STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435134	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST MARTIN VILLAGE	**4825 JERICHO WAY , RAPID CITY, South Dakota, 57702**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
=0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/28/26 through 7/30/26. Good Samaritan Society-St Martin Village was found not in compliance with the following requirements: F554, F655, F658, F676, F761, F800, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/28/26 through 7/30/26. Areas surveyed included wheelchair safety related to the use of wheelchair foot pedals, timely call light response, consistent bathing, resident confidentiality, timely incontinence care, medication administration practices related to infection control and the management of pain patches, food service related to offering a range of food options, and communication practices between the provider and the residents' representatives. Good Samaritan Society-St Martin Village was found not in compliance with the following requirement: F880.	F0000	Unable to correct prior deficient practice. For Resident 3, 9 and 12, we have conducted care plan reviews with them and offered a copy of that current care plan. Resident #3 has had 3 care plan reviews since admission, and a copy of the current care plan was offered on 8.21.26. Resident #9 has had 4 care plan reviews since admission, and a copy of the current care plan was offered on 8.21.26. Resident # 12 has had 4 care plan reviews since admission, and a copy of the current care plan was offered on 8.21.16. All residents are at risk when baseline care plans are not presented to them timely. Residents admitted in the past 12 months have been reviewed by SSD to determine if others are identified as not having documentation of being offered the baseline care plan. Education will be provided by the Administrator or designee to the IDT team on baseline care plans being presented to resident or family within 48 hours of admission. Completion of baseline care plan will be added to clinical stand up form, reviewed at week day Clinical meeting to ensure completion. Administrator or designee will audit completion of baseline care plan and documentation of being offered to resident and/or responsible party, weekly x3, every other week x3, and monthly x3. Administrator or designee will report all findings to the QAPI committee on a monthly basis for follow up.	9.13.26
=0655 SS = E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-	F0655		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jana McCroden	Senior Director	8.21.26

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F0655 SS = E	Continued from page 1 (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: 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 offered to the resident or the resident's representative within 48 hours of the resident's admission to the facility for three of four newly admitted residents (3, 9, and 12). Findings include:	F0655	**The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Administrator or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.**	9.13.26

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F0655 SS = E	Continued from page 2 1. Review of resident 9's electronic medical record (EMR) revealed he admitted to the facility on 10/14/25. There was no documentation that resident 9's baseline care plan was reviewed with him or his representative, and a copy was offered to him or his representative within 48 hours after his admission to the facility. 2. A copy of resident 9's baseline care plan was requested from the facility on 7/29/26. 3. Interview on 7/30/26 at 7:38 a.m. with director of nursing (DON) B revealed that a copy of resident 9's baseline care plan was not available. The facility nurses initiate a care plan after a resident's admission to the facility and then personalized it to fit the resident's care needs. 4. Review of resident 3's EMR revealed he admitted to the facility on 11/18/25. There was no documentation that resident 3's baseline care plan was reviewed with him or his representative, and a copy was offered to him or his representative within 48 hours after his admission to the facility. 5. Review of resident 12's EMR revealed she admitted to the facility on11/20/25. There was no documentation that resident 12's baseline care plan was reviewed with her or her representative, and a copy was offered to her or her representative within 48 hours after her admission to the facility. 6. Interview and review of resident 3 and 12's EMR on 7/30/26 at 9:39 a.m. with lead social services coordinator R revealed the resident's baseline care plans were started upon admission to the facility by Minimum Data Set (MDS) nurse S or clinical care leader T. Lead social services coordinator R was responsible for reviewing the resident's baseline care plan with the resident or the resident's representative. She reviewed and offered a copy of the resident's baseline care plan to the resident or the resident's representative during the resident's admission care conference, which usually occurred seven to fourteen days after the resident admitted to the facility. Lead social services coordinator R documented that she reviewed the baseline care plan with the resident or the resident's representative in a progress note in the resident's EMR. She	F0655		

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F0655 SS = E	Continued from page 3 acknowledged there was no documentation that resident 3 or 12 had their baseline care plan reviewed with and offered to them or their representatives within 48 hours after they admitted to the facility. She did not know the regulation required the baseline care plan to be reviewed and offered to the resident or the resident's representative within 48 hours after their admission to the facility. 7. Review of the provider's 12/1/25 Care Plan policy revealed, "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."	F0655	LPN N, RN I, RN F, CNA, G and CNA H have been re-educated by Clinical Learning Development Specialist on proper hand hygiene practices. All direct care staff received hand hygiene competencies by Clinical Learning Development Specialist or IP by 9.13.16. All residents are at risk when hand hygiene and glove use is not followed during wound care, medication pass and dining room assistance. Education will be provided by the Director of Nursing or designee to all direct care staff on the infection control practices of glove use and hand hygiene. Direct care staff will be skills validated by Clinical Learning Development Specialist annually and prn to ensure proper hand hygiene is being utilized. IP nurse or designee will conduct 20 hand hygiene observations monthly. Director of Nursing or designee will audit glove use and hand hygiene x3, every other week x3, and monthly x3. Director of Nursing or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Director of Nursing or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	9.13.26
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F0880		

