

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 46860	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - ECHO RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 931 FOX RUN DRIVE RAPID CITY, SD 57701		
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S 000	Compliance Statement A 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 8/10/26 through 8/11/26. Good Samaritan Society - Echo Ridge was found not in compliance with the following requirements: S096, S120, S320, S331, S415, S432, and S633.	S 000		8/26/26
S 096	44:70:02:05 Housekeeping Cleaning Methods And Equipment Equipment and supplies shall be provided for cleaning of all surfaces. Such equipment shall be maintained in a safe, sanitary condition. Hazardous cleaning solutions, chemicals, poisons, and substances shall be labeled, stored in a safe place, and kept in an enclosed section separate from other cleaning materials. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure three of three TB (tuberculosis) Disinfectant Cleaners inside two of two Biohazard Response boxes and one of one Emergency Burn Gel inside one of two Biohazard Response boxes were not expired and removed from those boxes. Findings include: 1. Observation on 8/10/26 at 9:20 a.m. of the	S 096	Emergency burn gel, TB disinfectant cleaner and bodily fluid clean up kit discarded. All residents are at risk when proper emergency supplies are expired. All staff were educated on location of blood spill kits as well as instruction of use on all staff meeting 8/25/26 Blood spill kits will be provided for use and located on housekeeping carts. Manager or designee will audit Blood spill kits monthly x 3. Manager or designee will report all findings to the QAPI committee on a monthly basis for follow up.	

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

TITLE

(X6) DATE

STATE FORM

6899

HP7P11

If continuation sheet 1 of 15

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S 096	Continued From page 1 housekeeping closet inside the kitchen revealed there was a Biohazard Response box mounted on one of the walls. Inside of the box, there was a tube of Emergency Burn Gel that expired in March 2025, a "Bodily Fluid Clean-Up" kit, and an Ecolab [a company that provides commercial cleaning supplies] box. Inside the Ecolab box there were two, 4-ounce bottles labeled "TB Disinfectant Cleaner" with an expiration date of 4/5/23. The 4-ounce TB Disinfectant Cleaner inside the Bodily Fluid Clean-Up kit expired in May 2019. 2. Observation and interview on 8/10/26 at 2:30 p.m. with nutrition and food services supervisor (NFSS) D of the above Biohazard Response box contents revealed that she was responsible for maintaining the products inside that box. She did not know that the gel and the TB disinfectant cleaners were expired. She should have removed and replaced those expired products with unexpired products. Continued observation and interview with NFSS D in the mechanical room in the 300 hallway revealed a second Biohazard Response box mounted on one of the walls. Inside of that box, there were two, Bodily Fluid Clean-up kits. Each kit contained a four-ounce bottle of TB Disinfectant Cleaner. There was a third, four-ounce bottle of TB Disinfectant Cleaner inside that box as well. NFSS D confirmed that all three of the TB disinfectant cleaners expired in May 2019. NFSS D acknowledged that the contents of the Biohazard Response boxes were available for any staff to use. She did not have a process for regularly auditing the contents of the boxes for	S 096			

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S 096	Continued From page 2 expired products. In the past, she was advised that it was cost-prohibitive to replace the contents of the Biohazard Response boxes. 3. Interview on 8/11/26 at 3:30 p.m. with registered nurse (RN)/manager A regarding the Biohazard Response boxes revealed that she did not know there were expired products inside the Biohazard Response boxes. She expected NFSS D to notify her of any issues related to the inability to restock expired supplies for the Biohazard Response boxes to ensure the contents of those boxes were properly maintained. 4. A Chemical Labeling and Storage policy was requested from RN/manager A on 8/11/26 at 2:00 p.m. A Cleaning Blood and Bodily Fluid Spill was provided. That policy provided guidance related to the proper methods for cleaning blood and other potentially infectious material, but it did not mention the expectations for maintaining the contents of a Biohazard Response box or using unexpired cleaning products.	S 096			
S 120	44:70:02:08 Linen The supply of bed linens must equal two times the licensed capacity of the facility. The facility shall develop and implement written procedures for the storage and handling of soiled and clean linens. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure a quantity of bed linens equal to two times the licensed capacity of the facility were available for use by all	S 120			

