STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435074	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW , DE SMET, South Dakota, 57231

(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
F0000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 10/22/25 through 10/23/25. Areas surveyed included potential abuse and neglect related to a resident who required rehospitalization and had acquired a pressure ulcer (skin and/or underlying tissue injury from prolonged pressure). Good Samaritan Society De Smet was found not in compliance with the following requirements: F655, F684, and F686.	F0000	The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F0655 SS = D	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- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.	F0655	1. Resident (1) was admitted to the facility on 10/9/2025 and discharged back to the hospital on 10/12/2025 (3 days later). A baseline care plan had not been completed within 48 hours of admission. As the resident was no longer in the facility at the time of the complaint survey of 10/22/2025, no further resident – specific corrective action was possible. Although Resident (1) was no longer in the facility, this incident was reviewed by the DNS and Admin to identify root causes and contributing factors. The review determined that the absence of a timely baseline care plan contributed to gaps in coordinated care and monitoring. Immediate corrective actions included: re-education of nursing staff (LPN/RN) by DNS/Designee involved in admission and skin assessments by the next worked shift or 11/20/2025 whichever is first, implementation of immediate skin integrity interventions for all current residents at risk, and completion of skin checks on all residents to ensure no additional unidentified pressure areas were present. 2. The DNS/designee conducted a 100% audit of all residents admitted within the 30 days prior to 10/22/2025 to ensure that each had a baseline care plan completed within 48 hours of admission; no other residents were identified as not receiving a baseline care plan. No other residents were identified as being without a completed baseline care plan within the required timeframe. Any potential risks found during this audit were immediately addressed through care plan review and appropriate interventions.	11/20/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brittney Arith	Administrator	11-17-25

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F0655 SS = D	Continued from page 1 §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 interview, record review, and policy review, the provider failed to complete a baseline care plan within 48 hours of her admission to the facility, for one of one newly admitted sampled resident (1) who developed a Stage II (2; open wound or blister with partial-thickness skin loss) pressure ulcer to her coccyx (tailbone) after she admitted to the facility. Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed: *She admitted to the facility on 10/9/25. *Her 10/9/25 Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated her cognition was intact. *Her diagnoses included infection due to an internal left knee prosthesis (artificial joint), Type II Diabetes Mellitus (a condition involving disruptions in how the body regulates blood sugar), Chronic Kidney	F0655	3. The Baseline Care Plan policy was reviewed on 11/06/2025 to reinforce that baseline care plans must be developed and implemented within 48 hours of admission; no changes were needed. All licensed nurses, MDS coordinator and admission personnel will receive education by DNS/Designee starting 11/6/2025 through 11/20/2025 regarding the policy and the importance of completing the baseline care plan promptly to ensure individualized interventions are in place. The nurse receiving the admission will be responsible for completing the baseline care plan, in the absence of DNS/MDS. A baseline care plan admission checklist was developed and incorporated into the admission process. The DNS/Designees must verify the completion within 48 hours of admission. 4. The DNS/Designee will conduct weekly audits for all newly admitted residents for completion and delivery of baseline care plans within 48 hours of admission for three months. Once 100% compliance is maintained for three consecutive months, monitoring will be moved to a monthly schedule for two months. Audit findings will be presented by DNS/Designee during monthly QAPI meetings for review and follow-up. Any identified noncompliance will result in immediate re-education and/or corrective action.	

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F0655 SS = D	Continued from page 2 Disease Stage 3 (kidneys do not effectively filter blood and have moderate damage), and adjustment disorder with mixed anxiety and depressed mood. *Her 10/9/25 physician orders indicated: -She was on a diabetic diet. -She was non-weight-bearing (unable to put pressure) on her left leg. -"Prevera [Prevena] wound vac (a device that uses negative pressure to remove excess fluid and debris from a wound to promote healing). Leave in place. Will be removed at follow up appointment." -She was to receive Triad Hydrophilic Wound Dressing Paste (a wound treatment cream) to her right and left buttocks two times a day for "skin breakdown." -She received "DAPTOmycin [an antibiotic] Intravenous Solution Reconstituted" once daily, related to an infection in her left knee. *Her 10/9/25 Braden Scale (a tool used to assess the risk of developing pressure ulcers) indicated: -She was confined to bed and needed moderate to maximum staff assistance with moving. -The ability to complete lifting to boost resident 1 in bed without sliding against the sheets was "impossible." -She frequently slid down in bed and needed "frequent repositioning with maximum assistance." -Her Braden Scale score was 15, which indicated she was at risk for developing pressure ulcers. *A 10/10/25 Skin Observation assessment indicated resident 1 had a "Large area on [her] bottom [that was] red, flaky, [and] macerated [softening of skin due to prolonged exposure to moisture] present on admission," and that resident 1 was "on an air mattress." *Her 10/10/25 physical therapy evaluation indicated resident 1 needed moderate staff assistance for rolling in bed, and the use of the total body lift (a mechanical lift and sling used to lift a person's full body) when being transferred. *Nursing progress notes from 10/9/25 through 10/12/25	F0655		

