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
	81254	A. BUILDING: _____ B. WING _____	C 10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - ST MARTIN VILLAGE	1851 CITY SPRINGS RD 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) COMPLETE DATE
S 000	Compliance Statement An initial licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 10/7/25 through 10/8/25. Good Samaritan - St Martin Village was found not in compliance with the following requirements: S200, S632, and S642. A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted on 10/7/25 through 10/8/25. The area surveyed was related to a staff member physically restraining a resident. Good Samaritan - St Martin was found in compliance.	S 000	Unable to correct prior deficient practice. All residents are at risk when there are not sidewalks connecting to a public way. Since this is a remodeled building, there has been communications with the general contractor and department of health on the best solution. There will be an agreed upon solution by the department of health and general contractor.	11.22.25
S 200	44:70:03:01 Fire Safety Code Requirements Each facility must meet applicable fire safety standards in NFPA 101 Life Safety Code, 2012 edition in chapter 32 or 33. An automatic sprinkler system is not required in an existing facility unless significant renovations or remodeling of greater than fifty percent of the facility occurs, provided that any existing automatic sprinkler system must remain in service. An attic heat detection system is not required in an existing facility unless significant renovations or remodeling of greater than fifty percent of the facility occurs. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview the provider failed to continuously maintain egress free of obstructions that would prevent its use to a public way for two of nine observed facility exit doors	S 200	Ancillary manager or designee will audit completion of agreed upon solution weekly x3, every other week x3, and monthly x3. Ancillary manager 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 Ancillary manager 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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jana McCroden — TITLE: Sr Director — (X6) DATE: 10.24.25

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S 200	Continued From page 1 (kitchen and activity room). Findings include: 1. Observation on 10/8/2025 at 11:50 a.m. in the facility courtyard with the maintenance supervisor revealed one kitchen exit door and one activity room exit door that opened to the courtyard. Each of those doors had separate concrete pads that did not have any connecting sidewalks to a public way. Interview with the maintenance supervisor at the time of the observation confirmed those findings. This finding affected 100% of those who may have needed to utilize two of the nine facility exits.	S 200	Unable to correct prior deficient practice. All medications were cross checked with Electronic Medical Record to ensure orders and medication cards match. Resident 1's order was changed to ensure that the dosage of the card and the order match. All residents are at risk when medication orders and medication cards do not match. Education will be provided by the Nurse Manager or designee to all medication aides on the 6 rights of medication administration. When a medication dosage is changed, any remaining dosages will be disposed of per policy. Nurse Manager or designee will audit Electronic Medical Record to medication cards to ensure accuracy of orders weekly x3, every other week x3, and monthly x3. Nurse Manager 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 Nurse Manager 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.	11.22.25
S 632	44:70:07:04 Storage And Labeling of Medications The medications or drugs of each resident for whom a medication is facility-administered must be stored in the container in which it was originally received and may not be transferred to another container. Single dose medication received by a resident from a physician, physician assistant, or nurse practitioner must be identified as single dose. Each prescription medication container, including manufacturer's complimentary samples, must be labeled with the resident's name; the name of the resident's physician, physician assistant, or nurse practitioner; medication name and strength; directions for use; and prescription date. This Administrative Rule of South Dakota is not met as evidenced by:	S 632		

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S 632	Continued From page 2 Based on observation, interview, and record review, the provider failed to ensure one of one sampled resident's (1) medication card of quetiapine fumarate tablets was labeled according to the physician's order for that medication. Findings include: 1. Observation and interview on 10/7/25 at 8:23 a.m. with unlicensed assistive personnel (UAP) B regarding resident 1's medication cards revealed: *Resident 1's morning dose medication card of quetiapine fumarate (medication for mental health conditions) was filled by the pharmacy on 9/10/25. -There was one 50 milligram (mg) tablet in each dose bubble of that medication card. *Resident 1's medication administration record (MAR) indicated he was to receive two tablets of quetiapine fumarate 25 mg in the morning. *UAP B stated she was aware that the dose of each tablet in that medication card and the physician's order were not the same. -She thought it was "ok" but had not confirmed that with a nurse. Review of resident 1's care record revealed: *His admission date was 4/29/25. *A 9/8/25 physician order indicated he was to be given two 25 mg tablets of quetiapine fumarate in the morning. Interview on 10/8/25 at 3:32 p.m. with registered nurse (RN) A regarding resident 1's physician orders revealed she confirmed: *His physician's order for two tablets of 25 mg of quetiapine fumarate and his medication card of 50 mg tablets of quetiapine fumarate did not match and required a medication dose	S 632		