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S 120	Continued From page 3 26 residents who resided in that facility. Findings include: 1. Observation on 8/11/26 at 9:45 a.m. in the laundry room revealed that inside a cabinet labeled, "Lost and Found," there were seven assorted towels and five absorbent pads (placed under a comforter and on top of a sheet to keep a resident's skin and bed linen dry). 2. Interview on 8/11/26 at 9:55 a.m. with registered medication aide (RMA) E revealed extra resident linen was stored inside the Lost and Found cabinet in the laundry room. 3. Interview on 8/11/26 3:30 p.m. with registered nurse (RN)/manager A regarding the provider's linen supply revealed that residents furnished their own linen when they admitted to the facility. She was not aware of the South Dakota assisted living regulation regarding the provider's responsibility for maintaining an adequate supply of linen for the residents' use. 4. Review of the provider's 3/3/26 Senior Resource Packet policy revealed, "In assisted living communities, state regulations may have specific requirements regarding laundry supply and water temperature, etc. The community should always refer to state regulations to ensure full compliance with applicable requirements." "The facility shall provide linens, equipment, and basic toiletries for personal care and for other activities of daily living commensurate with the needs of the resident served."	S 120	Facility purchased 56 sets of assorted linens 8/25/2026 All residents are at risk when linen supply does not meet the requirements for patient needs. All staff were educated on location of linens and expectations on what to do if there were a linen supply shortage at staff meeting on 8/25/26. Supply of linens equal to two times the licensed capacity will be available and stored in central location. Manager or designee will audit linen supply and handling monthly x 3 month and report to QAPI.	8/25/26
S 320	44:70:08 Prevention And Control Of Pneumonia	S 320		

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S 320	Continued From page 4 Each facility shall arrange for an immunization for pneumococcal disease. If immunization is lacking and the resident's physician, physician assistant, or nurse practitioner recommends immunization, the facility shall encourage a resident to obtain an immunization for pneumococcal pneumonia within 14 days of admission. Documentation of the vaccination or refusal must be recorded in the resident's care record. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to identify three of four sampled residents' (1, 2, and 4) pneumonia vaccination schedules were incomplete and they did not contact those residents' physicians regarding completion of that vaccination series. Findings include: 1. Review of resident 1's EMR revealed she received the PCV (pneumococcal conjugate vaccine) 15 pneumonia vaccine on 10/1/16. 2. Review of resident 2's EMR revealed she received the PCV 13 pneumonia vaccine on 2/18/16. 3. Review of closed record resident 4's electronic medical record (EMR) revealed she received the PPSV (pneumococcal polysaccharide vaccine) 23 pneumonia vaccine on 5/21/24. 4. Review of the March 2025 Centers for Disease Control and Prevention (CDC) "Pneumococcal Vaccine Timing for Adults [greater than 50 years of age]" publication and interview on 8/11/26 at 2:45 p.m. with registered nurse (RN)/manager A and nursing and clinical services consultant	S 320	Resident #1 PCP was contacted regarding vaccination status, if resident has not received appropriate pneumococcal vaccination arrangements will be made. Resident #2 PCP was contacted regarding vaccination status, if resident has not received the appropriate pneumococcal vaccination arrangements will be made. Resident #4 discharge, unable to update vaccination status. All residents are at risk when not vaccinated against pneumonia. RN audited all resident immunization records. PCP contacted regarding vaccination status for any residents with out proof of appropriate pneumococcal vaccination. RN will provide education to these residents and arrange for pneumococcal vaccinations as needed. Resident vaccination status will be reviewed at time of admission and seasonally during flu season to ensure all residents are vaccinated appropriately. Education will be provided to residents on vaccination requirements per CDC guidelines. Consents or declinations will be obtained by RN or designee. RN or designee will document the immunizations in medical record as well as a declination to keep medical records current. Echo Ridge admission checklist updated and admission packet updated with education related to Pneumococcal vaccine included. RN or designee will audit all resident's vaccination status monthly x 3 then report to QAPI	9/26/26