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F0655 SS = D	Continued from page 3 indicated resident 1 had frequent complaints of pain in her left leg. 2. Review of resident 1's 10/9/25 care plan revealed: *It did not indicate that resident 1 had a full-length left leg cast, a wound vac (a medical treatment to promote wound healing) to her left leg, a urinary catheter (flexible tubing inserted into the bladder to drain urine), or that she received intravenous antibiotics. *It did not indicate resident 1's transfer or weight-bearing status, the level of assistance she required to complete her activities of daily living, including toileting and repositioning, her risk for pressure injuries, the location or management of her pain, or interventions necessary to care for her or reduce the risk of her acquiring a pressure ulcer. *There was no documentation that indicated a baseline care plan was completed within 48 hours of her admission to the facility. 3. Interview on 10/23/25 at 9:09 a.m. with medical doctor (MD) E who participated by phone revealed: *He was resident 1's orthopedic surgeon for several surgeries involving resident 1's left knee and was familiar with her medical history. *Resident 1 was admitted to the hospital on 10/12/25 from the nursing home (provider) with fractures above and below the rod that had been surgically placed. The resident also had a Stage II (2; open wound or blister with partial-thickness skin loss) pressure ulcer to her buttocks/coccyx and associated moisture-related skin damage to her perineum (the area between the genitals and anus) that was not present when he discharged resident 1 from the hospital on 10/9/25. 4. Interview on 10/23/25 at 1:03 p.m. with administrator A and director of nursing (DON) B revealed: *DON B stated she typically completed resident baseline care plans within 48 to 72 hours after a resident admitted to the facility. *DON B was not at the facility from 10/9/25 through 10/12/25 and did not complete resident 1's baseline	F0655		

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F0655 SS = D	Continued from page 4 care plan. -She planned to complete that care plan documentation when she returned to work on 10/13/25. *Administrator A expected that baseline care plans would be developed and completed within 48 hours of a resident's admission to the facility by DON B. -No other nurses were trained on how to complete the residents' baseline care plans. -Administrator A expected DON B to complete resident 1's care plan when she returned to work on 10/13/25, but resident 1 discharged to the hospital on 10/12/25. *DON B stated that nursing staff used the baseline care plan to know how to care for a resident until the comprehensive care plan was completed. Without a written baseline care plan, she expected nursing staff members to "pass along" important information in their nursing report (staff verbal communication of residents' status) at the beginning and end of each shift. *Administrator A and DON B were unaware that resident 1 had developed a pressure ulcer after she admitted to the facility. 5. Review of the provider's updated 12/2/24 Care Plan policy revealed: *"Baseline care plan- Includes instructions needed to provide effective and person-centered care to the resident that meet professional standards of quality care." **"A baseline care plan will be developed upon admission according to federal and state regulations. The location [facility] must provide the resident and resident representative with a written summary of the baseline care plan." **"The resident/family or legal representative will have the opportunity to participate in the planning of his or her care to the extent practicable."	F0655		
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F0684		

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F0684 SS = G	Continued from page 5 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI) review, observation, interview, record review, resource packet review, and facility assessment review, the provider failed to ensure sufficient caregiver staff were available to meet the needs of: *One of one sampled resident (1) who relied on staff assistance for repositioning and developed a Stage II (2; open wound or blister with partial-thickness skin loss) pressure ulcer to her coccyx (tailbone) after she admitted to the facility. *One of one sampled resident (2) who relied on staff assistance for toileting and incontinence care and reported certified nursing assistant (CNA) H turned off the resident's call light without assisting the resident with toileting, which contributed to the resident being incontinent, remaining in wet garments overnight, inability to sleep, and expressed feeling of distress. Findings include: 1. Review of the provider's 10/13/25 SD DOH FRI regarding resident 2 revealed: *On 10/13/25 at 7:21 a.m., resident 2 reported "concerns about the care provided during the overnight shift," which included: -Certified nursing assistant (CNA) H had responded to her call light "multiple times," but "no assistance was provided." -CNA H turned off resident 2's call light and exited the room without assisting her, which led to an "episode of incontinence." *Resident 2 expressed distress related to that incident. *The provider "does not have the capacity to generate a call light usage and response time report."	F0684	1. On 10/22/2025 and 10/23/2025, the DNS and Admin reviewed care plans of resident (1) which were not present and resident had since been discharged to the hospital. Resident (2) care plan checked to check for accuracy of activities of daily (ADLs), repositioning, or toileting needs; this was completed on 10/23/2025. All issues that were identified were corrected immediately, and care plans were revised as necessary. The audit included review of care plans reviews to ensure individualized interventions were implemented and documented. 2. All residents have the potential to be affected; an audit on all care plans and Kardex's to ensure accuracy on all residents requiring staff assistance with activities of daily living (ADLs) repositioning, or toileting needs was completed on 11/5/2025. 3. The Administrator, Director of Nursing (DON), and interdisciplinary team (Activity Director, Social Services, MDS, and Dietary Manager), in collaboration with the Medical Director, reviewed the Quality-of-Care Policy on 11/5/2025. All nursing staff will be educated by DNS/designee on Quality-of-Care before their next scheduled shift starting on 11/6/2025 by 11/20/2025. Staff will have a clear understanding of the policy with clear outlines of staff responsibilities for: responding promptly to call lights, providing timely repositioning and continence of care by following the rounding process, documenting completion of these interventions. 4. The DNS/designee will conduct random weekly audits of 5 residents for 8 weeks. If compliance remains at 100% for three consecutive months, audit frequency will be reduced to quarterly for four quarters. Audits will include: repositioning, toileting care and rounding are provided as scheduled per the POC documentation completed by CNA/Nurses, call light responses meet resident satisfaction with questionnaire, and that care plans reflect individualized interventions. All findings will be brought to the monthly Quality Assurance and Performance Improvement (QAPI) meeting by DNS/designee. Any deficiencies identified will be addressed immediately through staff re-education and/or corrective action.	11/20/25

