

| | | | | |
|---|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435134 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 02/21/2024 |
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - ST MARTIN VILLAGE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4825 JERICHO WAY RAPID CITY, SD 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 |
| F 000 | INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 2/21/24. The area surveyed was physical environment. Good Samaritan Society- St Martin Village was found not in compliance with the following requirement: F689. | F 000 | Doors on both the north and south entrances will be locked at all times. Visitors will enter through the main entrance. Doors are systematically locked 24/7. They are connected to the fire alarms so they will unlock when the fire alarm is triggered. | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on the South Dakota (SD) Department of Health (DOH) facility reported incident (FRI), observation, interview, record review, and policy review, the provider failed to ensure a secure environment by silencing alarms on 2 of 8 egress doors located on the north and south units. Findings include: 1. Review of the SD DOH FRI on 2/21/24 at 8:30 a.m. revealed: *A physical environment complaint resulting in an elopement of a resident. *A resident eloped from an alarmed door, but the alarm was silenced when the door closed. *The resident was outside the facility for 6 minutes. *The temperature at the time of the incident was | F 689 | On number 6, administrator A activated the alarm attempting to break "into" the building, not "out" of the building in an elopement. In speaking with Convergent, they expressed that the alarm volume is set to be softer for someone coming "into" the building versus louder when someone is going "out" of the building. Therefore, in an elopement attempt, the louder alarm will be activated as the resident would be going "out" of the building versus "into" the building. During the survey, we did not demonstrate the correct method of exit for an elopement to occur. All resident have the potential to be effected. All staff was educated on the elopement policy and procedure by the Director of Nursing or designee. Director of Nursing or Designee will hold an elopement drill once a week x3, every other week x3, and monthly x3. The Director of Nursing or designee will report all findings to the QAPI committee will review the audit results and if necessary, make any recommendations for improvement. Monitoring 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 demonstrated sustained compliance then as determined by the committee. | 3.12.24 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Jana McCroden