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S 320	Continued From page 5 (NCSC) C revealed that the provider referred to that CDC publication for guidance related to pneumonia vaccination recommendations for their residents. Based on the above CDC guidance, NCSC C acknowledged that resident 1 should have been offered the PPSV 23 pneumonia vaccination, resident 2 should have been offered the PCV 20 or PCV 21 pneumonia vaccine to complete her pneumonia vaccination series, and closed record resident 4 should have been offered the PCV 15, PCV 20, or PCV 21 pneumonia vaccination to complete her pneumonia vaccination series. NCSC C stated that the provider did not administer residents' pneumonia vaccinations, but they could have offered residents 1, 2, and closed record resident 4 or their representatives education regarding the CDC's pneumonia vaccination recommendations. The provider should have, but did not contact those residents' physicians to discuss completing the residents' pneumonia vaccination series. RN/manager A acknowledged that their resident population was medically vulnerable. Offering resources and support for the residents to complete their pneumonia vaccination series mitigated the residents' risk of developing pneumonia. 5. Review of the provider's 11/18/25 Immunizations/Vaccinations for Residents, Pneumococcal, Influenza, COVID-19, Other policy revealed, "Resident vaccination history should be reviewed at the time of admission and on an ongoing basis (i.e., seasonally, per vaccine-specific recommendations) to determine eligibility for recommended/required vaccines, as	S 320			

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S 320	Continued From page 6 appropriate for the healthcare setting." "Adults 50 years and older, and 19-49 years with additional risk factors, are recommended to receive pneumococcal vaccines, unless contraindicated. See CDC Pneumococcal Vaccine Timing For Adults for eligibility and timing."	S 320	Resident #3 received TB gold blood test on 8/13/2026. Negative results verified on 8/17/2026. All residents are at risk for TB exposure when verification is not made on new admissions	8/26/26
S 331	44:70:04:10(1) Tuberculin Screening... Requirements Tuberculin screening requirements for healthcare personnel and residents are as follows: (1) Each healthcare personnel or resident shall receive an initial individual TB risk assessment that is documented and the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within twenty-one days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of admission or employment are considered two-step. A TB blood assay test completed within a twelve-month period prior to the date of admission or employment is an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare personnel or resident transfers from one licensed healthcare facility to another licensed healthcare facility within this state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin or blood assay TB testing having been completed within the prior twelve months. Skin testing or TB blood assay tests are not necessary if documentation is provided by the transferring healthcare facility, healthcare personnel, or resident, of a previous positive reaction to either test. Any healthcare personnel or resident who	S 331	All current resident records audited for TB testing with results and missed TB tests completed. TB tests completion added to admission checklist. RN or designee will audit current resident medical record for TB test completion monthly x 3 and report to QAPI.	

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S 331	Continued From page 7 has a newly recognized positive reaction to the skin or TB blood assay test must have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure one of four sampled residents (3) received a tuberculin (TB) two-step skin test or blood assay test within twenty-one days of admission to the facility, or provided evidence of a negative TB test in the twelve months before their admission. Findings include: 1. Review of resident 3's electronic medical record (EMR) revealed she admitted to the facility on 5/11/26. There was no documentation of a completed two-step TB skin test within the twelve months before her admission or within 21 days of her admission to the facility. 2. Interview on 8/11/26 at 2:10 p.m. with registered nurse (RN)/manager A revealed she acknowledged there was no documentation that resident 3 had a two-step TB skin test completed within the twelve months before her admission or within 21 days of her admission to the facility. A documented TB skin test was expected at the time each resident admitted to the facility. 3. Review of the provider's revised 1/27/26 State-Specific Senior Living Information policy revealed, the provider's tuberculin screening requirements for the residents included "...the two-step method of tuberculin skin test or a TB	S 331		

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S 331	Continued From page 8 blood assay test to establish a baseline within 21 days of employment or admission to the facility."	S 331			
S 415	44:70:05:03 Resident Care The facility shall employ or contract with a licensed nurse who assesses and documents that the resident's individual personal care, and medical, physical, mental and emotional needs, including pain management, have been identified and addressed. Any outside services utilized by a resident shall comply with and complement facility care policies. Each resident shall receive daily care by facility personnel as needed to keep skin, nails, hair, mouth, clothing, and body clean and healthy. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure the individual care needs for one of one closed record sampled resident (4) were assessed and documented by the licensed nursing staff related to the resident's change in cognitive and physical conditions. Findings include: 1. Review of resident 4's closed electronic medical record (EMR) revealed that she admitted to the facility on 5/15/24. Her diagnoses included dementia (a group of symptoms affecting memory, thinking, and social abilities), diabetes, anxiety, depression, and hypertension (high blood pressure). The resident's 6/13/25 Brief Interview for Mental Status (BIMS) assessment score was 1, which indicated her cognition was severely impaired. The resident's individual personal care, medical, physical, mental, and emotional needs	S 415	Resident #4 unable to be corrected related to discharge. All residents at risk for condition changes requiring reassessment. RN audited all current medical records for potential changes in condition and completed evaluations if needed. All nursing staff were educated on reporting changes in condition and policy reviewed at staff meeting on 8/25/2026. RN or designee will continue to audit current residents for any potential changes in condition that would require further assessment monthly x 3 months then report to QAPI.	9/25/26	