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F0684 SS = G	Continued from page 6 *"On the night of the incident there was a CNA and an RN [registered nurse] on duty [to care for] 38 residents." *"Based on the findings of the [providers] investigation, the allegation of neglect was unsubstantiated [by the provider]. There was no conclusive evidence that the CNA failed to provide care or turned off the call light without assisting the resident." 2. Observation and interview on 10/23/25 at 11:21 a.m. with resident 2 and her daughter in her room revealed: *Resident 2 was assisted by two CNAs to use the bedpan and then was assisted to her recliner using a total body lift (a mechanical lift and sling used to lift a person's full body). *Resident 2 recalled a recent night when she had called for staff assistance, became incontinent, remained "wet all night," and was unable to sleep. -On that night, she turned her call light on to ask for assistance, but the staff member was busy, shut off her call light, and did not come back to her room to help her. Resident 2 was occasionally incontinent and stated she "couldn't hold it" and was awake and "wet all night." *Resident 2's daughter washed her mother's laundry and recalled that when she arrived at the facility that day (10/13/25), she found her mother's pajamas were "soaking wet, both the top and bottoms." *Resident 2's daughter took her mother's pajamas and a bag of bedsheets that were left in her mother's room to her home to wash, and recalled being "shocked" at how wet they were. *Resident 2's daughter stated that resident 2 used a bedpan when staff responded quickly enough to prevent an incontinent episode. She noticed her mother's pajamas were wet more often over the past month, and she questioned if they had enough staff working at the facility to assist her mother at night or if her mother was having more frequent episodes of incontinence. 3. Review of resident 2's electronic medical record (EMR) revealed:	F0684		

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F0684 SS = G	Continued from page 7 *She admitted to the facility on 6/14/22. *Her 9/17/25 Brief Interview for Mental Status (BIMS) score was 13, which indicated her cognition was intact. *Her updated 10/14/25 care plan indicated she was incontinent at night, wore an incontinence garment, and wanted to be woken up at night for assistance with her toileting needs. 4. Review of the 10/17/25 anonymous complaint intake report regarding resident 1 revealed: *Resident 1 had been admitted to the facility on 10/9/25, after a surgery to place a rod in her left leg. She was in a full-length cast and was dependent on staff for repositioning and pain medication. *Resident 1 developed worsening pain in her left leg starting on 10/11/25 and "burning in her back and bottom" throughout the night. *She was admitted to the hospital on 10/12/25 with a pressure ulcer that measured four inches by six inches and was "deep." The rod in resident 1's left leg had "broken away," and requiring an additional surgery. 5. Review of resident 1's electronic medical record (EMR) revealed: *She admitted to the facility on 10/9/25. *Her 10/9/25 Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated her cognition was intact. *Her diagnoses included infection due to an internal left knee prosthesis (artificial joint), Type II Diabetes Mellitus (a condition involving disruptions in how the body regulates blood sugar), Chronic Kidney Disease Stage 3 (kidneys do not effectively filter blood and have moderate damage), and adjustment disorder with mixed anxiety and depressed mood. *Her 10/9/25 physician orders indicated: -She was on a diabetic diet. -She was non-weight-bearing (unable to put pressure) on her left leg. -"Prevera [Prevena] wound vac (a device that uses	F0684		

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F0684 SS = G	Continued from page 8 negative pressure to remove excess fluid and debris from a wound to promote healing). Leave in place. Will be removed at follow up appointment." -She was to receive Triad Hydrophilic Wound Dressing Paste (a wound treatment cream) to her right and left buttocks two times a day for "skin breakdown." -She received "DAPTOmycin [an antibiotic] Intravenous Solution Reconstituted" once daily, related to an infection in her left knee. *Her 10/9/25 Braden Scale (a tool used to assess the risk of developing pressure ulcers) indicated: -She was confined to bed and needed moderate to maximum staff assistance with moving. -The ability to complete lifting to boost resident 1 in bed without sliding against the sheets was "impossible." -She frequently slid down in bed and needed "frequent repositioning with maximum assistance." -Her Braden Scale score was 15, which indicated she was at risk for developing pressure ulcers. *A 10/10/25 Skin Observation assessment indicated resident 1 had a "Large area on [her] bottom [that was] red, flaky, [and] macerated [softening of skin due to prolonged exposure to moisture] present on admission," and that resident 1 was "on an air mattress." -The "Care Plan for Skin" section listed several potential focus areas, goals, and interventions to select if applicable. The care plan section had not been completed. -The "Education" section listed potential education provided, potential barriers, and potential persons educated to select if applicable. The education section had not been completed. *Her 10/10/25 physical therapy evaluation indicated resident 1 needed moderate staff assistance for rolling in bed, and the use of the total body lift (a mechanical lift and sling used to lift a person's full body) when being transferred. *Resident 1's "Roll left and Right" task documentation included:	F0684		

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F0684 SS = G	Continued from page 9 -On 10/9/25, one rolling task was documented as "Not applicable – Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or illness." -On 10/10/25, the rolling task was documented, at 11:36 a.m. and again at 9:59 p.m., as dependent or requiring the assistance of two caregivers. -On 10/11/25, the rolling task was documented: at 1:59 p.m., as "refused" and at 9:59 p.m., as dependent or requiring the assistance of two caregivers. -On 10/12/25, the rolling task was documented at 1:59 p.m., as dependent or requiring the assistance of two caregivers. *Resident 1's 10/9/25 care plan did not include resident 1's full-length left leg cast, wound vac (a medical treatment to promote wound healing) to her left leg, urinary catheter (flexible tubing inserted into the bladder to drain urine), transfer or weight-bearing status, assistance needs to complete activities of daily living such as toileting and repositioning, risk for developing pressure ulcers, or interventions to prevent acquiring a pressure ulcer. 6. Review of resident 1's 10/9/25 through 10/12/25 progress notes revealed: *On 10/9/25 resident 1 was admitted at 2:20 p.m., was "fully oriented", "was in significant pain and any movement was difficult." *On 10/10/25 resident 1 was pleasant and cooperative, refused to allow staff to remove her catheter due to her decreased mobility and increased pain, and had "remained in bed since [her] admission yesterday." *On 10/11/25 resident 1 "continues to remain in bed since admission," "continues to have red, flaky macerated skin to buttocks/coccyx area," that "staff attempts to relieve pressure to area with repositioning as res [resident 1] allows," and that resident 1 "tends to lean often to [her] R [right] side due to pain from her LLE [left lower extremity]." *On 10/12/25 PN resident 1 had reported her back and bottom "are on fire," the nurse (LPN D) went to put cream on her bottom, resident 1 did not "want the creams for [her] back and bottom; did not want to be touch[ed]/repositioned," and at 12:05 p.m., resident 1 was sent to the emergency room due to "being	F0684		

