STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435074	A. Building B. Wing	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, SD 57231

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (continued on next page)

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 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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE].*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.*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 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 [DATE] 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 [DATE]. 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 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 [DATE].*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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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.*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:*She admitted to the facility on [DATE].*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 [DATE], 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 [DATE] 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 [DATE].*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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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:1. Review of the 10/17/25 anonymous complaint intake report regarding resident 1 revealed:*Resident 1 had been admitted to the facility on [DATE], 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 [DATE] 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 [DATE]. *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.*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 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