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F0880 SS = E	Continued from page 4 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure infection prevention and control practices for hand hygiene (HH) (handwashing with soap and water or an alcohol-based hand sanitizer [ABHS]) and glove use were implemented by one of one licensed practical nurse (LPN) (N) during and after one of one sampled resident's (81) dressing change, one of one registered nurse (RN) (I) who did not perform HH before completing one of one sampled resident's (6)	F0880		

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F0880 SS = E	Continued from page 5 wound care treatment, one of one RN (F) who did not perform HH during medication administration for four of five sampled residents (60, 3, 49, and 24), one of one certified nursing assistant (CNA) (G) who did not perform HH during mealtime assistance provided for one of one sampled resident (28), and one of one CNA (H) who did not perform HH after removing her soiled gloves and before putting on a new pair gloves in the dining room during the noon meal service. Findings include: 1. Observation and interview on 7/28/26 at 10:10 a.m. with RN I in resident 6's room revealed RN I informed the resident that she was going to change the bandage on his back. RN I did not perform HH upon entering the room. RN I put on a pair of gloves, assisted the resident to lean forward in his chair, lifted the back of his shirt, removed the bordered gauze bandage from resident 6's back, and disposed of the bandage in the trash can. With the same gloved hands, she opened a new bordered gauze bandage that she had brought to the room, and then placed the new bordered gauze bandage over the skin on resident 6's back. She removed her gloves, disposed the gloves in the trash can, and then used an ABHS. RN I indicated the bandage was being used to prevent skin damage to his back. While still in resident 6's room, RN I acknowledged that she should have performed hand hygiene when she entered the resident's room and removed her gloves after she removed the soiled bordered gauze bandage from the resident's back. She should have performed HH before she applied a new bordered gauze bandage to resident 6's back. 2. Observation on 7/29/26 at 07:55 a.m. with RN F revealed she was administering medications on the south unit. RN F prepared resident 60's medications at the medication cart, walked to the dining area, and administered medications to resident 60. RN F returned to the medication cart, disposed of the used medication cup and water cup in the trash, and did not perform HH. RN F typed on the computer and then prepared resident 3's medication. No HH was performed. RN F walked to the dining room and administered resident 3's medications, returned to the medication cart, disposed of the medication cup and water cup, and then completed HH. 3. Observation on 7/29/26 at 8:24 a.m. with RN F at the medication cart on the south unit revealed she did not perform HH before she prepared resident 49's medications for administration. RN F walked to	F0880		

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F0880 SS = E	Continued from page 6 resident 49's room, set his medications on his bedside table, checked the resident's blood pressure, and administered his medications. RN F then returned to the medication cart and typed on the computer. No HH was performed. 4. Observation and interview on 7/29/26 at 10:51 a.m. with RN F revealed she did not perform HH before she prepared resident 24's medications. RN F put on a pair gloves, picked up resident 24's insulin pen, set the dosage on the pen, prepared the skin site on resident 24's abdomen with an alcohol wipe, and administered the insulin injection into resident 24's abdomen. While wearing the same unclean gloves, RN F opened the medication cart, returned resident 24's insulin pen to the cart, and typed on the computer. She then removed her gloves and did not perform HH. RN F stated she should have completed HH between administering and preparing each resident's medications. 5. Observation on 7/29/26 between 11:28 a.m. until 12:15 p.m. in the south unit dining area during noon meal service revealed CNA G sat at a table with gloves on and assisted resident 28 to eat. CNA G stood up from the table and removed her unclean gloves, did not perform HH, and repositioned herself next to an unidentified resident's wheelchair who was across the table from her. She sat back down at the table, put on clean gloves without performing HH, and continued to assist resident 28 to eat, CNA H stood up from a table with a pair of gloves on, walked to the dining room counter, picked up a box of gloves, and brought the box of gloves back to the table. She removed her unclean gloves, put the unclean gloves in the trash, and then put on clean gloves; no HH was performed. 6. Interview on 7/29/26 at 1:40 p.m. with CNA H revealed she should perform HH before and after providing resident care, before and after wearing gloves, and when going in or out of residents' rooms. 7. Observation and interview on 7/29/26 at 3:25 p.m. with LPN N completing resident 81's right knee dressing change revealed that without first performing HH, LPN N put on a gown and a pair of gloves. She laid a clean barrier on top of the resident's over-the-bed table and placed her dressing supplies on top of that barrier. She removed the medical tape from around the bandage on the resident's knee and removed the soiled bandage.	F0880		