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F0684 SS = G	Continued from page 10 inconsolable with increased pain to LLE." 7. Interview on 10/22/25 at 1:57 p.m. with registered nurse (RN) F revealed: *RN F completed resident 1's admission skin assessment on 10/9/25. Resident 1 was admitted to the facility with an area to her right and left buttocks that was approximately four inches by six inches wide and was "bright red" and "excoriated." RN F stated the area was not bleeding and did not "look like a pressure area," but rather appeared like an area associated with moisture where the top layer of skin was broken down. *RN F faxed the resident's physician for an order for "Triad cream" because RN/wound nurse C and director of nursing (DON) B were not at the facility that day. *RN F did not complete resident 1's baseline care plan. She expected that DON B would complete that care plan when DON B returned to work. *RN F repositioned resident 1 during her admission assessment and stated that resident 1 required the assistance of two staff members with rolling the resident due to her left leg cast and she was in a lot of pain. 8. Interview and staff schedule review on 10/22/25 at 12:43 p.m. with medical records (MR) staff member I revealed: *MR staff member I completed the staff schedules and would find additional staff to cover open shifts when needed. *During the overnight hours, there was to be one nurse scheduled from 6:00 p.m. until 6:30 a.m. *During the overnight hours, CNA staffing varied from one to two scheduled CNAs, depending on staff availability. -If two were scheduled, one CNA shift was from 10:00 p.m. until 6:30 a.m., and a second CNA shift was from 11:00 p.m. until 7:30 a.m. -The goal was to have two CNAs on duty for the overnight shifts, but that was not always possible. -She felt it was harder to staff two CNAs for the overnight shifts on the weekends because staff were not	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435074	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/23/2025

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F0684 SS = G	Continued from page 11 always available. *There were six overnight shifts during the two week period from 10/5/25 through 10/18/25, where one CNA and one nurse worked the overnight shift. -One nurse and one CNA worked the overnight shifts on Saturday, 10/11/25, and on Sunday, 10/12/25. *When DON B was out of the facility, the charge nurse would be the person in charge, and DON B would be available by phone, if needed. 9. Interview on 10/22/25 at 3:25 p.m. with CNA H revealed: *She had worked at the facility since 10/1/25 and typically worked the overnight shifts. -Sometimes two CNAs worked during the overnight shifts, and sometimes she was the only CNA for those shifts. -She felt that it was "really hard" when she was the only CNA working the overnight shift, but she was getting used to it. *She typically had 40 residents that she cared for during the overnight shift. She was responsible for answering the residents' call lights and "doing rounds (checking on residents' status and assistance needs)," by going room to room and checking on the residents. -She referred to the resident's care plans to know how much assistance residents required at night, but was unsure how many residents were incontinent, or how many required the assistance of two staff members. *She thought that she completed rounds and changed residents' incontinence products about four times each night. *She worked on 10/10/25 from 7:00 p.m. until 10/11/25 at 6:30 a.m. and again on 10/11/25 from 6:00 p.m. until 10/12/25 at 6:30 a.m. *She stated that on both of those days that she worked, there was one nurse and three CNAs on duty from 7:00 p.m. until 10:30 p.m., and from 10:30 p.m. until 6:30 a.m., CNA H and one nurse were on duty. *She could ask the nurse for assistance with the residents when the nurse was not busy with other tasks.	F0684		

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F0684 SS = G	Continued from page 12 *She felt that some nurses were more helpful than others with answering resident call lights and changing residents' incontinence products. *On the night resident 2 had reported concerns about not being assisted and having an incontinence episode, CNA H was the only CNA on duty, was very busy assisting another resident who was in the end of life process, and she thought that she may have missed one set of resident rounds. *She recalled that resident 1 had a catheter and that she emptied the urine from the resident's catheter at the end of her shift on 10/11/25. She did not know if resident 1 wore an undergarment or how much assistance she required for rolling or repositioning. *During the above worked shifts, she entered resident 1's room when resident 1 turned on her call light to request pain medication or water. She could not recall if she had repositioned resident 1 during those times. *She stated her interactions with resident 1 had been "limited," and she thought that the nurse would have assisted resident 1 when she went into her room to provide her with medications. 10. Interview on 10/23/25 at 9:09 a.m. with medical doctor (MD) E revealed who participated by phone revealed: *He was resident 1's orthopedic surgeon for several surgeries involving resident 1's left knee and was familiar with her medical history. *Resident 1 was admitted to the hospital on 10/12/25 from the nursing home (provider) with fractures above and below the rod that had been surgically placed. The resident also had a Stage II (2; open wound or blister with partial-thickness skin loss) pressure ulcer to her buttocks/coccyx and associated moisture-related skin damage to her perineum (the area between the genitals and anus) that was not present when he discharged resident 1 from the hospital on 10/9/25. *He felt that the fractures around the rod in resident 1's left leg could not have been prevented and could have occurred with very little force or movement due to her poor bone quality and multiple complicating medical factors. *He felt that resident 1's pressure ulcer on her	F0684		

