STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435134	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 9/3/25 through 9/4/25. Areas surveyed included resident falls, fall prevention interventions, facility staffing, accident investigation and notification, and call light response. Good Samaritan Society-St Martin Village was found not in compliance with the following requirements: F609, F610, and F684.	F0000	Unable to correct prior deficient practice. All residents are at risk when incidents are not reported timely. Other residents with bruises for the past month have been reviewed to ensure reports to DOH were submitted if warranted. No other incidents of failure to report were identified. Education will be provided by the Director of Nursing or designee to direct care staff on reporting guidelines. Electronic Medication Administration record notes will be reviewed in morning clinical meetings to ensure all events have been followed up on. State reporting guidelines were placed in check list binder at each nurses station to ensure that proper notification for reporting is completed. Director of Nursing or designee will audit residents with bruises and/or injury for completion of state reportable events as warranted weekly x3, every other week x3, and monthly x3. Director of Nursing or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Director of Nursing or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by:	F0609		10.19.25

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jana McCroden	Senior Director	9.26.25

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F0609 SS = D	Continued from page 1 Based on South Dakota Department of Health (SD DOH) complaint review, record review, interview, and policy review, the provider failed to follow their policy for reporting to the SD DOH and one of one sampled resident's (1) representative of the resident's injury of bruising to her left arm and hand with unknown cause (origin). Findings include: 1 Review of a 7/16/25 SD DOH complaint intake revealed that during the weekend of 7/4/25, resident 1 was visited by her family. The resident's left hand and arm had shown no signs of injury at that time. The resident's family had returned a few days later to visit and "noticed extreme bruising and swelling of her [the resident's] left hand and forearm." Digital photographs of resident 1's hand taken by the family during that visit showed the underside of the resident's hand had purple and black bruising of her fingers and palm that extended upwards to her forearm. The entire top of the resident's left hand was similarly bruised. The resident's family had not been notified that resident 1 had been injured. Interview on 9/4/25 at 9:00 a.m. and review of resident 1's electronic medical record (EMR) with infection preventionist (IP)/clinical care leader (CCL) B revealed the progress note she entered in resident 1's chart on 7/1/25 stated "received and returned her [the resident's daughter] call to discuss the bruise noted on the resident's arm. Explained that according to PCC [EMR] notes, the mark was most likely caused by a recent lab draw on 7/7/25." IP/CCL B confirmed resident 1's 7/7/25 blood draw was taken from the resident's right arm. She confirmed the cause of resident 1's left hand and arm injury was not the result of a lab draw. IP/CCL B confirmed that resident 1's left hand and arm injury was first documented in her medical provider's 7/11/25 Nursing Home Attending Physician Visit note, which indicated there was no definitive cause that was found for resident 1's left hand and arm injury. A 7/11/25 nurse progress note completed by licensed practical nurse (LPN) E after the above visit: indicated “[Medical provider's name] visited.” The medical provider and a nurse wrapped resident 1's "L [left] forearm, which is bruised and has a large hematoma [a raised bruised area] on the top of [her] L hand.” IP/CCL B stated it was LPN E's responsibility to have	F0609		

