STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society Sioux Falls Village	3901 S Marion Rd Sioux Falls, SD 57106

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	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, record review, observation, and policy review, the provider failed to ensure that one of one certified nursing assistant (CNA) (AA) used a gait belt (a waist strap gripped as support for safe mobility and transfers) while ambulating (walking) one of one sampled resident (91) to the bathroom, resulting in a fall and broken femur for resident 91. Findings include:1. Review of the provider's 6/23/26 SD DOH FRI revealed that at 8 a.m. on 6/23/26, resident 91 was ambulating to the bathroom using her front-wheeled walker (FWW) (a device with two wheels on the front legs and rubber tips on the back legs, designed for individuals who need stability and partial weight-bearing support) as CNA AA provided contact guard assistance (CGA) (hands-on physical light touch to support an individual without actively supporting their body weight), but did not use a gait belt. Resident 91 lost her balance and fell and suffered an elbow abrasion and a broken femur that required surgery to repair. Following surgery, resident 91 readmitted to the facility on [DATE]. 2. Review of resident 91's electronic medical record (EMR) revealed that she admitted to the facility on [DATE]. She had diagnoses of chronic obstructive pulmonary disease (a progressive, incurable lung condition that makes it hard to breathe), dementia (a group of symptoms affecting memory, thinking, and social abilities), and repeated falls, with a history of traumatic brain injury (caused by a bump, blow, jolt, or penetrating wound to the head that disrupts normal brain functions). Her 6/29/26 Brief Interview for Mental Status (BIMS) assessment score was 13, which indicated her cognition was intact. A 6/1/26 fall assessment score of 14 indicated she had a moderate risk for falling, displayed intermittent confusion, had an ambulation status of chairbound, and did not experience any falls during the past three months. Her 6/23/26 fall assessment completed at 1:58 p.m. was six, which indicated she had a low risk of falling, did not experience any falls during the past three months, was alert and oriented, and was chairbound. Resident 91's 6/23/26 care plan (a personalized plan that addresses a resident's care needs, goals, and interventions) indicated that for toileting and transferring, she required one staff member to assist her in a pivot transfer (when assisted to a standing position, the resident then turns their body to move to another surface) using a gait belt, wheelchair, or a sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position) as needed. 3. Interview on 6/30/26 at 3:12 p.m. with Administrator A revealed that she felt the terminology used in the residents' care plans (personalized plan that addresses a resident's care needs, goals, and interventions) needed to be clarified to avoid misinterpretation of a resident's level of assistance. Before she fell on 6/23/26, resident 91's care plan specified that she needed staff assistance with her activities of daily living (ADLs: routine self-care tasks people perform every day to maintain independence) due to impaired mobility and weakness. Her intervention for ambulation read, CGA with [the] use of [a] FWW. I use [a] wheelchair for primary locomotion. Administrator A wanted to replace CGA, a therapy acronym for contact guard assist, with assist of one staff member with gait belt, so it was clearer for the staff to understand. After resident 91 fell on 6/23/26, Administrator A reviewed all the residents' care plans to update the terminology used for the ambulation and locomotion interventions and to (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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F 0689 Level of Harm - Actual harm Residents Affected - Few	ensure that the resident's fall assessment scores accurately reflected the resident's risk of falling. 4. Observation and interview on 6/30/26 at 4:02 p.m. in resident 91's room with the resident and her family member revealed that before she fell on 6/23/26, for short-distance trips to the bathroom, she used a walker to help keep her balance when she walked. If she left her room, she used a wheelchair and was able to propel it independently. Resident 91 recalled that on the morning of 6/23/26, as she neared the bathroom door, she saw her roommate's pajamas lying on the floor and told CNA AA, Those are in my way. CNA AA replied, Go ahead, you'll be ok. Resident 91 said she moved forward, tripped on the pajamas, and fell backwards, hitting the back of her head on the floor. Her family member said he was surprised CNA AA did not pick up the pajamas or use a gait belt. Resident 91 said the staff does not always use a gait belt when assisting her. It just depends on who's helping me, she said. 5. Interview on 6/30/26 at 4:24 p.m. with registered nurse (RN)/clinical nurse leader I