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S 632	Continued From page 3 calculation. *A UAP was not qualified to calculate a medication dose. *A resident's physician ordered medication, and the medication card filled by the pharmacy needed to match.	S 632	Unable to correct prior deficient practice.	
S 642	44:70:07:05 Control And Accountability of Medications The facility must receive written authorization from the resident's physician, physician assistant, or nurse practitioner before releasing any medication to a resident upon discharge, transfer, or temporary leave from the facility. The release of medication must be documented in the resident's record, indicating quantity, drug name, and strength. The facility shall maintain records that account for all medications and drugs from receipt through administration, destruction, or return. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, record review, and policy review the provider failed to ensure controlled medications (medications with risk of abuse, addiction, and potential theft) count records were completed accurately for three of three reviewed months (August, September, and October 2025) according to their policy. Findings include: 1. Interview and observation on 10/7/25 at 8:23 a.m. with unlicensed assistive personnel (UAP) B of controlled medication count records and	S 642	Residents who receive narcotics are at risk for deficient practice. Education will be provided by the Nurse Manager or designee to all medication aides on expectations of counting the narcotics. New Controlled Drugs - Count Record form will be implemented for easier accountability for medication aides. Nurse Manager or designee will audit completion of Controlled Drugs – Count Record weekly x3, every other week x3, and monthly x3. Nurse Manager 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 Nurse Manager 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.	11.22.25

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S 642	Continued From page 4 regarding the provider's process for the accounting of residents' controlled medications revealed: *During shift change, the staff member who was leaving and the staff member who was coming on duty, would count all of the residents' controlled medications. -The oncoming staff member counted the number of medications in each resident's controlled medication cards, while the leaving staff member checked if that count matched the documented count on the controlled substances (medication) tracking form. -After all the controlled medications were counted, both staff members who completed that count sign the "Controlled Substances Count Record" which indicated that the controlled medication count was completed and there were no discrepancies. --If a discrepancy was discovered, during the controlled substance count, the nurse was to be notified. *The provider's controlled substance count record for 10/1/25 through 10/7/25 had two missing staff member signatures. *UAP B stated, "I forgot to sign this morning when we counted." -She then signed the form for one of those two missing staff signatures. Review of the provider's August 2025, September 2025, and October 2025 (from 10/1/25 through 10/7/25) Controlled Substances Count Records revealed: *For August 2025 there were three missing off-going staff member signatures and two missing oncoming staff member signatures to confirm the count was completed. The count was not recorded as correct or not correct for two of that month's medication counts.	S 642		

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S 642	Continued From page 5 *For September 2025 there were four missing off-going staff member signatures and two missing oncoming staff member signatures to confirm the count was completed. The count was not recorded as correct or not correct for one of that month's medication counts. *From 10/1/25 through 10/7/25 one off-going staff member had not signed the medication count form to confirm the count was completed with no discrepancies. Interview on 10/8/25 at 3:54 p.m. with registered nurse (RN) A regarding controlled medication accounting revealed: *The provider had two staff shifts, a twelve-hour day shift and a twelve-hour night shift. *The off-going staff member and the oncoming staff member were to count the controlled medications together at each shift change to confirm all controlled medications were accounted for. *She expected the staff to complete that process at each shift change. *She was not aware that there were missing staff signatures on each of the August 2025, September 2025, and October 2025 controlled substances count records and nd thought the staff members may have "just forgotten" to sign those records. Review of the provider's 8/13/25 Controlled Substances policy revealed: *"PURPOSE To provide expectations and procedures around the receipt, secure storage, security, integrity, destruction and documentation of all controlled substances [medications] in the assisted living community". *"POLICY 1. Every time the keys that secure medications	S 642		

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S 642	Continued From page 6 change from one shift employee to another shift employee, the oncoming and off going medication aides/universal workers work together to count all controlled substances, including discontinued controlled substances." *"PROCEDURE 1. The oncoming medication aide unlocks the controlled substances storage unit and physically counts each controlled substance container/package on hand for each resident ... 2. At the same time, the off-going medication aide assists by watching and verifying that the count matches the amount documented on each resident's Individual Resident's Narcotic Record or bound controlled substance log. 3. The activity of the shift change controlled substances count is recorded on the Controlled Substances - Count Record or bound controlled substances log. A. If each count showing on the [Individual Resident's Narcotic Record] or bound controlled substance log and the physical count are in agreement, both medication aides will sign the appropriate shift section and column to identify the off-going and oncoming medication aide performing the count."	S 642		