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S 415	Continued From page 9 were last assessed by a licensed nurse on 12/8/25. Resident 4's March 2026 through May 2026 progress notes indicated the resident's confusion, her verbalizations regarding a desire to leave the facility, and her wandering and exit seeking behavior increased. On 5/21/26, the resident eloped (left the facility without staff knowledge) through a door that connected the assisted living facility to the independent living facility. Additional progress notes indicated that the resident refused to take her medications at times and she was sometimes agitated. Resident 4 required more staff assistance during that time to ensure her care needs were met, specifically her incontinence (involuntary urine or bowel leakage) care and dressing. Continued review of the resident's progress notes revealed that there was ongoing communication between the facility and the resident's family regarding the resident's safety, cognitive and physical decline. On 5/28/26, resident 4 was discharged to another assisted living facility (ALF) with a memory care unit (an area within the ALF where specialized care is provided in a structured, safe, and supportive environment to meet the unique needs of residents with significant memory and cognitive decline, that is secured to minimize unsafe wandering). 2. Interview on 8/11/26 at 4:00 p.m. with registered nurse (RN)/manager A revealed she was responsible for documenting residents' cognitive screenings and care need evaluations. She acknowledged that the decline in resident 4's cognitive and physical condition began at least three months before the resident was discharged from the facility. She did not, but she should	S 415		

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S 415	Continued From page 10 have, reassessed and documented the resident's known personal care, medical, physical, mental, and emotional needs related to the resident's known change in condition. 3. Review of the provider's 1/27/26 State-Specific Senior Living Information, South Dakota policy revealed, "The facility develops written communication describing resident care and services provided and provides written communication to the resident's physician, PA [physician's assistant], or nurse practitioner prior to or upon admission, yearly, and after a significant change of condition of the resident." "Each facility shall use a validated screening tool for evaluation of a resident's cognitive status upon admission, yearly, and after a significant change in condition."	S 415			
S 432	44:70:05:05 Hospice Services A facility that admits or retains a resident who has requested hospice services shall have an order identifying the terminal illness. The facility shall have unlicensed assistive personnel on duty to administer medications to a resident receiving hospice services. At least two personnel must be on duty at all times if the care needs of the resident require additional staffing or if the resident is not capable of self-preservation. Family members may assist with the care of the resident. The facility and hospice agency shall develop a written care plan or service plan that delineates responsibilities. The facility must be equipped with an automatic sprinkler system if a resident becomes incapable of self-preservation. This Administrative Rule of South Dakota is not	S 432			

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S 432	Continued From page 11 met as evidenced by: Based on record review, interview, and policy review, the provider failed to develop, implement, and coordinate a care plan (a personalized plan that addresses a resident's care needs, goals, and interventions) between the facility and the hospice provider that described the responsibilities of each provider for one of one sampled resident (3) who received hospice services. Findings include: 1. Review of resident 3's electronic medical record (EMR) revealed a 7/17/26 progress note that stated, "Initial hospice visit to discuss services." A 7/21/26 progress note indicated that hospice services were initiated for the resident on that date. Resident 3's 7/21/26 revised hospice care plan identified the following hospice interventions, "Home health care nurse visits as determined by Hospice team or patient [resident] wishes," and "Hospice" followed by the name of the agency providing resident 3's hospice services. The hospice care plan did not identified the resident's terminal diagnosis or any hospice-specific interventions regarding the management of symptoms related to that diagnosis. The care plan failed to identify the types of services the hospice agency was providing the resident or the frequency with which those services occurred. 2. Interview on 8/11/26 at 10:15 a.m. with registered nurse (RN)/manager A revealed that the hospice agencies kept the individual residents hospice binders in a cabinet behind the facility's	S 432	Resident Hospice binder received with updated information on 8/11/26. Service plan updated on 8/26/26. All nursing staff staff educated on Hospice services at all staff meeting on 8/25/2026. No other current residents are on Hospice services at this time. All Hospice residents can be affected. RN or designee will ensure Hospice binder is left at facility at time of Hospice admission and will ensure Hospice care plan, Hospice orders and terminal diagnosis are in the Hospice binder. After Hospice admission occurs RN will be responsible for updated facility service plan to ensure collaboration with Hospice provider. RN or designee will audit this residents Hospice binder and services plan weekly for 4 weeks then monthly x2 and report to QAPI	9/25/26