TITLE

Adminsitator, Senior Director

(X6) DATE

3.7.24

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435134 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 02/21/2024 |
|---|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - ST MARTIN VILLAGE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4825 JERICHO WAY RAPID CITY, SD 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 | |
| F 689 | <p>Continued From page 1</p> <p>in the 40s and the resident was wearing a light jacket.</p> <p>*The resident was found by a nurse going to lunch.</p> <p>*The resident had no history of elopement.</p> <p>2. Observation on 2/21/24 at 8:50 a.m. of the east egress door on the south unit revealed:</p> <p>*A camera was located above the door on the ceiling.</p> <p>*An "alarm sounds" sign was painted on the top part of the glass door.</p> <p>*A keypad required a numerical code on the wall next to the door when exiting the facility.</p> <p>-A push bar located on that same door that activated the opening of the door.</p> <p>*A second keypad with the addition of a push button was on the opposite side of that door and was located on the wall.</p> <p>*A short 4-to-5 foot passthrough led to another door that led to the outside of the facility.</p> <p>3. Observation on 2/21/24 at 9:00 a.m. of the north egress door on the north unit revealed the same set up as the south unit's east egress door.</p> <p>4. Observation and interview on 2/21/24 at 9:20 a.m. with resident 1 revealed she:</p> <p>*Was sitting up in her bed eating her breakfast.</p> <p>*Had a WanderGuard [a device used to monitor the movement of residents that were an elopement risk; the device i was worn on the wrist like a bracelet or on the ankle] placed on her right wrist.</p> <p>*The WanderGuard was placed a couple of weeks ago.</p> <p>-Was attempting to take a shortcut to the activities room to play Bingo.</p> <p>-Went through the wrong door and ended up</p> | F 689 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/04/2024
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435134 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 02/21/2024 |
|---|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - ST MARTIN VILLAGE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4825 JERICHO WAY RAPID CITY, SD 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 | |
| F 689 | <p>Continued From page 2</p> <p>outside.</p> <p>*Remembered hearing the alarms going off, but she kept going through the door.</p> <p>*Realized she took a wrong turn when she ended up outside.</p> <p>-Stated it was chilly outside, but was wearing a light Columbia jacket.</p> <p>*Was escorted back inside by an employee.</p> <p>-Understood why he thought she was trying to run away, but she just wanted to get to bingo.</p> <p>-Bingo was her favorite game and because of her mistake, she had to wear that "stupid bracelet."</p> <p>5. Interview on 2/21/24 at 9:50 a.m. with ancillary manager C revealed:</p> <p>*Door checks were done on a weekly basis in a system he used called TELS.</p> <p>-The application was downloaded to his cell phone for easy use.</p> <p>*A WanderuGard was used to check the alarms and locking mechanisms on the doors.</p> <p>*He demonstrated how to perform a door check in the TELS system.</p> <p>*It was the responsibility of the nursing staff to check the individual resident's WanderGuard function.</p> <p>6. Observation and interview on 2/21/24 at 10:16 a.m. with administrator A and ancillary manager C regarding the double doors on the south unit that led to the independent living side of the building revealed:</p> <p>*An "alarm sounds" sign was posted on the metal doors.</p> <p>*A keypad required a numerical code on the wall next to the door when exiting the facility into a corridor that led to the independent living center.</p> <p>*A keypad with the addition of a push button was located on the opposite side of the double doors</p> | F 689 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435134 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 02/21/2024 |
|---|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - ST MARTIN VILLAGE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4825 JERICHO WAY RAPID CITY, SD 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 | |
| F 689 | <p>Continued From page 3</p> <p>that was located on the wall.</p> <p>*A push bar was used to activate the opening of those doors.</p> <p>*If the keypad was not used before opening the doors, the push bar would have to be activated for 15 seconds before the door lock mechanism would release allowing the doors to open.</p> <p>-The door alarms would sound during that time and could only be silenced by entering the code on the keypad.</p> <p>*Administrator A purposely activated the alarm.</p> <p>*A timer was started to observe how long it would have taken staff to respond to the alarm.</p> <p>*Administrator A's expectation was for staff to respond to the alarm immediately.</p> <p>*Ten minutes passed before ancillary manager C arrived to disarm the alarm.</p> <p>*He did not hear the alarm until he begun rounding the corner to the location which was approximately 87 feet from the double doors.</p> <p>-He had some hearing damage to one of his ears from previous trauma have which might have affected the hearing of the alarm.</p> <p>*Ancillary manager C silenced the alarms with the keypad.</p> <p>*Administrator A and ancillary manager C both agreed the volume on the door alarm should have been louder.</p> <p>-Ancillary manager C confirmed the same volume was set on both the east egress door on the south unit and the north egress door on the north unit.</p> <p>*Ancillary manager C confirmed the volume on the alarm system was adjustable.</p> <p>7. Observation and interview on 2/21/24 at 10:45 a.m. with administrator A and ancillary manager C regarding the east egress door on the south unit revealed:</p> | F 689 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/04/2024
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435134 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 02/21/2024 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - ST MARTIN VILLAGE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4825 JERICHO WAY RAPID CITY, SD 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 | |