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F0684 SS = G	Continued from page 13 buttocks/coccyx and the soft tissue skin damage to her perineum were preventable. *Resident 1's pressure ulcer required her to be transferred to a specialty hospital for further care and treatment. 11. On 10/23/25 at 9:10 a.m., administrator A was requested to provide a call light audit report for resident 1 and resident 2 from 10/9/25 through 10/12/25 to review. Their call light system did not have the capability to provide reports, and no call light audits were available for review. On 10/23/25 at 9:10 a.m., administrator A was requested to provide video surveillance footage for the overnight hours from 10/10/25 through10/13/25 for review. Their video monitoring system only monitored the exit doors, and no video surveillance was available for review. 12. Interview on 10/23/25 at 10:20 p.m. with licensed practical nurse (LPN) D revealed: *She had completed a skin assessment on resident 1 after resident 1 had a bed bath on the morning of 10/10/25. Resident 1's bottom was red, excoriated, and had areas of flaky skin. The area was large but was not open. *Resident 1 allowed CNAs to provide her care and roll her slowly and carefully. Her movements were "guarded," and she allowed them to place pillows under her leg to make her more comfortable. *Resident 1 would at times refuse to be repositioned if she was comfortable. *LPN D recalled that on the morning of 10/12/25, resident 1 was in significantly more pain, allowed CNAs to provide her with a bed bath, reported that her "butt and back were on fire," and allowed CNAs to put a pillow under her leg. Resident 1 refused to allow LPN D to put the cream on her back and bottom that morning. *LPN D called the on-call medical provider, and the decision was made to send resident 1 to the emergency room for evaluation due to uncontrollable pain in her left leg. 13. Interview on 10/23/25 at 10:53 a.m. with LPN G	F0684		

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F0684 SS = G	Continued from page 14 revealed: *She worked the overnight shift on 10/10/25 at 6:00 p.m. until 6:30 a.m. on 10/11/25. -There typically was one CNA and one nurse who worked the overnight shifts to provide care to all the residents. *She remembered resident 1 was in a lot of pain when she had arrived at work on 10/10/25 and that she had given resident 1 PRN (as needed) pain medication and her scheduled evening medications. *LPN G called DON B that evening because resident 1's left leg pain was not controlled and was advised by DON B to contact the on-call medical provider. LPN G called the on-call medical provider, who approved LPN G to provide resident 1 with an early dose of her pain medication that day. *LPN G recalled that resident 1 "must have slept all night," because she did not recall giving resident 1 any additional pain medication or having gone into resident 1's room again after giving her that pain medication. She could not recall if she assisted CNA H on 10/10/25 or 10/11/25 with repositioning resident 1. *She had not worked the night shift on 10/12/25 when resident 2 had reported being incontinent overnight. *She felt that when she worked with CNA H, CNA H became "overwhelmed" and "frustrated" at times, and would need to take "short breaks." *LPN G felt that it was harder to meet the needs of the residents when there was just one CNA on duty on night shifts, but stated she felt that they did the best they could and the staff were always busy. *LPN G stated that she helped with repositioning residents and changing the residents' incontinence products when the night CNA requested her assistance, but those tasks were typically done by the CNA. She could not recall if she had assisted CNA H on 10/10/25 or 10/11/25 with repositioning resident 1. 14. Interview on 10/23/25 at 12:50 p.m. with RN/wound nurse C revealed she: *She was not present at the facility while resident 1 resided there and did not provide any of the resident's care.	F0684		

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F0684 SS = G	Continued from page 15 *Was the provider's wound nurse, and typically provided monitoring and interventions for residents who admitted with skin wounds, were identified as at risk for wounds, or developed a wound. *Would assess a resident identified by the nursing staff as "at risk" for a pressure ulcer, complete a Wound Data Collection form, obtain physician's orders if treatment was needed, and implement interventions to decrease the likelihood that a resident would develop a pressure ulcer. *Expected that the nurse who completed resident 1's admission assessment, or DON B, would have implemented and care planned interventions due to resident 1's skin condition on admission and her identified risk for developing pressure ulcers because she was bedbound. She expected those interventions to have included frequent repositioning, skin care to prevent moisture, and offloading of bony prominences like her heels. *Was aware that resident 1 had an air mattress. 15. Interview on 10/23/25 at 1:03 p.m. with administrator A and DON B revealed: *Administrator A stated that staffing levels were determined based on resident care hours and the number of staffing hours she was allowed by the facility's corporate management. *Their current night staffing was for one nurse and one or two CNAs on duty to care for all residents, depending on staff availability. They were trying to hire more night shift staff and depended on contracted travel staff to work extra shifts when they were able. *The average facility census was 38-40 residents in the past month. *Administrator A felt that one nurse and one CNA on duty from 10:30 p.m. until 6:30 a.m. was sufficient to care for the current residents' needs. *Administrator A and DON B were aware of resident 2's concerns about not being assisted and having an incontinence episode on the morning of 10/14/25, and had suspended CNA H while they completed an investigation. -They concluded that no abuse or willful neglect had occurred related to resident 2's concerns, DON B	F0684		