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F0609 SS = D	Continued from page 2 notified resident 1's family of the left hand and arm injury. Because the cause of that injury was unknown, LPN E should also have notified a nurse supervisor or administrator A. Injuries of unknown origins were expected to have been documented, investigated, and reported to the SD DOH, but that had not occurred. Interview on 9/4/25 at 10:15 a.m. with administrator A confirmed the staff had not followed the provider's procedure for notifying families, and the SD DOH regarding resident injuries of unknown cause. Review of the provider's revised 4/7/25 Abuse and Neglect policy revealed: Procedure: "4.c. Designated agencies will be notified in accordance with state law, including the State Survey and Certification Agency [SD DOH]." "4.g. Notify the physician and family regarding the facts of the situation. If there is alleged or suspected abuse/neglect or in an injury of unknown origin, inform them that an investigation is in progress." That notification was expected to have been recorded.	F0609	Unable to correct prior deficient practice. Resident #1's bruising was fully investigated on 9.3.25 by DNS and ADM. All residents are at risk when events are not investigated to their fullest. Residents with bruising in the past month have been reviewed to ensure an investigation had occurred. All other residents identified with bruising had a full investigation completed. Education will be provided by the Director of Nursing or designee to licensed nurses on the steps of a complete investigation as directed by the department of health. Injuries including the investigation will be reported using our SAFE system. These events will be reviewed at our daily clinical stand up meeting to ensure an investigation had been started. Continuation of the investigation will occur by the Interdisciplinary team as warranted. Director of Nursing or designee will audit residents with injuries for completion of investigations on all state reportable events weekly x3, every other week x3, and monthly x3. Director of Nursing or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Director of Nursing or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance, then as determined by the committee.	10.19.25
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by:	F0610		

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F0610 SS = D	Continued from page 3 Based on South Dakota Department of Health (SD DOH) complaint review, observation, record review, interview, and policy review, the provider failed to ensure an investigation was completed and documented for one of one sampled resident (1) with an injury of bruising to the resident's left arm and hand with unknown cause (origin). Findings include: 1 Review of a 7/16/25 SD DOH complaint intake revealed that during the weekend of 7/4/25, resident 1 was visited by her family. The resident's left hand and arm had shown no signs of injury at that time. The resident's family had returned a few days later to visit and "noticed extreme bruising and swelling of her [the resident's] left hand and forearm." Digital photographs of resident 1's hand taken during that visit showed the underside of the resident's hand had purple and black bruising of her fingers and palm that extended upwards to her forearm. The entire top of the resident's left hand was similarly bruised. Observations 9/3/25 at 10:10 a.m. of resident 1's room revealed there were bilateral 1/4 siderails on her bed, and it was positioned low towards the floor. She had a cylindrical-shaped call light with a red button at one end to alert staff for assistance. Continued observation on 9/3/25 at 10:15 a.m. of resident 1 in an activity room revealed she was participating in a game of Jeopardy with other residents. She sat in a wheelchair that tilted slightly back and had been customized with things like a left arm trough (a device attached to the wheelchair armrest for positioning comfort and posture support) that accommodated her left-sided weakness. Her hands had no visible bruising. Review of resident 1's electronic medical record (EMR) revealed that her admission date was 5/9/25. Her diagnoses included hemiplegia (muscle weakness or partial paralysis on one side of the body) due to a stroke affecting her left side, dysphagia (difficulty swallowing), congestive heart failure, anxiety, and insomnia. She had fallen multiple times after she had been admitted, but she had no documented falling incidents since the beginning of July 2025. Resident 1 had episodes of restlessness, anxiousness, and calling out. At times when staff had responded to her calling out, resident 1 was not able to identify what she had needed. Her ability to functionally use her call light was infrequent. Redirecting the resident	F0610		

