been administered on 1/22/26 and 2/9/26 at 8:00 p.m. -Basaglar insulin (a long-acting insulin used to lower blood sugars) 20 units one time daily was not documented as having been administered on 1/22/26, 1/26/26, 2/6/26, and 2/9/26 during the HS [bedtime] medication pass. -On 1/8/26 at 11:56 a.m. Morphine sulfate (a narcotic used to treat severe pain) 20 mg/ml give 0.25 ml was documented as having been removed from the locked storage for controlled medications but it was not documented as having been administered in resident 3's MAR. 5. Observation and interview on 2/19/26 at 2:33 p.m. with certified nurse aide(CNA)/unlicensed assistive personnel (UAP) I of a binder labeled Narcotic Binder on the east medication cart revealed: *CNA/UAP I stated that the residents' controlled medications were sent from the pharmacy in bubble pack medication cards and stored in a locked box in a locked drawer in each medication cart. *She said the nurse and UAPs were to count the residents' controlled medications at each shift change, and both were to sign as complete with no discrepancies on the narcotic inventory records. *The controlled medication count for each medication cart was to be completed at every shift change by the on-coming and off-going nurses and UAPs. *When the nurses and UAPs signed the residents' narcotic inventory records, it would indicate that the controlled medications were counted, and the medication counts were accurate. *The residents' controlled medications were stored in the east medication cart within the locked drawer and in a locked compartment. *She said that if a controlled medication count was off, she was to notify the nurse and the director of nursing (DON) B, and they would investigate what could have happened. *Review of the East medication carts Controlled Drug - Count Record inventory sheet for February 2026 revealed 48 out of 116 missing signatures. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She acknowledged that there were missing signatures on the February 2026 inventory sheet for the East medication cart. 6. Review of the East medication carts Controlled Drug – Count Record inventory sheets for November 2025, December 2025, and January 2026 for the East medication cart revealed: -November 2025 had 17 missing signatures out of 180 opportunities. -December 2025 had 28 missing signatures out of 186 opportunities. -January 2026 had 62 missing signatures out of 186 opportunities. 7. Observation on 2/19/26 at 2:37 p.m. with CNA/UAP I with the count of the controlled medications locked in the East medication cart revealed that resident 1 had: *A bubble pack medication card dated 2/3/26 that had a pharmacy label reading Pregabalin 150 mg (milligram) capsules, and to take 1 capsule by mouth two times a day. [a.m. and p.m.]. *The Controlled Drug – Count Record inventory sheet identified that the facility received 12 Pregabalin 150 mg capsules from the pharmacy on 2/3/26 that were to be given to him in the mornings. *It was documented on 2/10/26 at 8:32 a.m. that resident 1 received 1 Pregabalin 150 mg capsule, leaving 5 Pregabalin 150 mg capsules remaining. *Resident 1 was transferred to a local hospital on 2/10/26 at 12:54 p.m. and did not receive another dose of that controlled medication as he had not returned to the facility. *It was observed during the controlled medication count that resident 1's a.m. bubble pack medication card, which contained his Pregabalin 150 mg capsules, recorded a remaining count of 4 capsules. *CNA/UAP I acknowledged that resident 1's a.m. bubble pack medication card count for his Pregabalin 150 mg capsules was short by 1 capsule. *CNA/UAP I said she did not know anything about the discrepancy and would need to report the information to DON B immediately. *CNA/UAP I acknowledged that she and the nurse going off shift counted all the residents' controlled medications in the East cart and said all the counts were accurate that morning. 8. Observation and interview on 2/19/26 at 2:42 p.m. with DON B and CNA/UAP I revealed: *The residents' controlled medications were stored in the east medication cart within the locked drawer and in a locked compartment. *DON B acknowledged that resident 1's a.m. bubble pack medication card count for his Pregabalin 150 mg capsules was short by 1 capsule *DON B and CNA/UAP I searched the East medication cart and surrounding areas for resident 1's (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	missing capsule of Pregabalin and were unable to locate it. *She said the nurse and UAPs were to count the residents' controlled medications at each shift change, and both were to sign off on the narcotic inventory records. *The controlled medication count for each medication cart was completed at every change of shift by the nurses and UAPs. *When the nurses and UAPs signed the residents' narcotic inventory records, it would indicate that the controlled medications had been counted, and the medication count was accurate. *DON B stated that if there was an incorrect count, the nurse or UAP would notify her immediately, and she would investigate. *DON B stated that usually the counts were off due to a nurse or UAP adding and/or subtracting incorrectly after administering a dose. *DON B said she was going to review the camera footage and notify the pharmacist. 9. Interview on 2/19/26 at 3:00 p.m. with DON B revealed: *DON B expected that each nurse and UAP would check their own charting for completion before they left their shifts. *She acknowledged that there were multiple missing signatures on the Controlled Drug – Count Record inventory sheet from November 2025 through February 2026 for the East medication cart, which could indicate that the counts had not been completed. *She acknowledged that with the staff not counting the controlled medications at every change of shift by the on-coming and out-going nurse or UAP could increase the risk of drug diversion, and it would make it difficult to determine when the controlled medication went missing. 