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F0880 SS = E	Continued from page 7 LPN N removed and discarded her gloves in the garbage can and, without performing HH, she put on a clean pair of gloves. She applied a clean bandage to the resident's knee and secured that bandage to the resident's skin with medical tape. LPN N removed and discarded her gloves in the garbage can, then washed her hands in the resident's bathroom sink. She attempted to dry her hands with a paper towel from the automatic paper towel dispenser in the bathroom, but it was not working. LPN N attempted to get a paper towel from the dispenser opening, and then tried to open the dispenser from the top. LPN N then used a hand towel on the counter of the resident's sink to dry her hands. She turned the sink faucet handle off with her dry hand, and discarded the hand towel in a soiled linen container. LPN N applied an ABHS to her hands before she left the resident's room. LPN N stated that she was expected to, but did not, perform HH each time she had put on clean gloves during the above bandage change. She should not have used the hand towel in the resident's bathroom to dry her hands. If that towel was soiled, she had increased the risk of cross-contamination occurring when she turned the faucet handle off with her potentially soiled hand. 8. Interview on 07/30/2026 at 10:28 a.m. with director of nursing (DON) B and Clinical Care Leader C revealed that handwashing should occur before entering a resident's room, after exiting the resident's room, after contact with bodily fluids, and before and after glove use. Hand hygiene should be completed prior to putting on a pair of gloves assist residents with eating. Gloves should be worn when touching the resident's food, and should be removed and hand hygiene performed before assisting a different resident to eat. Gloves should be removed and hand hygiene performed after touching the resident's wheelchair handles or other chair surfaces. Hand hygiene should be performed before and after each resident during a medication pass. 9. Review of the provider's 6/8/26 Hand Hygiene policy revealed: "Hand hygiene should be performed by employees: before contact with a resident/patient/client, before performing a clean/aseptic task, after contact with blood or body fluids, after removal of personal protective equipment/gloves, after contact with a resident/patient, after contact with resident/patient/client surroundings." The policy includes: "Glove Use: gloves are not a substitute	F0880		

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F0880 SS = E	Continued from page 8 for hand hygiene. If a task requires gloves, perform hand hygiene before donning gloves and touching the resident/patient/client. Perform hand hygiene after removing gloves."	F0880		
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (6) observed to have Cortisone 10 (a medicated steroid cream that is used on the skin to treat inflammation and itching) and a container labeled Hempvona cream (a topical cream with hemp-seed oil) located on his bedside table was evaluated for his ability to safely self-administer those medications. 1. Observation and interview on 7/28/26 at 10:15 a.m. with resident 6 in his room revealed a tube of Cortisone 10 and a container labeled Hempvona cream. The resident used the Cortisone 10 for facial itching and the Hempvona cream for discomfort. He did not know if the staff knew he had it. 2. Observation on 7/29/26 at 2:20 p.m. in resident 6's room revealed the same Cortisone 10 and Hempvona cream on his bedside table. 3. Review of resident 6's electronic medical record (EMR) revealed he admitted to the facility on 5/16/25. His Brief Interview for Mental Status (BIMS) assessment score was 12, which indicated his cognition was moderately impaired. No medication self-administration assessment was completed to determine whether the resident was able to safely self-administer the above observed medications. His 7/29/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) did not indicate that he self-administered any medications. There was a physician's order dated 11/13/25 for Hempvona cream to be applied topically prn (as needed). There was no physician's order for Cortisone 10 cream. There was no physician's order indicating resident 6 was able to self-administer any of his medications.	F0554	Medications were removed from resident 6's room, until self administer process was completed. Residents who have outside medications brought into the facility are at risk for deficient practice. All rooms were audited for medications that did not have a self administer process. Education will be provided by the Director of Nursing or designee to all direct care staff on medications in residents rooms. Outside medication information will be placed in admission packet for families to follow self administration process. Director of Nursing or designee will audit rooms for undocumented self administration medications weekly x3, every other week x3, and monthly x3. Director of Nursing or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Director of Nursing or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	9.13.26

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F0554 SS = D	Continued from page 9 4. Interview, record review, and observation on 7/30/26 at 9:06 a.m. with licensed practical nurse (LPN) J revealed no creams were ordered for resident 6's face, and there was no order for self-administration of the Hempvona cream. LPN J stated that no medications were to be left in resident 6's room. LPN J entered resident 6's room and confirmed that resident 6 had Hempvona cream in his room. 5. Interview on 7/30/26 at 9:15 a.m. with certified nursing assistant (CNA) K revealed that any medicated lotions should not be left in the resident's rooms. 6. Interview on 7/30/26 at 9:43 a.m. with Clinical Care Leader C revealed the provider failed to follow their process for self-administering medications by not ensuring resident 6 was assessed to safely self-administer the above creams, securing a physician's order for the resident to self-administer those creams, and ensuring those medications were not stored in his room. 7. Interview and EMR review on 7/30/26 at 9:45 a.m. with director of nursing (DON) B revealed that resident 6 did not have a self-administration assessment completed or a physician's order to safely store and administer the Cortisol 10 and Hempvona creams in his room, and he should have. DON B removed the Hempvona cream from resident's room. 8. Interview on 7/30/26 at 11:36 a.m. with CNA L revealed that nurses should be notified if medications or medicated creams were found in a resident room. 9. Review of the provider's 3/30/26 Medication: Administration policy revealed "The resident has the right to self-administer medications if the interdisciplinary team determine that this practice is safe for the individual resident and is documented in the care plan. An order from the provider is required for this activity. Nursing Employees will be aware of medications kept in the room and responsible for recording self-administration doses in the resident's medication record."	F0554		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as	F0658		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST MARTIN VILLAGE	**4825 JERICHO WAY , RAPID CITY, South Dakota, 57702**