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F0684 SS = G	Continued from page 16 provided education to all staff, and CNA H had returned to work on the evening of 10/14/25. *Administrator A and DON B were not aware that resident 1 had developed a Stage II (2; open wound or blister with partial-thickness skin loss) pressure ulcer after she admitted to the facility on 10/9/25 and prior to her discharge on 10/12/25. *DON B worked recently as a CNA on the night shift with one nurse and stated, "It can be done," and "it's not easy." She added she felt exhausted after completing that shift. *The caregiver workload depended on many factors, such as how much assistance the residents required, if a resident needed care during the end of life process, how experienced the staff were, and if the staff worked as a team to ensure that all the residents were cared for. *DON B confirmed that she was out of the facility from 10/9/25 through 10/13/25. *Administrator A confirmed that RN/wound nurse C had been out of the facility from 10/6/25 through 10/14/25. *Administrator A and DON B agreed that several staffing factors could have contributed to resident 1 developing a pressure ulcer, and resident 2's reported care concerns regarding the weekend from 10/11/25 through 10/13/25, but felt that the staff worked hard to care for the residents. 16. Review of the provider's updated 7/7/25 Staffing and Scheduling Resource Packet revealed: *"...You want to make sure you have the necessary staff to fulfill the needs of the customers you serve." *"Managing schedules requires attentiveness and responsiveness of census fluctuations..." *The resource packet did not address the provider's current staffing levels or census. Review of the provider's 8/5/25 Facility Assessment revealed: *The facility assessment was used "to determine what resources are necessary to care for its residents competently during both day-to-day operations and	F0684		

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F0684 SS = G	Continued from page 17 emergencies." *The question "How do you staff on all shifts, including nights and weekends, to meet acquity [acuity] & [and] needs of residents?" was answered, "We staff by a per diem basis. We listen to feedback from our staff when they feel they could use more support, and what times of the day they could use support. We also listen to feedback from residents and families. Part of our assessment of whether or not we are meeting residents' needs and have appropriate staffing is by reviewing our quality measures and outcomes." *There was no documentation of the current staffing levels.	F0684		
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on complaint intake report review, record review, interview, and resource packet review, the provider failed to develop and implement pressure ulcer (skin and/or underlying tissue injury from prolonged pressure) prevention interventions for one of one sampled resident (1) identified at risk for developing pressure ulcers, and dependent on staff assistance with repositioning, who developed a Stage II (2; open wound or blister with partial-thickness skin loss) pressure ulcer to her coccyx (tailbone) after she admitted to the facility. Findings include:	F0686	1. Resident (1) was discharged prior to complaint survey. Her medical record was reviewed on 10/22/2025 to confirm that appropriate interventions were in place prior to discharge and they weren't in place. 2. A skin integrity audit was completed by DON for all residents identified as at-risk for pressure injury (per Braden scale) on 11/06/2025. The audit verified that all residents had individualized pressure injury prevention documented and implemented. There were no residents identified that needed to be reassessed for the risk of developing pressure ulcers. 2. The facility's Pressure ulcer prevention and management policy was reviewed on 11/14/2025 by the Admin, DNS and interdisciplinary team, in collaboration with the medical director. All nursing staff will be educated on pressure ulcer prevention and management and repositioning by DNS/Wound nurse/designee before their next scheduled shift between 11/10/2025-11/20/2025. Staff will have clear understanding of the policy with clear outlines of staff responsibilities for: identifying residents at risk for pressure injuries, implementing individualized interventions, correct repositioning and offloading techniques, and accurate documentation of skin assessments and interventions. The repositioning tasks were assigned in POC for all residents at risk of pressure injury, and charge nurses are responsible for verifying completion each shift. 3. The IP nurse/designee will conduct weekly skin audits for all residents with pressure ulcers for 8 weeks to ensure identification and development of pressure ulcer prevention interventions and consistent implementation and documentation of interventions. Once 100% compliance is maintained for three consecutive months, monitoring will be moved to a monthly schedule for two months. Audit findings will be presented by DNS/Designee during monthly QAPI meetings for review and follow-up. Any identified noncompliance will result in immediate re-education and/or corrective action.	11/20/25

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F0686 SS = G	Continued from page 18 1. Review of the 10/17/25 anonymous complaint intake report regarding resident 1 revealed: *Resident 1 had been admitted to the facility on 10/9/25, after a surgery to place a rod in her left leg. She was in a full-length cast and was dependent on staff for repositioning and pain medication. *Resident 1 developed worsening pain in her left leg starting on 10/11/25 and "burning in her back and bottom" throughout the night. *She was admitted to the hospital on 10/12/25 with a pressure ulcer that measured four inches by six inches and was "deep." The rod in resident 1's left leg had "broken away," and requiring an additional surgery. 2. Review of resident 1's electronic medical record (EMR) revealed: *She admitted to the facility on 10/9/25. *Her 10/9/25 Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated her cognition was intact. *Her diagnoses included infection due to an internal left knee prosthesis (artificial joint), Type II Diabetes Mellitus (a condition involving disruptions in how the body regulates blood sugar), Chronic Kidney Disease Stage 3 (kidneys do not effectively filter blood and have moderate damage), and adjustment disorder with mixed anxiety and depressed mood. *Her 10/9/25 physician orders indicated: -She was on a diabetic diet. -She was non-weight-bearing (unable to put pressure) on her left leg. -"Prevera [Prevena] wound vac (a device that uses negative pressure to remove excess fluid and debris from a wound to promote healing). Leave in place. Will be removed at follow up appointment." -She was to receive Triad Hydrophilic Wound Dressing Paste (a wound treatment cream) to her right and left buttocks two times a day for "skin breakdown." -She received "DAPTOmycin [an antibiotic] Intravenous Solution Reconstituted" once daily, related to an infection in her left knee.	F0686		

