

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  355097	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/09/2025
NAME OF PROVIDER OR SUPPLIER  Good Samaritan Society - Larimore		STREET ADDRESS, CITY, STATE, ZIP CODE  501 E Front St Larimore, ND 58251	

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 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on record review, review of the facility reported incident (FRI), and review of facility policy, the facility failed to properly utilize assistive devices necessary to prevent accidents for 1 of 1 sampled resident (Resident #1) who fell during a staff assisted transfer. Failure to utilize the gait belt resulted in Resident #1's fall/fracture and placed all residents transferred with a gait belt at risk for injury. This citation is considered past non-compliance based on review of the corrective actions the facility implemented immediately following the incident. Findings Include: The surveyor determined a deficient practice existed on 06/17/25. The facility implemented corrective action immediately and completed corrective action on 07/07/25. Review of the facility policy titled Gait Belt-Therapy &amp; Rehab occurred on 07/09/25. This policy, dated September 2024, stated, Gait belts are used to aid patients during transfers and/or ambulation. The gait belt provides a firm grasping surface for the healthcare provider, protects the patient from accidental trauma, and helps reduce healthcare provider injury. Review of the initial FRI, dated 06/17/25, stated, Resident had a fall at this time. CNA [certified nurse aide] [#1] called nurse on walkie to let this nurse know that resident had an assisted fall to the floor during transfer from wheelchair to recliner. Resident was being transferred with 1 staff assist and states that her knees gave out. Resident assisted into recliner with hooyer [mechanical] lift and 2 staff assist. CNA reported that she observed resident hitting her head on dresser. Review of Resident #1's medical record occurred 07/09/25. Diagnoses included right hip fracture. The care plan stated, . The resident has an ADL [activities of daily living] self-care performance deficit R/T [related to] weakness E/B [evidenced by] need for assist . TRANSFER: Resident requires assist of 1 . Resident #1's progress notes, dated 06/17/25, stated, at 8:21 p.m., . Resident had a fall at this time. At 10:05 p.m. Resident sent to ER [emergency room] at this time for 10/10 [a numerical pain rating] pain in R) hip. The facility failed to ensure staff utilized a gait belt while assisting Resident #1. Based on the following information, non-compliance at F689 is considered past non-compliance. The facility implemented the following corrective actions to ensure all residents affected by the deficient practice were transferred in an appropriate manner: * Completed an investigation into Resident #1's fall/right hip fracture.* Educated CNA (#1) following the incident on 06/17/25 and 06/30/25.* Provided staff education regarding staff-assisted transfers/gait belt use via electronic messages and/or posted memos on 06/25/25 and 07/07/25.</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 355097	If continuation sheet Page 1 of 1