10. Interview on 2/19/26 at 3:20 p.m. with administrator A revealed: *He was notified by DON B that they were unable to locate resident 1's missing medication capsule and that he was reporting the incident to the SD DOH as it was a reportable incident per their facility policy. 11. Interview on 2/19/26 at 4:07 p.m. with RN K revealed: *She stated resident 3 had a few medications that were in pill form, that were to be crushed and administer through his feeding tube, but most of his medications were liquid. *The pills were sent out through a scheduled monthly refill and the pills are administered from the bubble pack number that corresponds with the date, so those would be more obvious if a medication was not punched out of the medication card. *RN K stated the liquid medications and insulin would be more difficult to determine if a scheduled medication administration had been missed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*If she identified a medication was not administered, she would fill out a medication error form and notify that resident's provider. Review of the provider's medication error reports from September 2025 through 2/19/26 revealed there were no medication error reports completed for resident 3. 12. Phone interview on 2/20/26 at 8:15 a.m. with retail pharmacist S revealed: *He said that he was at the facility monthly and that the pharmacy delivered resident medications on a daily basis with provider orders and provided the scheduled monthly medication bubble pack cards for all the residents. *He said that he contracted a pharmacist to provide the facility with a consultant pharmacist to review resident charts every month and said that they shared responsibilities. *He said they checked the emergency medication kit, medication carts, and medication storage room for expired medications when they were at the facility. *He said that he had not reviewed medication error or incident reports involving missing medications for the provider, but that DON B would notify him of incidents and discrepancies. *He would not be able to determine if resident 3's liquid medications and insulin were being used at an expected rate because those medications are on a routine refill schedule to avoid resident 3 running out of those medications. 13. Interview on 2/20/26 at 9:20 a.m. with CNA/UAP I revealed: *All of resident 3's medications were administered by nurses because they were administered through his feeding tube. *If a resident's medication was not documented as having been administered in that resident's MAR, she would assume that medication had not been administered because the medications should be signed off as administered in the resident's MAR immediately after they were administered to that resident. 14. Interview on 2/20/26 at 9:30 a.m. with DON B revealed: *DON B said that the camera footage confirmed that licensed practical nurse (LPN) T and CNA/UAP I completed the controlled medications count of the East cart the morning of 2/19/26 at 6:30 a.m. *The camera footage confirmed that CNA/UAP I counted the medications and LPN T acknowledged the count from the Controlled Drug – Count Record inventory sheets. *DON B said that she called LPN T during her investigation, and she stated that LPN T did not recall the exact remaining amount of resident 1's Pregabalin medication on the morning of 2/19/26. *DON B said she educated LPN T and CNA/UAP I on 2/19/26 and that during the count, they both were to look at the medication cards and narcotic inventory sheets together for accuracy and confirmation of correct counts. (continued on next page)

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Good Samaritan Society Miller	421 East 4th St Miller, SD 57362

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*DON B said she did not know when resident 1's medication went missing or what had happened with it. 15. Interview on 2/20/26 at 10:28 a.m. with RN K revealed: *This was her fifth shift at that facility. *She had not checked in medications from the pharmacy. *The controlled medication count was to be completed at every change of shift by the nurses and UAPs. *The nurse worked 12-hour shifts so the controlled medication count on the treatment cart would be twice daily. *When the nurses and UAPs signed the Controlled Drugs Count Record it would indicate the controlled medications had been counted and the medication count was accurate. *If the controlled medication count was not accurate, she would not let any staff member leave and would search for the missing medication. *She acknowledged that resident 3's alprazolam Individual Resident's Narcotic Record did not have his name on them, and she would not be able to identify whose forms those forms were if they were not on the treatment cart, because he was the only resident whose medications were stored in that cart. *If a resident's medication was not administered at its designated time the medication would display red on the MAR to alert the nurse or UAP that the medication was not administered or if it was it was not documented. *If she noticed that there were medications that had not been documented as administered, she would notify her supervisor. 