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F0658 SS = D	Continued from page 10 outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on 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) interventions were attempted and documented, and the indication for administration was documented for an as-needed (PRN) anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability) medication that was administered to one of one sampled resident (11). Findings include: 1. Review of resident 11's electronic medical record (EMR) revealed he admitted to the facility on 12/9/24. He had a 5/1/26 physician's order for lorazepam (a medication used to treat anxiety) 0.5 milligrams (mg) one to four tablets to be administered every two hours as needed for anxiety and dyspnea (difficulty breathing). There were no parameters to guide which dose of the lorazepam was to be administered. His 5/1/26 psychotropic medications (drugs that affect brain activities associated with mental processes and behavior) consent was for lorazepam. The symptom identified on the consent that the lorazepam was intended to help was "drowsiness". There were no non-pharmacological alternatives listed on the consent where it indicated the alternatives attempted were to be listed. His medication administration record (MAR) indicated that on 5/8/26 at 8:26 p.m. resident 11 was administered 0.5 mg of lorazepam. There was no documentation of what the lorazepam was administered for or if non-pharmacological interventions were attempted before he was administered the lorazepam. The 0.5 mg of lorazepam was documented as effective. On 5/9/26 at 12:13 a.m. resident 11 was administered 1 mg of lorazepam. There was no documentation of what the lorazepam was administered for or if non-pharmacological interventions were attempted before he was administered the lorazepam. The 1 mg of lorazepam was documented as effective.	F0658	Unable to correct prior deficient practice as resident has expired. All residents who receive PRN psychotropics are at risk for deficient practice. A review of residents with prn psychotropics was conducted to determine care plan interventions were listed, interventions were attempted and documented and indication for administration was documented. All residents who have a PRN psychotropic had their orders changed to ensure that non-pharmacological alternatives are documented and why the medication is being given. All consent forms have been updated to include non-pharmacological alternatives. Education will be provided by the Director of Nursing or designee all add parameters of medications to all PRN psychotropic medications. Will add to clinical stand up form to check orders to ensure parameters are in place. Will read all eMAR notes for documentation in morning clinical stand up meeting. Director of Nursing or designee will audit PRN psychotropic documentation for non-pharmacological alternatives weekly x3, every other week x3, and monthly x3. Director of Nursing or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Director of Nursing or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	9.13.26

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F0658 SS = D	Continued from page 11 On 5/28/26 at 3:54 p.m. resident 11 was administered 0.5 mg of lorazepam. There was no documentation of what the lorazepam was administered for or if non-pharmacological interventions were attempted before he was administered the lorazepam. The 0.5 mg of lorazepam was documented as effective. On 5/29/26 at 8:09 p.m. resident 11 was administered 2 mg of lorazepam. There was no documentation of what the lorazepam was administered for or if non-pharmacological interventions were attempted before he was administered the lorazepam. The 2 mg of lorazepam was documented as effective. On 5/31/26 at 8:00 p.m. resident 11 was administered 1 mg of lorazepam. There was no documentation of what the lorazepam was administered for or if non-pharmacological interventions were attempted before he was administered the lorazepam. The 1 mg of lorazepam was documented as effective. On 6/4/26 at 10:43 a.m. resident 11 was administered 1 mg of lorazepam. There was no documentation what the lorazepam was administered for or non-pharmacological interventions that had been attempted before he was administered the lorazepam. The 1 mg of lorazepam was documented as effective. On 6/27/26 at 9:51 p.m. resident 11 was administered 1 mg of lorazepam. There was no documentation of what the lorazepam was administered for or if non-pharmacological interventions were attempted before he was administered the lorazepam. The 1 mg of lorazepam was documented as effective. On 7/2/26 at 1:50 p.m. resident 11 was administered 1 mg of lorazepam. There was no documentation what the lorazepam was administered for or non-pharmacological interventions that had been attempted before he was administered the lorazepam. The 1 mg of lorazepam was documented as effective. On 7/18/26 at 9:58 p.m. resident 11 was administered 2 mg of lorazepam. There was no documentation of what the lorazepam was administered for or if non-pharmacological interventions were attempted before he was administered the lorazepam. The 2 mg of lorazepam was documented as effective.	F0658		

