STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435075	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society Howard	300 West Hazel Avenue Howard, SD 57349

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 - Minimal harm or potential for 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 interview, observation, record review, and policy review, the provider failed to ensure an environment free from accident hazards for one of one sampled resident (24) with a diagnosis of hemiplegia (paralysis effecting one side of the body) following cerebral infarction (a stroke) who, while reaching for his call light, fell, hit his head, and sustained a laceration (a deep cut) to his left arm when left unattended in his bathroom, seated on the toilet, with a stand aid (a manual lift used to assist a person from a seated to a standing position) positioned in front of him, without the staff ensuring that the lift brakes were locked and that his call light was within his reach. Findings include: 1. Interview and observation on 5/19/26 at 10:48 a.m. with resident 24 in his room revealed he had fallen from the toilet in his bathroom onto the floor a couple of weeks ago. He had hit his head on the floor and received a cut on his left arm. He indicated that a certified nursing assistant (CNA) had taken him into the bathroom and left him on the toilet without his call light within his reach. He could not recall the name of the CNA who had transferred him to the toilet. He indicated that the stand aid (a manual lift used to assist a person from a seated to a standing position) was left in front of him when he was seated on the bathroom toilet, but the brakes were not locked, and the stand aid scooted forward when he lost his balance reaching for the call light cord to call for staff assistance, and fell. His bathroom was situated so that the toilet was in the southwest corner of the bathroom. If a person was sitting on that toilet, they would be facing to the east. The call light cord was attached to the wall on the northwest corner of the bathroom (situated to a person's left side if they were seated on the toilet), and the sink was in the northeast corner of the bathroom. He had a seat riser on the toilet and a grab bar that was on the right side of the toilet. Resident 24 had a stroke that resulted in him having left-sided weakness in his body, which potentially could have contributed to his fall as he had to lean over on his left side to reach the call light cord with his right hand. He confirmed he did not have to go to the emergency room for further treatment after his fall. 2. Review of resident 24's electronic medical record (EMR) revealed that he was admitted to the facility on [DATE]. He had medical diagnoses that included hemiplegia (paralysis of one side caused by brain damage) following cerebral infarction (stroke) of the left nondominant side, chronic obstructive pulmonary disease (COPD) (progressive long-term lung condition that causes obstructive airflow from the lungs), and atrial fibrillation (irregular heartbeat). On 11/19/25, his Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact. His current undated care plan included that he was to transfer with one staff (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 - Minimal harm or potential for actual harm Residents Affected - Few	member using the white stand-aid, and that he was assessed and found to be at risk of falling with a history of falls. A care plan intervention added on 4/22/26 read, Educate/remind CNAs to give [the] resident [his] call light while in [the] restroom and educate/remind [resident 24] to ensure he has [the] call light before [the] CNA leaves [the] room. Resident 24's 4/21/25 Physical Therapy Treatment Encounter progress note read, Challenging patient's forward reach while sitting unsupported to both ipsilateral [on the same side of the body] and contralateral [on opposite side] sides reaching for objects 4 [four inches] above [the] floor with [his] right hand. Needs supervision for safety, able to bend forward with no loss of balance (LOB) instances. 3. Interview on 5/21/26 at 3:15 p.m. with CNA G regarding resident 24ˆrevealed he transferredˆwith assistance from the staff and the use ofˆthe stand aid. She would drape ˆthe call light cord over the bar frame of the stand aid, and the residentˆwould hold onto the string and pull it to turn the call light on to indicate when he was finished using the bathroom. CNA G usuallyˆwaitedˆoutside of the bathroom in the resident's room for the resident to finish in the bathroom, but the staff could keep the resident to the stand aid and leave the bathroom if the stand aid brakes were locked. Resident 24 could not fully grip the bar of the stand aid while the staff stood him up to transfer him, but rather, he rested his hand on the bar. She indicated that Physical Therapy and Occupational Therapy assessed the residents to determine which transfer machine they could safely use. 4. Interview on 5/21/26 at 3:52 p.m. with CNA F revealed that residents were left in their bathroom with the stand aid when they used the toilet, and the call light cord was draped over the stand aid for the residents to pull when they were finished and needed the staff to return to assist them. 5. Interview on 5/21/26 at 3:54 p.m. with CNA E revealed he did not leave the stand aid in the bathroom with resident 24. Instead, he would remove the stand aid from the bathroom until resident 24 needed assistance again. He reviewed the resident's Kardex (a report of the resident's care needs and interventions) to know how the resident transferred and what equipment the resident could use.