16. Interview on 2/20/26 at 11:02 a.m. with CNA/UAP L revealed: *She had received medications from the pharmacy delivery person and compared the medication list against the medications that were received from the pharmacy with the pharmacy delivery person. *When a controlled medication was received she would put the resident's name or a resident sticker on a Individual Resident's Narcotic Record and complete the documentation related to the medication such as the name of the medication, dose of the medication, the administration instructions, the prescription number, the amount of the medication that was received, and the date the medication was received. 17. Interview on 2/20/26 at 12:53 p.m. with director of nursing (DON) B revealed: *The pharmacy brings the medications to the facility. *The pharmacy delivery person and the nurse or UAP review the list of medications sent to the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility and compare it to the medications that were received. *If the list and the medications received match the pharmacy delivery person and the nurse or UAP sign that the medications sent were received and each keep a copy of the receipt. *The nurse or the UAP filled out the information related to the medication and the resident on the Individual Resident's Narcotic Record for each controlled medication that was received. *DON B expected the nurse or UAP to complete the medication name, medications strength, medication form, method of administration, medication dosage, the prescription number, the pharmacy name, the date the medication was received, and the amount received, as well as the resident's name or a resident sticker on the Individual Resident's Narcotic Record. *DON B acknowledged there was missing information related to the medication information and resident's name on the Individual Resident's Narcotic Records. *The controlled medications were to be counted by the on-coming and off-going nurse or UAP at every shift change. *After the controlled medications were counted both nurses or UAPs were to sign the Controlled Drugs Count Record, which indicated the controlled medication count had been completed and the count was accurate. *If the count was not accurate the nurse was to notify DON B immediately and search for the missing controlled medication. *She acknowledged there were multiple shifts where the controlled medication count was not documented as having been completed and accurate. *She acknowledged that staff not counting the controlled medications at every change of shift by the on-coming and out-going nurse or UAP could increase the risk of drug diversion, and it would make it difficult to determine when the controlled medication went missing. *She acknowledged there were controlled substances removed from the medication cart, checked out on the Individual Resident's Narcotic Record and not documented as having been administered to the resident. *She acknowledged there were multiple doses of medications that were not documented as having been administered to resident 3. *She had not been aware of the undocumented medications. *She expected the nurses and UAP staff to review each resident's MAR to be sure all the medications for that shift had been administered and documented that they were administered. *She acknowledged that resident 3's sliding scale insulin dose would not be able to determine if his blood sugar had not been checked. *She acknowledged resident 3's medications that had not been documented as having been (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered to him, such as his insulin and seizure medications, could significantly affect his physical wellbeing. 18. Review of the provider's revised 7/30/25 Pharmaceutical Services – R/S, LTC policy revealed: *A licensed pharmacist will be employed to provide consultation on all aspects of pharmacy services. Establish a system of records of receipt and disposition of all controlled medications in sufficient detail to enable accurate reconciliation. *Determine that medication records are in order and that an account of all controlled medications is maintained and periodically reconciled. Report any irregularities to the attending physician or the director of nursing services or both. (These reports must be acted upon, and follow-up documentation maintained). 19. Review of the provider's revised 10/20/25 Medication: Missing/Diversion of Medication – R/S, LTC, AL policy revealed: *Upon discovery of a medication that may be missing or diverted, notify the Director of Nursing/AL Nurse. Document the incident in SAFE Event Reporting application. *If controlled medication is discovered missing during perpetual count, consider: Recount, Checking addition and subtraction from previous activity, check the outdated medications. *Nursing employees with access to the medication cart are asked to search the cart, their pockets and surrounding areas for the missing medications. *An investigation of the situation is performed by the investigation team. *Notify the administrator, the state survey and certification agency, law enforcement, and other designated agencies in accordance with state law of a medication diversion. 20. Review of the provider's revised 3/4/25 Medications: Acquisition, Receiving, Dispensing, and Storage – R/S, LTC policy revealed: *It Is preferred that a licensed nurse receive and verify the medications. Once the medications are received, they will be secured in the appropriate storage area (i.e., medication cart or medication room). Licensed nurses and medication aides (when allowed by state law) are responsible for reconciling medications received. *Disposal will be done in accordance with state/pharmacy regulations. *Controlled drugs (Schedule II) and other drugs subject to possible abuse will be stored in separate, locked, permanently fixed compartments, except when a single unit package drug distribution is used. These drugs will be reconciled daily through an appropriate system of records of receipt and disposition established by the licensed pharmacist.