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F0658 SS = D	Continued from page 12 On 7/19/26 at 6:51 p.m. resident 11 was administered 1 mg of lorazepam. There was no documentation of what the lorazepam was administered for or if non-pharmacological interventions were attempted before he was administered the lorazepam. The 1 mg of lorazepam was documented as effective. On 7/28/26 at 8:35 p.m. resident 11 was administered 0.5 mg of lorazepam. There was no documentation if non-pharmacological interventions were attempted before he was administered the lorazepam. The 0.5 mg of lorazepam was documented as effective. 2. Interview on 7/30/26 at 9:03 a.m. with registered nurse (RN) E revealed resident 11 screamed and became restless in the evening. Non-pharmacological interventions were not always effective in managing his behaviors. 3. Phone interview on 7/30/26 at 1:25 p.m. with RN D revealed she gave resident 11 lorazepam for agitation. He would get "ramped up" at night, so she gave him the lorazepam to calm him down. She did not document in resident 11's EMR any non-pharmacological interventions attempted or what she was administering the lorazepam for because the order indicated the lorazepam was for anxiety. She felt she administered the lorazepam for his anxiety. She chose the dose of the lorazepam within the range of doses ordered by using her personal judgement. If resident 11 was displaying behaviors before she began her shift, she would choose to administer a larger dose of the lorazepam. She did not think about starting with a lower dose of the lorazepam and increasing the dose of the medication if the lowest dose was not effective. She did not receive any guidance on which dose of lorazepam to give resident 11 for his behaviors. 4. Interview on 7/30/26 at 2:34 p.m. with director of nursing (DON) B revealed she expected non-pharmacological interventions that were attempted for the resident's behavior be documented in the resident's EMR before an as needed anxiety medication was administered. She was not aware resident 11's psychotropic consent stated the indication for use of his lorazepam was drowsiness. She did not expect the	F0658		

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F0658 SS = D	Continued from page 13 psychotropic consent to include the non-pharmacological interventions attempted, but she did expect the non-pharmacological interventions on the resident's care plan to be listed. She expected that if a resident had an as needed anxiety medication with a range of doses that the lowest dose should be tried first to minimize the risk of adverse effects from the medication. 5. Review of the provider's 12/9/25 Psychotropic Medications policy revealed, "Before [the] administration of non-emergency psychotropic medications, the following must be completed: Documentation in [the EMR] observations of mood, symptoms, or behaviors that cause the resident distress and/or endanger the resident or others and response to interventions used."	F0658	White board in resident's # 48 room was updated to reflect walk to dine program and POC tasks were updated to reflect walk to dine program. All residents who are on a walk to dine program have the potential to be at risk of deficient practice. No other residents were effected. Education will be provided by the Director of Nursing or designee to all direct care staff regarding walk to dine program information to be on resident's white board in their room. Clinical stand up meeting form updated to reflect all residents who are on the walk to dine program. Director of Nursing or designee will audit resident's who are on the walk to dine program weekly x3, every other week x3, and monthly x3. Director of Nursing or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Director of Nursing or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	9.13.26
F0676 SS = D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking,	F0676		

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F0676 SS = D	Continued from page 14 §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to implement a physical therapist recommended walk-to-dine program for one of one sampled resident (48). Findings include: 1 Observation and interview on 7/28/26 at 10:05 a.m. with resident 48 in his room revealed that he was seated in his recliner. There was a walker near the wall by his dresser. He used the walker to get to and from his bathroom. He was supposed to use the walker to walk to and from the dining room for meals. The staff were to follow behind him with his wheelchair in case he became fatigued and needed to sit down. Resident 48 said he used his wheelchair to get to the dining room that morning for breakfast, because the staff were "too busy" to follow behind him if he walked to the dining room with his walker. He said the purpose of using the walker to get to and from the dining room was to "keep my strength up." There was a dry-erase board on the resident's wall in his room. On it was written, "assist x1 [assistance of one staff person] with FWW [a front-wheeled walker] and gait belt [a waist strap gripped as support for safe mobility and transfers]" regarding resident 48's mobility needs. 2. Observations and interviews on 7/28/26 at 12:30 p.m. and at 5:45 p.m. during the noon and evening meal services revealed that resident 48 sat in his wheelchair in the dining room for both of those meal services. He used his wheelchair to get to and from the dining room for both of those meal services. The staff did not offer to walk behind him with a wheelchair while he used his walker to walk to and from the dining room for those meals. 3. Observation and interview on 7/29/26 at 12:30	F0676		