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S 432	Continued From page 12 reception desk. The hospice binder contained information and documents regarding how and when to contact the hospice provider, a copy of the resident's signed hospice agreement, the physician's signed hospice orders that included the resident's terminal illness diagnosis, the hospice care plan, and the hospice provider's interdisciplinary progress notes regarding their visits. RN/manager A confirmed that resident 3 did not have a hospice binder in the cabinet. It was RN/manager A's responsibility to ensure resident 3's hospice agency had provided the facility with a hospice binder that contained the above hospice-related documentation for the facility staff to refer to regarding the resident's individualized hospice care. She acknowledged that without that information, the resident's care plan was incomplete and there was no continuity between the hospice agency and the facility concerning the resident's hospice care. 3. Review of the provider's 1/27/26 State-Specific Senior Living Information, South Dakota policy revealed, "The facility and hospice agency shall develop a written care plan or service plan that delineates responsibilities and takes into account the ability of the resident to be capable of self-preservation."	S 432		
S 633	44:70:07:04 Storage And Labeling Of Medications A container with a medication that will not be used within thirty days of issue or with contents that expire in less than thirty days of issue must bear an expiration date. If a single-dose system is used, the medication name and strength, expiration date, and a control number must be on the unit dose packet.	S 633		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 46860	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/11/2026
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - ECHO RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 931 FOX RUN DRIVE RAPID CITY, SD 57701		
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S 633	Continued From page 13 This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure twelve of twelve expired influenza vaccines and one of one expired Hepatitis B vial were removed from one of one medication refrigerator. Findings include: 1. Observation and interview on 8/10/26 at 2:15 p.m. with lead registered medication aide (RMA) B of the medication refrigerator revealed there were two boxes of influenza vaccines. The outside of those boxes indicated the vaccines were "2025-2026 Formula." There were ten influenza vaccine syringes inside the unopened box, and two remaining influenza vaccine syringes inside the opened box. The syringes in both boxes had June 2026 expiration dates on them. There was a vial inside a prescription bottle in the medication refrigerator. The label on the prescription bottle read, "Engerix-B" [Hepatitis B]. The expiration date on the prescription label was December 2024. Lead RMA B acknowledged the above influenza vaccines and Hepatitis B vial were expired. They should have been removed from the refrigerator and destroyed. There was a process for regularly auditing each residents' medications for expired medications, but there was no process for auditing the contents of the medication	S 633	Expired vaccinations were destroyed per protocol on 8/11/26. All residents can be affected by storage of expired medications Education provided to all nursing staff on 8/25/26 by RN related to medication refrigerator needing to be checked for expired medications and open dates. Developed new Weekly audit form to be completed by RN or designee. Fridge audit form will be audited weekly x 3 then monthly x2 and report to QAPI.	8/26/26

South Dakota Department of Health

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - ECHO RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 931 FOX RUN DRIVE RAPID CITY, SD 57701		
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S 633	Continued From page 14 refrigerator for expired medications. 2. Interview on 8/10/26 at 3:00 p.m. with registered nurse (RN)/manager A regarding the above medication refrigerator revealed the medication refrigerator usually only had unopened insulin inside it. She was not aware the refrigerator contained expired vaccines. 3. Review of the provider's 10/30/25 Medications Acquisition, Receiving, Packaging, and Storage policy revealed, "9. The ALC [assisted living center] will routinely check for expired medications. Expired medications will be disposed of in accordance with state/pharmacy regulations."	S 633		