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the provider failed to ensure one of two sampled resident (4) who received an antipsychotic medications (a drug that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions) and a psychotropic medication (drugs that affect brain activities associated with mental processes and behavior) had an attempted gradual dose reduction (systemic dose reduction over time to determine if the condition could be managed with a lower dose or discontinuation of the medication) (GDR) or a physician's documented rationale to support that a GDR was clinically contraindicated (not appropriate based on the resident's condition, potential risks, or adverse effects) for the use of those medications. Findings include:1. Review of resident 4's electronic medical records (EMR) revealed:*He was admitted on [DATE].*His diagnoses included dementia (a group of symptoms affecting memory, thinking, and social abilities) with psychotic disturbance (a state of losing touch with reality) and residual schizophrenia (a chronic mental disorder that affects how a person thinks, feels, and behaves, causing a distorted sense of reality).*A 12/21/23 physician's order to be given two 50 milligram (mg) tablets of thioridazine hydrochloride (an antipsychotic) by mouth daily for schizophrenia and one 50 mg tablet of trazodone hydrochloride (an antidepressant) by mouth daily for insomnia (inability to sleep).*His 2/19/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) had a focus area that indicated The resident uses psychopharmacological medications [the use of medications to treat mental health disorders by altering brain chemistry] R/T [related to] schizophrenia, and insomnia. Takes antipsychotic and anti-depressant medication with an intervention to Consult with pharmacy, health care provider, etc. to consider dosage reduction when clinically appropriate.*Resident 4's consultant pharmacist recommendations from 12/30/23 through 1/29/26 did not include a GDR for resident 4's trazodone or thioridazine or documentation that a GDR reduction was clinically contraindicated by resident 4's physician since his admission to the facility.2. Interview on 2/20/26 at 8:52 a.m. with consultant pharmacist R revealed:*She reviewed all of the residents progress notes, labs, and medications monthly.*She spoke with staff to determine if there were any areas of concern related to medication use for that resident.*If she had any recommendations based on her record review and interviews with staff, she would document that in her consultant pharmacist progress note.*She stated the physicians were receptive to her recommendations and replied promptly to them.*She stated director of nursing (DON B) asked her about resident 4's GDR recommendation and she was unable to find that she had made that recommendation in his EMR.*The notes she made during her monthly medication review (MMR) stated in April 2025 that resident 4 needed to have a GDR recommended but she could not find where that recommendation was made and addressed by his physician.*If a resident was due for a GDR recommendation she would document that in her consultant pharmacist note for staff to address it with the resident's physician.3. Interview on 2/20/26 at 12:53 p.m. with DON B revealed:*Each month, consultant pharmacist R completed an MMR, for each resident.*During those MMRs, consultant pharmacist R reviewed when each resident was due for a GDR recommendation and documented that recommendation in her progress note.*DON B would then print consultant pharmacist R's progress note and give it to that resident's physician to document why or why not a GDR was clinically contraindicated.*DON B stated GDRs were to be recommended by the consultant pharmacist and addressed by the resident's physician quarterly for the first year after the resident's admission to the facility or after the medication was started, and annually after that.*She stated she was unable to find documentation that a GDR had been recommended for resident 4 or documentation from resident 4's physician that indicated a GDR was clinically contraindicated.4. Review of the provider's 12/9/25 Psychotropic Medications policy revealed:*Definition Graudal Dose Reduction The stepwise tapering of a dose to determine whether (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	symptoms, conditions or risks can be managed by a lower dose or whether the dose or medication can be discontinued.*Based on a comprehensive assessment of a resident, the location must ensure that:- Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.*The reduction committee will review the need for psychotropic medications at least every three months and document the rationale for continuing the medication.*The purpose of tapering medication is to find an optimal dose or to determine if continued use of the medication benefits the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolved and/or non-pharmacological interventions have been effective in reducing the symptoms.- Within the first year a resident is admitted on an antipsychotic medication or after the location has initiated an antipsychotic medication, the location must attempt a gradual dose reduction (GDR) in two separate quarters with at least one month between attempts, unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated.- The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the location and the physician has documented the clinical rationale for why any additional attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review the provider failed to ensure one of four sampled resident (3) who was recently admitted to hospice (specialized care for individuals with a terminal illness that focuses on comfort and quality of life rather than curative treatments) services had a significant change 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) completed within 14 days after the resident admitted to hospice.Findings include:1. Review of resident 3's electronic medical record (EMR) revealed:*He was admitted to the facility on [DATE].*He had a 10/15/25 physician's order for Hospice referral and admit if appropriate.*He was admitted to hospice services on 10/20/25.*His significant change MDS assessment was completed on 11/21/25, 32 days after he was admitted to hospice.2. Interview on 2/20/26 at 12:53 p.m. with administrator A revealed:*He expected the MDS coordinator to initiate significant change assessments.*The clinical team would discuss a resident who may qualify for a significant change MDS assessment during their daily meetings.*He was aware that a significant change MDS assessment needed to be completed when a resident was admitted to hospice, but he did not know how soon it needed to be completed after the resident's admission to hospice services.*He acknowledged that resident 3's significant change MDS assessment was not completed within 14 days after he admitted to hospice.*The provider's MDS coordinator was from the provider's corporate office and was not at the facility.*He felt resident 3's significant change MDS assessment had was missed during the transition from having an on-site MDS coordinator to an off-site corporate MDS coordinator.3. Review of the provider's 11/12/25 Hospice Provided Services policy revealed review of documentation for residents receiving Hospice Service.A significant change MDS was completed when the resident enrolled in a hospice program.m.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and policy review, the provider failed to ensure the care plan (personalized plan that addresses a resident's care needs, goals, and interventions) was reviewed and revised to reflect the current care needs for two of seventeen sampled residents (2 and 16).Findings include: 1. Interview on 2/20/26 at 9:25 a.m. with certified nursing assistant (CNA) H regarding residents' care needs revealed she would reference the residents' care plans or Kardex (a report of the resident's care needs and interventions) to know how to care for each resident. 2. Review of resident 2's electronic medical record (EMR) revealed:*His admission date was 10/16/25.*His 12/9/25 Brief Interview of Mental Status assessment score was a 7, which indicated his cognition was severely impaired.*His diagnoses included: dementia (a group of symptoms affecting memory, thinking, and social abilities), fracture of the right hip, insomnia, and heart failure.*His weight record included the following weights:*On 10/16/25, his weight was 147.0 lbs.*On 11/6/25, his weight was 157.0 lbs.*On 12/11/25, his weight was 149.0 lbs.*On 1/8/26, his weight was 169.0 lbs.*On 1/26/26, his weight was 151.5 lbs.*On 2/6/26, his weight was 139.5 lbs. 3. Review of resident 2's care plan revealed:*A 1/26/25 focus area that indicated The resident has unplanned/unexpected weight loss R/T [related to] (SPECIFY) E/B [evidenced by] (SPECIFY).-The goal for that focus area was the Resident will maintain weight between (SPECIFY: ____ and ____ lbs. [pounds]) by review date.-The intervention for that focus area was Weigh (SPECIFY FREQ. [frequency]). 4. Interview on 2/20/26 at 2:00 p.m. with director of nursing (DON) B and interim DON C regarding residents' care plans revealed:*When a resident had weight loss, it was to be addressed on that resident's care plan. She expected care plan prompts such as SPECIFY to be replaced with the resident's individualized status and needs. She acknowledged that resident 2's care plan regarding his weight loss was not individualized.*DON B stated she did not feel resident 2's weight loss was a true weight loss. She indicated he had edema (excess fluid) and took a diuretic to reduce fluid build-up, which would cause fluctuations in his weight. 5. Review of resident 16's EMR revealed:*She was admitted on [DATE].*Her 12/22/25 BIMS score was a 2, which indicated her cognition was severely impaired.*Her diagnoses included: anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), and chronic pain.*She had a physician's order for Haldol (brain-calming medicine that improves thinking, mood, and behavior and calms severe agitation) to be given before her bath. 6. Interview on 2/20/26 at 9:33 a.m. with CNA H regarding resident 16 revealed:*Resident 16 does not like her baths, and she received medicine to help her stay calm.-Resident 16 required two staff members to assist her with bathing, one to wash her and the other to keep her calm.-She was to receive a bath on Mondays and Thursdays and the medicine unless she is having a good day. 7. Review of resident 16's care plan revealed bathing interventions that included BATHING: Resident requires assist [assistance] of 1-2 [one to two] staff with bathing. Prefers 1 w/p [whirlpool] bath a week. No preference to time of day.-There was no indication on the care plan that resident 16 had behaviors with her bathing activity. 8. Interview on 2/20/26 at 10:43 with registered nurse (RN) K, regarding developing and updating a residents' care plan, revealed that she thought DON B completed a residents' admission and then developed the residents' care plan. 9. Interview on 2/20/26 at 1:53 p.m. with DON B and interim DON C regarding residents' care plans revealed:*Each department was to develop and edit the residents' care plan based on their assigned areas.