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F0676 SS = D	Continued from page 15 p.m. revealed that resident 48 sat in his wheelchair in the dining room. He used his wheelchair to get to and from the dining room for the noon meal service. The staff did not offer to walk behind him with a wheelchair while he used his walker to walk to and from the dining room for the meal. 4. Observation and interview on 7/30/26 at 8:00 a.m. revealed that resident 48 sat in his wheelchair in the dining room. He used his wheelchair to get to and from the dining room for the noon meal service. The staff did not offer to walk behind him with a wheelchair while he used his walker to walk to and from the dining room for the meal. 5. Review of resident 48's electronic medical record (EMR) revealed his revised 3/31/26 activities of daily living (bathing/hygiene, dressing, eating, transferring/mobility, and continence) care plan indicated, "Ambulation: Walk to dine with [the] staff following [the resident] with a wheelchair and [the staff using a] gait belt [around the resident's waist]." 6. Interview and EMR review on 7/30/26 at 9:30 a.m. with occupational therapist (OT) Q revealed that recommendations for a resident to participate in a walk-to-dine program were made by the therapy staff. Those recommendations were communicated to a nurse supervisor to add to a resident's plan of care (POC) for implementation. The therapy staff had recommended a walk-to-dine program for resident 48 after his 6/22/26 discharge from therapy services. The recommendation stated, "Walk-to-dine with FWW, W/C [wheelchair] follow _A X1 [assistance from one] staff)." 7. Interview on 7/30/26 at 9:35 a.m. with registered nurse (RN) P revealed that walk-to-dine recommendations were discussed in morning interdisciplinary team meetings, then communicated to the nursing staff. The therapy staff also communicated directly with the nursing staff regarding the initiation of walk-to-dine programs. It was the responsibility of the certified nursing assistants (CNAs) to implement and document the walk-to-dine program each day on their ADL task list. RN P did not know if resident 48 was on a walk-to-dine program. 8. Interview on 7/30/26 at 9:45 a.m. with CNA O revealed that she referred to the dry-erase board in a resident's room to know if a resident was on a walk-to-dine program. She was not sure if resident 48 was on a walk-to-dine program. 9. Interview on 7/30/26 at 1:45 p.m. with director of	F0676		

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=0676 SS = D	Continued from page 16 nursing (DON) B revealed that the therapy staff were responsible for communicating to her their walk-to-dine recommendations for a resident. It was her responsibility to ensure that the caregiver's were informed of the recommendation and the recommendation was added to the resident's POC. Adding the program to a resident's POC populated the walk-to-dine program task on the caregiver's task list within the resident's EMR. That enabled the caregiver to document when the walk-to-dine program was implemented. That process had failed for resident 48 because she did not add the walk-to-dine recommendation to his POC. 10. Review of the provider's revised 7/30/25 Restorative-Walk and Dine Program revealed, " 2. A resident capable of ambulating to and from the dining room will be placed on the Walk and Dine Program, identified in the approaches in the resident's care plan, indicates the resident is able to walk to and from [the] resident['s] room for meals."	F0676	All medications that were expired were disposed of. Residents who receive medications are at risk for deficient practice. All medication carts and medication storage rooms have been cleared of all expired and open undated medications. Education will be provided by the Director of Nursing or designee to all licensed nurses and medication aides on checking for open dates, expired medications, and securing medications at all times. Calendar reminders put on nurse manager's calendars to check carts and medication rooms for expired items monthly. Director of Nursing or designee will audit medication carts, medication storage rooms for open dates, expired medications, and ensuring medications aren't unattended weekly x3, every other week x3, and monthly x3. Director of Nursing or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Director of Nursing or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	9.13.26
=0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by:	F0761		

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F0761 SS = D	Continued from page 17 Based on observation, interview, and policy review, the facility failed to ensure drugs and biologicals were labeled, securely stored, and discarded regarding one of one medication cart on the south unit that was left unattended by one of one registered nurse (RN) (F) with pre-poured medications observed on top of the medication cart in a hallway where residents, unauthorized staff, and visitors could access it, one of one sampled resident's (63) medication with a shortened expiration date (medication that expires in a time frame after opening that is before the manufacturer's expiration date) that was not labeled with an open date, and for one of one medication storage room and one of one medication cart on the north unit that had expired medications and supplies. Findings include: 1. Observation and interview on 7/28/26 at 5:44 p.m. with Clinical Care Leader C in the medication storage room revealed four Universal Viral Transport for Viruses (a specialized liquid solution used to safely collect and preserve clinical samples for transport) with an expiration date of 2/28/26 and approximately half a box of 75 count of Banatrol Plus powder (to manage diarrhea) packets with an expiration date of 5/21/26. Clinical Care Leader C confirmed above medications and supplies were expired and that they should be removed from the medication room. 2. Observation and interview on 7/28/26 at 5:54 p.m. with licensed practical nurse (LPN) N at the north unit medication cart revealed there was a Trelegy Ellipta (treats chronic obstructive pulmonary disease and asthma) 200 microgram (mcg) /62.5mcg/25mcg inhaler opened and not dated, and one box of Bisacodyl (laxative) 10 milligram (mg) suppository with an expiration date of 6/30/26. LPN N confirmed the expiration date of the Bisacodyl and stated that the nurse that opened the Trelegy was responsible for labeling it with the opened date. LPN N removed the above medications from the cart. 3. Observation on 7/29/26 at 7:55 a.m. revealed the south unit medication cart in the hallway near the dining room had 2 medication cups sitting on top of it. One medication cup had an orange gummy medication and a red gummy medication, and the other medication cup had 3 white pills. No nurse or staff member was present at the cart at the time of observation. Clinical Care Leader C approached the medication cart and put the medication cups in the	F0761		