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F0610 SS = D	Continued from page 4 was not always successful. Changes to her anti-depressant and anti-anxiety medications had been made by her medical provider in May 2025 and June 2025. Interview on 9/3/25 at 2:20 p.m. with physical therapist (PT) F revealed that resident 1 was receiving therapy services. PT F had seen resident 1's left hand and arm injury after the 4th of July weekend. It was "black and blue and puffy." She stated that resident 1 was unable to provide any insight into the cause of her injury. PT F stated there was no known cause for the injury that she remembered, but she thought the resident's hand could have been injured when she was transferred. Staff had used an Easy Stand lift (a type of mechanical lift used for transferring from one position to another) for transferring her. PT F also stated that resident 1's previous wheelchair did not have a left arm trough that kept her weakened left arm stable and safely positioned, like her current customized wheelchair had. Resident 1 had started using that wheelchair in early August 2025. Resident 1's left hand and arm injury was first documented by the resident's medical provider in her 7/11/25 Nursing Home Attending Physician Visit note. "This patient [resident] developed swelling and bruising of her left hand on July 7 or 8. Her family had visited on the weekend, and the [resident's] hand appeared normal, although she has left arm weakness because of a stroke. Yesterday they visited and found the left hand very swollen with bruising extending from the fingertips to up the forearm. [Resident 1] thinks she might have rolled out of bed (staff says that has not happened this week) or bumped it on a door [she] but does not really know how it happened. Staff thought it might have been related to a blood draw on July 7 but [resident 1] says the blood draw was from the other arm. [resident 1] is on aspirin and apixaban [anticoagulant] for history of stroke and DVT [deep vein thrombosis] with PE [pulmonary embolism]." A 7/11/25 progress note completed by licensed practical nurse (LPN) E after the above medical provider's visit indicated "[Medical provider] visited." We wrapped "the L [left] forearm which is bruised and has a large hematoma [a raised bruised area] on the top of [her] L hand." There was no documentation to support that an investigation had been initiated to identify a cause for resident 1's injury, any factors that might have contributed to that injury occurring, or what actions had been implemented to decrease the likelihood of that injury reoccurring. Interview on 9/4/25 at 10:10 a.m. with LPN E revealed	F0610		

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F0610 SS = D	Continued from page 5 she stated, “I don’t recall knowing it [resident 1's left hand and arm injury] was there earlier that day [on 7/11/25 before the medical provider's visit].” LPN E stated the cause of that injury might have been related to the resident's 7/7/25 blood draw. LPN E had not known that a blood draw was taken from resident 1's right hand and not her left hand, so it could not have caused that injury. LPN E confirmed that after the left hand and arm bruise was identified on 7/11/25, she had not reported that injury of unknown cause to a nurse supervisor. As a result, an investigation was not initiated to identify the cause or possible cause for that injury. Without having identified a cause for resident 1's left arm and hand bruising, LPN E agreed that nothing different had been done to prevent a similar injury from recurring. Interview on 9/4/25 at 9:00 a.m. with infection preventionist (IP)/Clinical Care Leader (CCL) B revealed it was LPN E's responsibility to have notified a nurse supervisor or administrator A of resident 1's injury of unknown origin. Injuries of unknown origin were expected to have a thorough investigation completed and documented, but that had not occurred. Interview on 9/4/25 at 10:15 a.m. with administrator A confirmed that the staff had not followed the provider's procedure for documenting and investigating resident injuries of unknown cause. Review of the provider's revised 4/7/25 Abuse and Neglect policy revealed: Purpose: "To ensure that all identified events of alleged or suspected abuse/neglect, including injuries of unknown origin, are promptly reported and investigated. To ensure a complete review by the investigation team to identify events, such as suspicious bruising of residents/clients, occurrences, patterns and trends that may constitute abuse to determine the direction of the investigation."	F0610	Unable to correct prior deficient practice. Residents who are high fall risk are at risk for deficient practice. Residents with falls in the past month requiring neurological checks have been reviewed for initiation of neurological checks and continuation of neurological checks upon return unless discontinued by physicians order. No other concerns noted. Education will be provided by the Director of Nursing or designee to licensed nurse on expectations of neruo checks post fall, including continuation of neurological checks unless order from MD to discontinue. Transfer check list updated to ensure that all neuro’s are completed prior to resident transferring out of the facility. Fall checklist to ensure Point Click Care triggers all scheduled neruo checks. Director of Nursing or designee will audit completion of neuro checks with falls weekly x3, every other week x3, and monthly x3. Director of Nursing or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Director of Nursing or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	10.19.25
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care 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	F0684		