*The Minimum Data Set (MDS) nurse would make changes to the resident's care plan after completing the MDS assessments (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs), and as the residents' care needs changed, and quarterly.-The MDS (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse worked remotely.-All of the nurses had access to update the residents' care plans, as the residents' care needs changed, and quarterly.*DON B expected resident 16's care plan to include interventions for her behaviors that occurred with bathing. 10. Review of the provider's 12/1/25 Care Plan policy revealed:*Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. Any problems, needs and concerns identified will be addressed through use of departmental assessments, the Resident Assessment Instrument (RAI) and review of the physician's orders.*This plan of care will be modified to reflect the care currently required/provided for the resident.*The care plan will emphasize the care and development of the whole person ensuring that the resident will receive appropriate care and services. It will address the relationship of items or services required and facility responsibility for providing these services.*The interdisciplinary team will review care plans at least quarterly. Care plans also will be reviewed, evaluated and updated when there is a significant change in the resident's condition.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure the staff members followed professional standards of care for:*The assessment, care, and accurate documentation regarding one of one sampled resident (4) with a newly placed suprapubic catheter (flexible tubing surgically placed in the bladder through the abdominal wall to drain urine).*Accurately entering physician's orders into the electronic medical record to ensure one of one sampled resident's (16) Haldol (medication for reducing symptoms of mental health conditions) was transcribed and administered as ordered. Findings include: 1. Observation and interview on 2/18/26 at 3:21 p.m. with resident 4 in his room revealed he: *Had a suprapubic catheter. *Did not know how long he had the suprapubic catheter but stated it had not been too long. 2. Review of resident 4's EMR revealed: *He was admitted on [DATE]. *His 12/22/25 Brief Interview for Mental Status (BIMS) assessment score was 12, which indicated his cognition was moderately impaired. *He had a 3/6/25 physician's order for an indwelling foley catheter [flexible tubing placed in the bladder to drain urine] to straight drainage. 18 FR [French: a standardized sizing system for urinary catheters] Coude tip [a specialized catheter with a curved tip]. *There was a 12/12/25 physician's order to Keep appointment with Urology on 12/16/25. They are to further discuss with Dr. [redacted name] possible placement of a suprapubic catheter. *His treatment administration record (TAR) had a 1/18/26 nursing order to, Cleanse supra pubic [suprapubic] catheter site with soap and water. Apply slit sponge [a gauze dressing with a cut through half of the gauze] and tape daily. The TAR indicated that was to be documented as completed daily at bedtime. -That treatment was not documented as completed on his TAR from 1/18/26 through 1/31/26 from 2/1/26 through 2/9/26, on 2/11/26, and on 2/12/26. *There was no documentation that resident 4 had a suprapubic catheter inserted and when that occurred. 3. Interview and record review regarding resident 4's suprapubic catheter on 2/20/26 at 8:02 a.m. with director of nursing (DON) B revealed: *On 2/18/26 she requested documentation related to resident 4's suprapubic catheter from the hospital where it was surgically placed. *On 2/20/26 administrator A received resident 4's history and physical examination documentation (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and a procedure note from the hospital regarding his suprapubic catheter placement. -That procedure note indicated resident 4 had his suprapubic catheter surgically placed on 1/15/26. -It did not include any instructions related to the care of the suprapubic catheter site or follow-up after the procedure. *DON B verified there were no discharge instructions provided by the hospital, as she requested on 2/18/26. 4. Interview and record review regarding resident 4's TAR on 2/20/26 at 10:28 a.m. with registered nurse (RN) K revealed: *Resident 4's suprapubic catheter site was scheduled on his TAR to be cleaned and a gauze sponge applied to that site daily at bedtime. *She looked at his suprapubic catheter site that morning (2/20/26), after resident 4's bath, and felt the site looked normal for a newly inserted suprapubic catheter. *She expected the nurse who completed a treatment on a resident would document that treatment as completed in the resident's TAR. -If there was no documentation that the treatment had been completed in the resident's TAR, she would assume that the treatment had not been completed. 5. Interview and record review regarding resident 4 on 2/20/26 at 12:53 p.m. with DON B and administrator A revealed: *Administrator A and DON B did not know what was used as the provider's reference for professional standards. *DON B expected that when a resident left the facility for an appointment or procedure and returned to the facility, a progress note would be entered into that resident's EMR. *DON B acknowledged that there was no documentation in his EMR that indicated resident 4 left the facility to have a suprapubic catheter surgically placed or when he returned to the facility. *DON B acknowledged that there was no documentation that resident 4 and his newly placed suprapubic catheter were assessed when he returned from the surgical procedure. *DON B expected the staff would have assessed resident 4 and his suprapubic catheter insertion site upon his return to the facility and documented their findings. *DON B acknowledged that there were no discharge instructions provided to the facility on how to care for resident 4's newly placed suprapubic catheter when he returned to the facility. *DON B stated the nurse should have called the medical facility where resident 4's suprapubic catheter placed and requested discharge instructions. (continued on next page)