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=0761 SS = D	Continued from page 18 top drawer of the cart. 4. Interview on 7/26/26 at 8:00 a.m. with registered nurse (RN) F revealed that she had previously prepared the medications and left them sitting unsecured on top of the medication cart. RN F states she left the medications there while she went to another room. 5. Interview on 7/30/26 at 2:56 p.m. with director of nursing (DON) B revealed she expected medications to not be pre-poured and left unattended on top of medication carts, expired medications and supplies were to be removed from the medication carts and medication storage rooms by clinical coordinators and nurses, medications were to be checked for expiration dates before being administered to the residents and as needed, medications are to be labeled by the nurse that opens the medication, and medication carts were to be checked quarterly by pharmacists. 6. Review of the providers 3/30/26 Medications: Acquisition Receiving Dispensing and Storage policy revealed: "Medications will be stored in a locked medication, cart, drawer or cupboard, the location will routinely check for expired medication and necessary disposal with be done in accordance with state/pharmacy regulations, all medications (including samples or other medication dispensed by the physician) are packaged in accordance with the location dispensing system and state pharmacy regulations. Cautionary and accessory instructions, as well as the expiration date will be included. New labels may be applied by the pharmacist or the pharmacists' agent as needed." 7. Review of the provider's 3/30/26 Medication: Administration Including Scheduling and Medication Aides policy revealed: "Pre-setting medications in not an acceptable practice. For medication designed for multiple administrations (e.g. inhalers, eye drops, insulin, the employ opening the medication writes the open date on the label to promote correct administration."	F0761		
=0800 SS = D	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each	F0800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435134	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST MARTIN VILLAGE	4825 JERICHO WAY , RAPID CITY, South Dakota, 57702

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F0800 SS = D	Continued from page 19 resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, record review, and policy review, the facility failed to provide the dietary staff initial and ongoing education regarding a physician-ordered gluten-free diet, ensure menus were developed, and that an early breakfast was provided before a morning medical appointment for one of one sampled resident (48) to enable the resident to make food choices that he preferred and that his nutritional needs were met. Findings include: 1. Interview on 7/28/26 at 10:05 a.m. with resident 48 revealed he was placed on a gluten-free diet after his April 2026 hospitalization. He was provided a menu each day that listed a main menu option for breakfast, lunch, and dinner. Beneath each of those main menu options, there was an alternate meal option. Resident 48 stated that for breakfast that morning, pancakes were on the main breakfast menu that he had selected, but he was not able to choose the pancakes because they were not gluten-free. He had yogurt, eggs, and toast instead. 2. Observation, interview, review of resident 48's menu on 7/28/26 at 12:10 p.m. with resident 48 in the dining room revealed that sweet potatoes were on the main lunch menu, which he had selected. He was not served the sweet potatoes he had ordered. The resident's meal consisted of a turkey sandwich, peas and carrots, and a dessert. Resident 48's 7/28/26 menu was labeled "Gluten Restricted" and listed his allergies as peanuts, watermelon, and wheat. There was a line through the pancakes option for breakfast, and beside it the word, "ALLERGY." There was no gluten-free option listed on the menu to replace the pancakes that the resident could not have. Resident 48 did not understand the reason for the pancake restriction because he had made and eaten pancakes during a recent occupational therapy session. Resident 48 had selected a turkey sandwich, baked sweet potato fries, and peas and carrots for the lunch menu option. There was a line through the baked sweet potato fries option, and beside it the word, "ALLERGY." There was no gluten-free option	F0800	Menu for gluten free diet has been updated. Provided education to resident #48 on gluten free menu choices and gluten free pancake batter has been purchased. All residents on a gluten free diet are at risk for deficient practice. All Nutrition Data Collection assessments were audited for resident food preferences. Education will be provided by the Dining director or designee to all direct care staff on menu options for residents on a gluten-free diet. Menus have been altered by registered dietician to ensure options are available for gluten free diets. Education will also be given to all direct care staff to ensure breakfast is offered to residents who have morning appointments. Dining staff have been added to transportation communication to ensure they know who have early appointments. Dining Director or designee will audit gluten free menu options and that early morning appointments were offered nutrition weekly x3, every other week x3, and monthly x3. Director of Nursing or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Director of Nursing or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	9.13.26