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F0686 SS = G	Continued from page 19 *Her 10/9/25 Braden Scale (a tool used to assess the risk of developing pressure ulcers) indicated: -She was confined to bed and needed moderate to maximum staff assistance with moving. -The ability to complete lifting to boost resident 1 in bed without sliding against the sheets was "impossible." -She frequently slid down in bed and needed "frequent repositioning with maximum assistance." -Her Braden Scale score was 15, which indicated she was at risk for developing pressure ulcers. *A 10/10/25 Skin Observation assessment indicated resident 1 had a "Large area on [her] bottom [that was] red, flaky, [and] macerated [softening of skin due to prolonged exposure to moisture] present on admission," and that resident 1 was "on an air mattress." -The "Care Plan for Skin" section listed several potential focus areas, goals, and interventions to select if applicable. The care plan section had not been completed. -The "Education" section listed potential education provided, potential barriers, and potential persons educated to select if applicable. The education section had not been completed. *Her 10/10/25 physical therapy evaluation indicated resident 1 needed moderate staff assistance for rolling in bed, and the use of the total body lift (a mechanical lift and sling used to lift a person's full body) when being transferred. *Resident 1's "Roll left and Right" task documentation included: -On 10/9/25, one rolling task was documented as "Not applicable – Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or illness." -On 10/10/25, the rolling task was documented at 11:36 a.m. and again at 9:59 p.m., as dependent or requiring the assistance of two caregivers. -On 10/11/25, the rolling task was documented at 1:59 p.m., as "refused" and at 9:59 p.m., as dependent or	F0686		

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F0686 SS = G	Continued from page 20 requiring the assistance of two caregivers. -On 10/12/25, the rolling task was documented at 1:59 p.m., as dependent or requiring the assistance of two caregivers. 3. Review of resident 1's 10/9/25 care plan revealed it did not include the resident's full-length left leg cast, wound vac (a medical treatment to promote wound healing) to her left leg, urinary catheter (flexible tubing inserted into the bladder to drain urine), transfer or weight-bearing status, assistance needs to complete activities of daily living such as toileting and repositioning, risk for developing pressure ulcers, or interventions to prevent acquiring pressure ulcers. 4. Review of resident 1's 10/9/25 through 10/12/25 progress notes revealed: *On 10/9/25 resident 1 was admitted at 2:20 p.m., was "fully oriented", "was in significant pain and any movement was difficult." *On 10/10/25 resident 1 was pleasant and cooperative, refused to allow staff to remove her catheter due to her decreased mobility and increased pain, and had "remained in bed since [her] admission yesterday." *On 10/11/25 resident 1 "continues to remain in bed since admission," "continues to have red, flaky macerated skin to buttocks/coccyx area," that "staff attempts to relieve pressure to area with repositioning as res [resident 1] allows," and that resident 1 "tends to lean often to [her] R [right] side due to pain from her LLE [left lower extremity]." *On 10/12/25 PN resident 1 had reported her back and bottom "are on fire," the nurse (LPN D) went to put cream on her bottom, resident 1 did not "want the creams for [her] back and bottom; did not want to be touch[ed]/repositioned," and at 12:05 p.m., resident 1 was sent to the emergency room due to "being inconsolable with increased pain to LLE." 5. Interview on 10/22/25 at 1:57 p.m. with registered nurse (RN) F revealed: *RN F completed resident 1's admission skin assessment on 10/9/25. Resident 1 was admitted to the facility with an area to her right and left buttocks that was approximately four inches by six inches wide and was	F0686		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DE SMET	411 CALUMET AVENUE NW , DE SMET, South Dakota, 57231

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F0686 SS = G	Continued from page 21 "bright red" and "excoriated." RN F stated the area was not bleeding and did not "look like a pressure area," but rather appeared like an area associated with moisture where the top layer of skin was broken down. *RN F faxed the resident's physician for an order for "Triad cream" because RN/wound nurse C and director of nursing (DON) B were not at the facility that day. *RN F did not complete resident 1's baseline care plan. She expected that DON B would complete that care plan when DON B returned to work. *RN F repositioned resident 1 during her admission assessment and stated that resident 1 required the assistance of two staff members with rolling the resident due to her left leg cast and she was in a lot of pain. 6. Interview on 10/22/25 at 3:25 p.m. with certified nursing assistant (CNA) H revealed: *She worked overnights on 10/10/25 from 7:00 p.m. until 10/11/25 at 6:30 a.m. and again on 10/11/25 from 6:00 p.m. until 10/12/25 at 6:30 a.m. *She stated that on both of those days, there was one nurse and three CNAs on duty from 7:00 p.m. until 10:30 p.m., and then from 10:30 p.m. until 6:30 a.m., CNA H and one nurse were the only caregivers on duty. *She recalled that resident 1 had a catheter and that she emptied the urine from the resident's catheter at the end of her shift on 10/11/25. She did not know if resident 1 wore an undergarment or how much assistance she required for rolling or repositioning. *During the above worked shifts, she entered resident 1's room when resident 1 turned on her call light to request pain medication or water. She could not recall if she had repositioned resident 1 during those times. *She stated her interactions with resident 1 had been "limited," and she thought that the nurse would have assisted resident 1 when she went into her room to provide her with medications. 7. Interview on 10/23/25 at 9:09 a.m. with medical doctor (MD) E revealed who participated by phone revealed: *He was resident 1's orthopedic surgeon for several	F0686		