ˆHe did not indicate how he ensured resident 24 was able to use the call light while in the bathroom. 6. Interview on 5/21/26 at 4:39 p.m. with director of nursing (DON) B revealed the incident that occurred on 4/22/26 at 6:19 a.m. with resident 24 was due to the resident overreaching for his call light cord while he was sitting on the toilet in his bathroom. The resident had fallen off the toilet and hit his head on the floor and received a laceration to his left upper arm. The resident was transferred with the white stand aid with staff assistance. She indicated that the staff could leave a resident in the bathroom with the call light cord within their reach and the stand aid in front of them if the resident was assessed to safely use the stand aid and if the stand aid brakes were engaged to prevent it from moving. She stated, I can't guarantee that they always use them correctly, when referring to the CNAs using the stand aids. Competency validation checklists were provided for all staff that were working the day of the incident indicated the staff were trained before the incident on 4/22/26 on how to use the stand-aid. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. Interview on 5/21/26 at 6:16 p.m. with licensed practical nurse (LPN) H revealed that she was present on 4/22/26 when resident 24 was found on his bathroom floor at 6:19 a.m. He had hit his head on the floor and received a laceration to his left upper arm.ˆShe assessed him and followed the policy and procedures for resident falls. 8. Review of the provider's 4/8/25 Falls Resource Packet-Rehab/Skilled Policy revealed that Fall reduction begins with proactively recognizing potential fall risk factors and proceeds with communicating actions to reduce the possibility of falls. Early identification of each resident's risk for a fall and promptly communicating interventions to avoid falls is vital for resident safety. Common risk factors to consider and proactively address to reduce falls.Lower body weakness.Gait and balance problems.Newly admitted to the facility, room change, and room arrangement changes.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and policy review, the provider failed to ensure the staff followed standard infection prevention and control practices related to one of two certified nursing assistant (CNA) (I) who wore two pairs of gloves during one of one sampled resident's (30) cares and did not remove potentially soiled gloves before touching the resident's wardrobe and clean clothes.Findings include:1. Observation on 5/19/26 at 11:20 a.m. revealed that CNAs I and J were assisting resident 30 with changing his clothes after he was incontinent (involuntary urine or bowel leakage). Both CNAs were wearing gloves. With her potentially soiled gloves, CNA I walked over to resident 30's wardrobe, grabbed the handles and opened the doors, grabbed a pair of clean pants from the wardrobe, and closed the doors. She helped the resident put on his clean incontinence brief and pants and then removed and discarded her gloves in the trash can. She was wearing another pair of gloves underneath the first pair of gloves that she had removed and discarded.2. Interview on 5/19/26 at 11:27 a.m. with CNA I revealed that she was wearing two pairs of gloves during the above observation. She usually removed the outer layer of gloves after performing peri-cares (cleaning a person in the perineum area, the skin between the genitals and anus). She confirmed she did not remove the outer layer of gloves after performing peri-cares on resident 30. She touched the wardrobe door and handles, and resident 30's clean clothes with the soiled gloves. She said it was a normal practice at that facility to wear multiple pairs of gloves at one time.3. Interview on 5/20/26 at 2:54 p.m. with director of nursing B revealed that it was not their normal practice to wear multiple pairs of gloves at one time. She explained that it was not part of the provider's policy or good practice. She expected the direct care staff to remove their soiled gloves and perform hand hygiene (cleaning hands with soap and water or alcohol-based hand sanitizer) before touching the resident's clean clothes and wardrobe.4. Review of the provider's undated Personal Protective Equipment (PPE), Application and Removal, All Service Lines-Enterprise policy revealed that the policy did not include directions for wearing two pairs of gloves.5. Review of the provider's 11/13/25 Hand Hygiene-Enterprise policy revealed that All employees in patient care areas.will adhere to the 4 Moments of Hand Hygiene and 2 Zones of Hand Hygiene. 1. Entering Room. 2. Before Clean Task. 3. After Bodily Fluid/Glove Removal. 4. Exiting Room. 5. Zones: Patient zone and Health-care zones. HCW [Healthcare worker] will use waterless alcohol-based hand sanitizer or soap and water to clean their hands: .After removing gloves regardless of task completed .When entering healthcare zone (supply drawers, linen drawers or cupboards) Glove use: .Change gloves when moving from a dirty to a clean or sterile activity performing hand hygiene in between changing gloves.Hand hygiene must be performed after removal [of gloves] regardless of task.