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=0800 SS = D	Continued from page 20 listed on the menu to replace the sweet potato fries that the resident could not have. 3. Interview and resident 48's menu review on 7/28/26 at 5:45 p.m. with resident 48 in the dining room revealed he was served a piece of baked cod and wild rice pilaf for the evening meal. His 7/28/26 dinner menu indicated that the alternate meal that the resident selected for that evening included baked cod, wild rice pilaf, and breaded cauliflower. There was a line through the breaded cauliflower option, and beside it the word, "ALLERGY." There was no gluten-free option listed on the menu to replace the breaded cauliflower that the resident could not have. 4. Review of resident 48's electronic medical record (EMR) revealed a 4/8/26 physician's Nursing Home Progress Note that indicated the resident was hospitalized from 4/2/26 to 4/6/26 for treatment of a small bowel obstruction "likely due to dietary indiscretion." Registered dietician (RD) U's 4/7/26 and 5/19/26 RD progress notes indicated that resident 48's diet order was changed to gluten-free after the resident's 4/7/26 hospital discharge. The note indicated that the resident was eating and drinking well since his hospital return. There was no indication that RD U had met with the resident to discuss the resident's April 2026 diet order change. Former dietary manager (DM) V's post-hospitalization 4/15/26 Food and Nutrition Data Collection assessment for resident 48 revealed that section 3 of that assessment identified the resident's meal and snack preferences. There was space to indicate resident-specific dietary information such as food likes, dislikes, and preferences. The space was left blank. Section 9 of that assessment was "Education." There was no indication that DM V had provided resident 48 with instructions or education related to his new diet order. No follow-up Food and Nutrition Data Collection assessments were completed by former DM V after 4/15/26. 5. Interview on 7/29/26 at 1:30 p.m. with occupational therapist (OT) Q revealed she confirmed that the resident used a gluten-free pancake mix provided by the therapy department to make gluten-free pancakes during a therapy session after the resident's discharge from the hospital in April 2026. 6. Interview on 7/29/26 at 5:45 p.m. with former DM V revealed that as of 7/29/26, he was no longer the	F0800		

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=0800 SS = D	Continued from page 21 DM. He was still employed by the facility, providing training to the new DM. Former DM V stated that he was expected to have interviewed resident 48 when he completed the resident's post-hospital Food and Nutrition Data Collection assessment to ensure that changes in the resident's food likes, dislikes, and preferences were documented, communicated to, and followed by the dietary staff. Former DM V was not aware of how much or if resident 48 understood his new gluten-free diet, but he agreed that interviewing the resident for his 4/15/26 post-hospital assessment may have addressed some of the above uncertainties that the resident had about foods he was no longer being served. Former DM V indicated that the facility did not have a gluten-free pancake mix or the necessary ingredients to make gluten-free pancakes from scratch if that was on the menu and the resident wanted to have them. That food choice was not, but should have been accommodated for the resident. Former DM V thought that the reason resident 48 was not served sweet potato fries and the breaded cauliflower was because of the coating that was on both of them. He agreed that the resident's menu should have reflected gluten-free alternatives for both of those vegetables. Not offering gluten-free substitutions on the menu for the resident to choose from increased the resident's risk of not having a nutritionally balanced diet. 7. Review of the revised 7/30/26 DM job description revealed that the responsibilities of that position included communicating with the food preparation and service department to ensure that therapeutic menus were fully understood and executed. In addition, the DM was expected to "employ sound methods of planning, introducing, and following through on change," and "monitoring progress, providing feedback, support, and course correction as necessary." Providing resident care was also expected. 8. Review of the provider's revised 11/13/25 Dignity in Dining policy revealed that staff were expected to "offer residents a choice of food and beverages that respect their preferences..." and "monitor [food service] to ensure that residents receive their identified preferences." 9. Observation and interview on 7/29/26 at 7:45 a.m. with resident 48 revealed he was in his wheelchair and moving it towards the front lobby. He	F0800		

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F0800 SS = D	Continued from page 22 had a medical appointment that he was going to. Neither the kitchen staff nor a caregiver had offered him the option to eat his breakfast early that morning, or provided him with a ready-to-eat breakfast food item to take with him before he left the building and was transported to his appointment. 10. Interview on 7/29/26 at 8:15 a.m. with food service assistant W revealed that she relied on former DM V or the receptionist to let her know the residents' appointment schedules so that she could arrange for early meal trays for the residents when they had early morning medical appointments. Food service assistant W was not aware of resident 48's 7/29/26 appointment, so he was not offered or provided breakfast before he left for his appointment that morning. 11. Interview on 7/30/26 at 2:30 p.m. with senior director A revealed that upcoming resident appointments were discussed daily during the morning interdisciplinary team meetings. Department leaders were expected to communicate resident appointment information with their staff. Signs were also placed outside of the residents' rooms with appointment information. It was expected that all staff had used that information to ensure residents' nutritional needs were met on appointment days. She expected the staff to have offered and provided resident 48 with something to eat before he left for his appointment on 7/29/26. 12. Review of the provider's revised 12/18/25 Dining Service Standards policy revealed that the staff will, "provide assistance in dining in a way that promotes independence, maintains dignity and focuses on quality of life."	F0800		

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E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 7/28/26. Good Samaritan Society - St Martin Village was found in compliance.	E0000		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jana McCroden	Senior Director	8.21.26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435134	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - SERENITY P...** B. WING	(X3) DATE SURVEY COMPLETED **07/28/2026**

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<0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 7/28/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Good Samaritan Society - St Martin Village was found in compliance.	K0000		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jana McCroden	Senior Director	8.21.26

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68237	A. BUILDING: _____ B. WING _____	07/30/2026

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 7/28/26 through 7/30/26. Good Samaritan Society - St Martin Village was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jana McCroden

TITLE: Senior Director

(X6) DATE: 8.21.26