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F0686 SS = G	Continued from page 22 surgeries involving resident 1's left knee and was familiar with her medical history. *Resident 1 was admitted to the hospital on 10/12/25 from the nursing home (provider) with fractures above and below the rod that had been surgically placed. The resident also had a Stage II (2; open wound or blister with partial-thickness skin loss) pressure ulcer to her buttocks/coccyx and associated moisture-related skin damage to her perineum (the area between the genitals and anus) that was not present when he discharged resident 1 from the hospital on 10/9/25. *He felt that the fractures around the rod in resident 1's left leg could not have been prevented and could have occurred with very little force or movement due to her poor bone quality and multiple complicating medical factors. *He felt that resident 1's pressure ulcer on her buttocks/coccyx and the soft tissue skin damage to her perineum were preventable. *Resident 1's pressure ulcer required her to be transferred to a specialty hospital for further care and treatment. 8. Interview on 10/23/25 at 10:20 p.m. with licensed practical nurse (LPN) D revealed: *She had completed a skin assessment on resident 1 after resident 1 had a bed bath on the morning of 10/10/25. Resident 1's bottom was red, excoriated, and had areas of flaky skin. The area was large but was not open. *Resident 1 allowed CNAs to provide her care and roll her slowly and carefully. Her movements were "guarded," and she allowed them to place pillows under her leg to make her more comfortable. *Resident 1 would at times refuse to be repositioned if she was comfortable. *LPN D recalled that on the morning of 10/12/25, resident 1 was in significantly more pain, allowed CNAs to provide her with a bed bath, reported that her "butt and back were on fire," and allowed CNAs to put a pillow under her leg. Resident 1 refused to allow LPN D to put the cream on her back and bottom that morning. *LPN D called the on-call medical provider, and the decision was made to send resident 1 to the emergency	F0686		

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F0686 SS = G	Continued from page 23 room for evaluation due to uncontrollable pain in her left leg. 9. Interview on 10/23/25 at 10:53 a.m. with LPN G revealed: *She worked the overnight shift on 10/10/25 at 6:00 p.m. until 6:30 a.m. on 10/11/25. -There typically was one CNA and one nurse who worked the overnight shifts. *She remembered resident 1 was in a lot of pain when she had arrived at work on 10/10/25 and that she had given resident 1 PRN (as needed) pain medication and her scheduled evening medications. *LPN G called DON B that evening because resident 1's left leg pain was not controlled and was advised by DON B to contact the on-call medical provider. LPN G called the on-call medical provider, who approved LPN G to provide resident 1 with an early dose of her pain medication that day. *LPN G recalled that resident 1 "must have slept all night," because she did not recall giving resident 1 any additional pain medication or having gone into resident 1's room again after giving her that pain medication. She could not recall if she assisted CNA H on 10/10/25 or 10/11/25 with repositioning resident 1. 10. Interview on 10/23/25 at 12:50 p.m. with RN/wound nurse C revealed she: *She was not present at the facility while resident 1 resided there and did not provide any of the resident's care. *Was the provider's wound nurse, and typically provided monitoring and interventions for residents who admitted with skin wounds, were identified as at risk for wounds, or developed a wound. *Would assess a resident identified by the nursing staff as "at risk" for a pressure ulcer, complete a Wound Data Collection form, obtain physician's orders if treatment was needed, and implement interventions to decrease the likelihood that a resident would develop a pressure ulcer. *Expected that the nurse who completed resident 1's admission assessment, or DON B, would have implemented	F0686		

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F0686 SS = G	Continued from page 24 and care planned interventions due to resident 1's skin condition on admission and her identified risk for developing pressure ulcers because she was bedbound. She expected those interventions to have included frequent repositioning, skin care to prevent moisture, and offloading of bony prominences like her heels. *Was aware that resident 1 had an air mattress. 11. Interview on 10/23/25 at 1:03 p.m. with administrator A and DON B revealed: *DON B was not at the facility from 10/9/25 through 10/12/25 and did not meet resident 1. *DON B was contacted by phone on 10/10/25 and again on 10/11/25 regarding resident 1's left leg pain. She instructed the two nurses who called her those days to call the on-call medical provider for additional guidance on how to address resident 1's leg pain. *DON B confirmed that a Wound Data Collection form had not been completed because RN/wound nurse C had been on vacation and DON B was not at the facility during resident 1's stay. *DON B stated she completed all of the residents' care plans, but she did not complete a care plan for resident 1, and there were no documented interventions to prevent resident 1 from developing a pressure ulcer. -She had planned to complete that documentation when she returned to work on 10/13/25, but resident 1 had been discharged to the hospital on 10/12/25. *DON B expected that resident 1 would have been provided frequent repositioning, thorough cleaning of her perineum area, pain medications as needed, and the physician ordered Triad wound cream to prevent skin breakdown. *Administrator A and DON B were unaware that resident 1 developed a pressure ulcer after she admitted to the facility on 10/9/25 and prior to her hospital readmission on 10/12/25. *They expected that the nurses on duty would have implemented interventions to prevent resident 1 from developing a pressure ulcer when DON B and RN/wound nurse C were not available at the facility. 12. Review of the provider's updated 7/7/25 Pressure	F0686		

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F0686 SS = G	Continued from page 25 Ulcer/Wound Care Resource Packet revealed: *The provider's "wound care programs, pressure guidelines and protocols have been developed and implemented to provide quality services to our residents." *"Programs may include… A comprehensive management program to prevent [the] development of pressure ulcers or other skin conditions (Braden, following interventions identified on care plan, nutritional intervention, specialty surfaces…)." *"Promotion of healing, pain management and prevention of complications is extremely important, as well as accurate assessment and documentation." *"Wound Data Collection UDA [user defined assessment] completed by a licensed nurse and is required for documenting daily monitoring, is required at least weekly when skin integrity is impaired…" *"…The facility must ensure 1. A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable."	F0686		