| F 689 | <p>Continued From page 4</p> <p>*When the push bar on the door was activated, there was no delay in opening the door.</p> <p>*The alarm sounded when the door was opened without using the keypad located on the wall.</p> <p>-The alarm did not sound if the keypad was used.</p> <p>*The alarm was silenced when the door closed.</p> <p>*A second keypad with an addition of a push button was on the opposite side of that door and it was located on the wall.</p> <p>-That keypad and push button were used to operate the door if an individual was entering the facility from the outside.</p> <p>*A short 4-to-5 foot passthrough that led to another door that led to the outside of the facility.</p> <p>-That door was not secured by a lock or a keypad and opened freely.</p> <p>*If the numerical keypad code was not used prior to opening the door, the alarm would sound and would silence once the door closed between the hours of 7:30 a.m. to 4:00 p.m. Monday through Friday.</p> <p>-The only time the door alarm would continue to sound during that adjusted setting time frame would have been if the individual was wearing a WanderGuard.</p> <p>*Ancillary manager C tested the door alarm with a WanderGuard.</p> <p>*The door alarm sounded when he did not use the numerical keypad code prior to opening the door.</p> <p>-When he did not use the numerical keypad code prior to pushing the door open, the door alarm sounded.</p> <p>*The adjusted setting was implemented for family or visitors that came through the door without using the numerical keypad code.</p> <p>*It was becoming a nuisance to have to silence the alarm manually each time someone did not use the numerical keypad code.</p> | F 689 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435134 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 02/21/2024 |
|---|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - ST MARTIN VILLAGE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4825 JERICO WAY RAPID CITY, SD 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 | |
| F 689 | <p>Continued From page 5</p> <p>-The adjusted setting was used as a convenience.</p> <p>*The north egress door on the north unit was set up to function the same way.</p> <p>*Resident 1 exited the facility during the adjusted setting on 2/9/24 at 12:50 p.m.</p> <p>-She was outside for 6 minutes when a staff member saw her outside of the window while going to lunch.</p> <p>*At that time, resident 1 was not wearing a WanderGuard.</p> <p>*It was administrator A's expectation that staff would still check if a resident exited the facility even though the alarm silenced once the door was closed during the adjusted time frame.</p> <p>*The charge nurse should have performed a headcount of the residents and followed the process on the elopement checklist if a resident was missing.</p> <p>*Administrator A confirmed that when resident 1 exited the facility, staff had not followed the elopement checklist.</p> <p>8. Interview with administrator A on 2/21/24 at 11:45 a.m. revealed:</p> <p>*She provided an example of the elopement checklist.</p> <p>*Staff were educated on the checklist during various training opportunities and it was located in a binder at the 2 nurses' stations.</p> <p>*She was unable to provide documentation of that education as she had given verbal education on the topic.</p> <p>9. Interview with administrator A on 2/21/24 at 11:52 a.m. revealed:</p> <p>*She provided documentation of staff education that was performed on 2/15/24.</p> <p>*The agenda showed 8 items listed.</p> | F 689 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435134 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 02/21/2024 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - ST MARTIN VILLAGE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4825 JERICHO WAY RAPID CITY, SD 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 | |
| F 689 | <p>Continued From page 6</p> <p>*There was a separate sheet that was not included on the agenda that listed "elopement policy and procedure" and had a handwritten addition listing "checklist binder."</p> <p>*She had not finished the education as that was an ongoing process.</p> <p>*Staff that were unable to attend the staff meeting were shown the education on the days when they arrived to work and signed the signature sheet at that time.</p> <p>10. Interview with activities supervisor E on 2/21/24 at 1:06 p.m. revealed: *On Bingo days, she usually went to get resident 1. -Sometimes the resident would meet her halfway to the activities room. *On 2/9/24 around 1:00 p.m. resident 1 decided to make her way to bingo on her own. *Bingo was held in the activities room and scheduled to begin at 2:00 p.m. *Resident 1 was embarrassed after the incident and was making jokes about her new bracelet.</p> <p>11. Interview on 2/21/24 at 2:30 p.m. with administrator A, director of nursing (DON) B, ancillary manager C, and administrator F revealed: *Administrator F would be filling in for administrator A when she goes on vacation for the next 2 weeks. *The doors that have the adjusted setting time frame went back to it's regular setting at 4:00 p.m. on weekdays and was not implemented on the weekends. *Ancillary manager C has a meeting tomorrow with the door alarm system project manager to re-evaluate the adjusted setting. *They agreed the volume of the door alarms were</p> | F 689 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/04/2024
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435134 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 02/21/2024 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - ST MARTIN VILLAGE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4825 JERICHO WAY RAPID CITY, SD 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 | |
| F 689 | <p>Continued From page 7</p> <p>not loud enough for staff to hear if they were on the opposite side of the unit.</p> <p>*They would be addressing the volume of the door alarms with the door alarm system project manager.</p> <p>*The adjusted settings time frame was more convenient for resident family members to enter the facility without having to use the front entrance.</p> <p>*They would be looking into a solution that would accommodate both the families of the residents and for resident safety.</p> <p>Review of the provider's 8/22/23 Alarms: Bed, Chair, and Door Rehabilitation/Skilled Care policy revealed "Procedure: 3. All staff will be responsible for physically checking on the resident when an alarm goes off."</p> | F 689 | | | |