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F0684 SS = D	Continued from page 6 professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and policy review, the provider failed to follow nursing professional standards of practice for implementing and documenting neurological checks according to the provider's policy for one of one sampled resident (2) who had fallen and sustained a head injury. Findings include: 1. Record review of resident 2's electronic health record (EHR) revealed: *She was admitted to the facility on 7/22/20. *Her diagnoses included blindness, cerebral infarction (stroke), hearing loss, rheumatoid arthritis (an auto-immune disease affecting small joints in the hands and feet, and can damage other body systems), repeated falls, major depressive disorder, dementia (a group of symptoms affecting memory, thinking, and social abilities) without behavioral, psychotic, and mood disturbance, anxiety disorder, and traumatic subdural hemorrhage (fall with head injury that caused bleeding inside the skull). *She had been taking Aspirin (an anticoagulant or blood thinner medication) since 2021. *Her fall risk assessments (an assessment of a resident's risk for falling) indicated her risk for falling was: -High (score of 20) after she fell on 2/21/25. -Low (score of 11) after she fell on 3/4/25 and 3/20/25. -Medium (score of 14) after she fell on 5/21/25 and 6/15/25. -High (score of 20) after she fell and sustained an injury on 7/22/25. *She had seven falls in the last six months (between April 2025 and September 2025). *She had a fall in her room on 7/22/25 and sustained a head injury with bleeding.	F0684		

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F0684 SS = D	Continued from page 7 -She was found lying on the floor, next to her bed at 6:52 a.m. in a pool of blood under her left face/head. -The pool of blood was partially coagulated (thickened) and was approximately 10 by 14 inches in diameter. *Resident 2 was talking and stated, “I fell and hit my head and my hips hurt” and “Get me up.” *A head-to-toe assessment had been completed and her vital signs (measurements of the body’s basic functions, such as temperature, blood pressure, pulse, and respiration rate) were checked by registered nurse (RN) G. -RN G did not perform a neurological assessment (an evaluation of mental status, cranial nerve function, motor strength, reflexes, sensation, and coordination) of resident 2. *Resident 2 was transferred to the emergency room and admitted to the hospital for treatment of a subdural hemorrhage (a collection of blood between the brain and the inner layer of the skull). -Neurological assessments were not performed of resident 2 upon her return to the facility from the hospital. 2. Interview with administrator A on 9/4/25 at 1:50 p.m. revealed: *Nurses were expected to follow the fall prevention policy and protocols. *She verified that neurological exams should be completed for all residents who fell and hit their head during that fall. -She agreed that no neurological exam had been completed for resident 2 after she fell and hit her head on 7/22/25. 3. Review of the facility’s 2/17/25 Neurological Evaluation Policy revealed: *The policy is used following: -“a witnessed fall when a resident has hit his/her head.	F0684		

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F0684 SS = D	Continued from page 8 -an unwitnessed fall. -a resident event that results in known or suspected head injury." *The policy procedure includes: -"After the completion of initial neurological evaluation with vital signs, continue with evaluations every 30 min [minutes] x4 [times four], then every eight hours [times three] days or as directed by the provider. -Notify responsible party of event, resident condition, and findings and document. -If after completing one or more Neurological Evaluations the resident goes to the hospital for a few hours or is admitted to the hospital and returns to the center, documentation should resume using the existing schedule". 4. Review of the provider's 4/8/25 Fall Prevention and Management Policy revealed: *The purpose of the policy is "to give prompt treatment after a fall occurs" and "to provide guidance for documentation". *Procedure:" -1. "Do not move resident. -2. Remain calm and reassure and comfort the resident. -3. Stay with the resident and summon the licensed nurse or other help. If able, observe the fall scene. -5. For a fall WITH injury, do the following: --a. If the resident is bleeding, locate the injured area and apply continuous, form pressure to the area. --b. Do not remove any blood-soaked dressings or clothing but instead add more layers to absorb the blood. -6. A nurse must observe the resident and perform a full-body exam to determine if there may be suspected injury and direct whether to move the resident. --b. If the fall was not witnessed, neurological checks are required and must be documented in the medical	F0684		

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F0684 SS = D	Continued from page 9 record".	F0684		