revealed that she expected staff members to reference a resident's Kardex (a report listing the resident's care needs and interventions) to know whether they should use a gait belt when assisting with transfers, walking, and toileting tasks. The staff were to use a gait belt if specified in the Kardex and be aware of all care plan updates posted in the nurse's station. She was aware that resident 91 said she tripped on pajamas that were on the bathroom floor, but CNA AA recalled nothing lying on the floor. RN/clinical nurse leader I said recent complications from resident 91's COPD could have caused resident 91 to become confused. Resident 91 did not require the use of a gait belt when ambulating to the bathroom, and she used a wheelchair when traveling longer distances, such as to the dining room. 6. Interview on 7/1/26 at 11:01 a.m. with certified occupational therapy assistant (COTA) DD revealed that it was standard protocol for the therapy staff to use a gait belt when assisting residents. She did not know whether resident 91 needed to use a gait belt and would prefer that all CNAs used a gait belt when assisting residents, regardless of their status. She said, If someone were to lose their balance while walking, the gait belt is something they can grab onto. 7. Interview on 7/1/26 at 11:20 a.m. with CNA AA revealed that she referenced a resident's Kardex to know whether they required a gait belt when being assisted by the staff. On 6/23/26, she was assisting resident 91's roommate when resident 91 said she needed to use the bathroom. CNA AA did not know if resident 91 needed a gait belt but knew she used a walker, so that's what I did with her. As they neared the bathroom door, resident 91 fell. She said there were clothes on the floor, but I don't think there was anything on the floor, CNA AA stated. 8. Interview on 7/1/26 at 11:30 a.m. with certified medication aide (CMA) Y revealed that she referenced a resident's Kardex to determine their level of assistance and that the Kardex could change frequently. She said, We work with new residents every day, so I always check [the Kardex] if I don't know. 9. Interview on 7/1/26 at 11:33 a.m. with director of nursing (DON) B revealed that she expected the staff to reference a resident's care plan or Kardex to determine the level of assistance they required. Staff members who were helping someone they did not routinely work with should ask another staff member about their needs or refer to the care plan. She said, All staff have access to the care plan and the Kardex. 10. Interview on 7/1/26 at 3:45 p.m. with physical therapist supervisor EE revealed that before she fell on 6/23/26, resident 91 was participating in physical therapy to increase strength and endurance. She stated that although therapy staff used a gait belt when assisting residents, some staff members did not use a gait belt. Therapy will recommend how a resident should transfer, whether that's with a gait belt or a lift and one or two staff [members] assisting them, she said, but the nursing team ultimately specified the resident's assistance needs on the resident's care plan. 11. Interview on 7/1/26 at 3:53 p.m. with CMA BB revealed that she referenced the residents' care plans or the Kardex to determine their needs during a transfer. She said the Kardex would specify the use of a gait belt if a resident required that level of assistance, but she did not think resident 91 needed a gait belt. 12. Interview on 7/2/26 at 9:05 a.m. with CNA/restorative nursing aide (RNA) CC revealed that she was working as a CNA in the special care unit (an area 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, (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	that is secured to minimize unsafe wandering). Her primary role was to assist residents with restorative therapy exercises (designed to help residents maintain or improve their functional independence). She referenced a resident's Kardex to determine their required level of assistance. She said it's common sense to use a gait belt when helping residents stand up and when walking with residents who are unstable or cognitively impaired. 13. Interview on 7/2/26 at 9:50 a.m. with DON B revealed the nursing team or the therapy team evaluated residents to determine the level of supervision they required for transfers, toileting, and walking. The nursing team conducted fall assessments quarterly, after each fall, and when a resident's health status changed. 15. Review of the provider's 4/30/26 Gait-Transfer Belt policy revealed that gait belts are a device used for stability and/or support for a short time during the actual transfer or ambulation, and should be used with assisted ambulation unless medically contraindicated. 16. Review of the provider's 12/1/25 Care Plan policy revealed that the residents' care plans were reviewed and modified at least quarterly and when there was a significant change in a resident's condition. The care plan should reflect the care currently required/provided for the resident.