OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 437086			(X3) DATE SURVEY COMPLETED 03/26/2025			
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOC-HOME HEALTH OF THE BLACK HILLS			1	STREET ADDRESS, CITY, STATE, ZIP CODE 851 City Springs Rd , 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 PREF TAG		(X5) COMPLETION DATE			
E0000		ompliance with 42 CFR tion 484.102 Emergency for Home Health Agencies, was ugh 3/26/25. Good Samaritan	E0000	Short or Managara and Anada and Anad				
Any deficien	cy statement ending with an as	terisk (*) denotes a deficiency which	the in	stitution may be excused from correcting providing it is o	etermined that other			

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

HH Administrator

(X6) DATE

04/02/2025

FORM APPROVED

OMB NO. 0938-0391

	MENT OF DEFICIENCIES LAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 437086		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2025			
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOC-HOME HEALTH OF THE BLACK HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 1851 City Springs Rd , 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)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE				
G0000	INITIAL COMMENTS A recertification health surve CFR Part 484, Subparts B-C Health Agencies, was conduct 3/26/25. Good Samaritan SO Hills was found in compliance	y for compliance with 42 , requirements for Home cted from 3/24/25 through C-Home Health of The Black	G0000		ENGTY			
2								

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 ollowing 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.

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

TITLE

HH administrator

(X6) DATE 04/02/2025