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	435124	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society Miller	421 East 4th St Miller, SD 57362

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*DON B acknowledged the treatment order to clean and apply a gauze sponge to resident 4's suprapubic site was entered on 1/18/26, three days after his suprapubic catheter placement. *DON B acknowledged there was no documentation that the cleaning and gauze sponge treatment was completed until 2/10/26, 23 days after the suprapubic catheter placement. *DON B stated the treatment order was not entered into resident 4's EMR correctly so it did not show up on the TAR as a treatment to be completed by the nurse. *DON B stated the nurses told her they had been cleaning the site and applying the gauze sponge around resident 4's suprapubic catheter but there was no documentation to support that. *DON B expected the nurse who identified that the treatment order was not on resident 4's TAR to have corrected the entry error to ensure accurate documentation of completion. *DON B acknowledged that not cleaning and dressing a new suprapubic catheter insertion site could increase the resident's risk of infection. 6. Review of the provider's 4/6/25 Catheter: Care, Insertion and Removal 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. 7. Review of the provider's 4/6/25 Physician/Practitioner Orders policy revealed: *Order must be obtained for wound care including products to be used, when to change and when to reassess. *Nursing orders are not crested as physician/practitioner orders. Nursing orders must be documented as care plan approaches. Based on record review, interview, and policy review, the provider failed to ensure: *One of one sampled resident's (16) physician order for scheduled Haldol was entered into the resident's electronic medical record (EMR) as ordered. 8. Review of resident 16's electronic medical record (EMR) revealed: *She was admitted on [DATE]. *Her medication administration record (MAR) included a 10/7/25 physician order for Haloperidol [an antipsychotic medication that alters neurotransmitter activity to reduce symptoms of mental health conditions] Oral Tablet 1 MG (Haloperidol) Give 1 tablet by mouth as needed for prn [as needed] 1 hour prior to bath. *The 10/7/25 original physician order stated Give Haldol [haloperidol] 1 mg 1 hr [hour] prior to shower scheduled. 9. Interview on 2/20/26 at 1:49 p.m. with DON B and interim DON C regarding resident 16's physician (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order for Haldol revealed: *DON B acknowledged the 10/7/25 written physician's order for Haldol was to be scheduled to be administered one hour before resident 16 received a bath. -She acknowledged the 10/7/25 written physician's order for Haldol was entered into resident 16's EMR as a PRN (as needed) order and that resident 16 had not received the medication as ordered, as she had not received it before each bath, as the order had been entered as a PRN order. *DON B expected the physician's orders entered into a resident's MAR to be verified by two nurses, to ensure they are accurate and followed as ordered, and this order had been. -She was unable to determine how that transcription error had occurred. 10. Review of the provider's 4/6/25 Physician/Practitioner Orders policy revealed: *Physician/Practitioner orders are a critical component to providing quality care to residents. Accurate processing of physician/practitioner orders is important. The nursing services and health information management (HIM) departments each have responsibilities for processing physician/practitioner orders in a timely and accurate manner. *Orders are processed and transcribed into [electronic medical records system] – Clinical – Orders immediately upon receipt of an order. All orders must be noted by the licensed nurse who has processed the order. -Prescriber Entered Orders must be confirmed by a licensed nurse.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and policy review, the provider failed to ensure the medication labels and the resident's medication administration record (MAR) matched during two of two observed medication administrations for two of eleven sampled residents (7 and 29) by certified nurse aides (CNAs)/unlicensed assistive personnel (UAPs) L and I. Findings include:1. Observation and interview on 2/19/26 at 11:00 a.m. with certified nurse aide (CNA)/unlicensed assistive personnel (UAP) L during medication administration revealed:*The medication cart contained resident 7's medications.*The resident's Blink Tears Solution 0.25% (polyethylene glycol 400) (a medication to treat dry eye symptoms) eye drop pharmacy label on the medication container read: Instill 1 drop in both eyes every morning and at bedtime.*Her February 2026 medication administration record (MAR) read: Instill 1 drop in both eyes four times a day for macular degeneration.*CNA/UAP L agreed that resident 7's medication label for that medication did not match the 4/7/22 physician order on her MAR.*She did not know why they did not match and stated that the medication container came from the pharmacy with the label.*She said she was to report the discrepancy to the floor nurse or the director of nursing (DON) B for clarification and notified the floor nurse.*She waited to administer resident 7's eye drops until she had clarification from the nurse. 2. Interview on 2/19/26 at 11:10 a.m. with registered nurse (RN) K revealed:*She acknowledged that the medication label for resident 7's Blink tears solution eye drops did not match the 4/7/22 physician's order on her MAR.*She said she was calling the pharmacy to clarify the physician's order they had recorded for resident 7's Blink tears solution eye drops from the physician.*RN K said that the pharmacy received an order from the physician in February 2025 to change resident 7's Blink tears solution eye drops from four times daily to twice daily.-RN K could not recall the date the physician's order was received by the pharmacy.*She acknowledged that the facility had not received the February 2025 physician order for resident 7. 3. Observation and interview on 2/19/26 at 2:20 p.m. with CNA/UAP I during medication administration revealed:*The medication cart contained resident 29's medications.*The resident's Genteal Tears Solution Moderate(a medication to treat dry eye symptoms) eye drop pharmacy label on the medication container read: Instill 1-2 drops 2-3 times a day into affected eye as directed.*Her February 2026 MAR read: Artificial Tears Solution 1.4% (Polyvinyl Alcohol) Instill 1 drop in both eyes three times a day for dry eyes, irritation.*CNA/UAP I agreed that resident 29's medication label for that medication did not match the 10/23/24 physician order on her MAR.*She did not know why they did not match and stated that the medication container came from the pharmacy with the label.*She said she was to report the discrepancy to DON B for clarification and notified her.*She waited to administer resident 29's eye drops until she had clarification from DON B. 4. Interview on 2/19/26 2:30 p.m. with DON B revealed:*She acknowledged that the medication label for resident 7's Blink tears solution eye drops did not match the 4/7/22 physician's order on her MAR.*DON B said she was calling the pharmacy to clarify the physician's order they had on file for resident 29's Genteal tears solution eye drops from the physician.*DON B stated that resident medication containers or cards requiring a new medication label were to be removed from the medication carts and sent to the pharmacy for new packaging and labeling.*She said the nurse or UAP's working on the floor were responsible for removing any medication containers or cards that needed new labels and notifying the pharmacy promptly to avoid missed medication doses for residents.*She expected the nurses and UAPs to promptly identify discrepancies between the medication label and the physician's order in the MAR when they completed their safety checks with medication administration.*She acknowledged that a discrepancy between pharmacy labels and resident MARs increases the risk of medication errors with UAPs, who may not recognize medications and cannot calculate dosages.*She acknowledged that the pharmacy had received a physician's order on 4/9/25 to substitute resident (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	29's previous eye drop medication with Genteal Tears eye drop medication.*She acknowledged that the pharmacy had not received a physician's order for resident 29's dose change. 5. Phone interview on 2/20/26 at 8:15 a.m. with retail pharmacist S revealed:*The pharmacy provides daily and monthly medications for the residents.*He said that he or consultant pharmacist R would review and check resident medications in the medication storage room and carts for expiration dates, correct labels, narcotic logs, and perform chart audits monthly.*He said if there was a physician's order change, the resident's medications would be sent back to the pharmacy to be re-packaged with a new pharmacy label.*He stated that he had specialty physicians send new orders to the pharmacy, and those specialty physicians did not forward that new order information on to the resident's primary physician at the facility, which created discrepancies between the pharmacy labels and the resident's MARS.*He stated that the nurses usually caught the discrepancies in a timely manner and called to notify the pharmacy of the updated information. 6. Review of the provider's revised 3/4/25 Medications: Acquisition, Receiving, Dispensing, and Storage-R/S, LTC policy revealed:*The medication orders/changes are communicated to the pharmacy.*The order will include the date of the change, the location name, resident's name, medication name, dosage, route, quantity or duration and strength, diagnosis or indication for use and the physician's name.*All medications (including medication samples or other medications dispensed by the physician) are packaged in accordance with the location dispensing system and state pharmacy rules. These medications must be labeled according to state pharmacy regulations. Cautionary and accessory instructions, as well as the expiration date, will be included. New labels will be applied by the pharmacist or the pharmacist's agent as needed. 7. Review of the provider's revised 4/8/25 Medication: Administration Including Scheduling and Medication Aides- R/S, LTC revealed:*Because medication aides may only dispense medications, they are not allowed to make a determination if one or two tabs [tablets] are needed; therefore, orders with ranges are not accepted from prescribers. For example: 1-2 tablets every 3-4 hours should not be accepted.*Perform three checks: Read the label on the medication container and compare with the MAR when removing the container from the supply drawer, when placing the medication in an administration cup/syringe and just before administering the medication.