STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435098	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society Tyndall	2304 Laurel Street Tyndall, SD 57066

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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, record review, and policy review, the provider failed to assess for potential accident hazards and safety related to the usage of a lift chair for one of one sampled resident (1) and was transferred to the emergency department (ED) for evaluation and treatment of injuries acquired from the fall.Findings included:1. 1. Review of the providers 7/8/25 SD DOH FRI revealed:*On 7/8/25 at 10:45 a.m., resident 1 was found lying face down on the floor in front of his lift chair.*His lift chair was raised all the way up in the air.*He had a laceration (a cut or tear in the skin) to the left side of his forehead.*A registered nurse (RN) completed neurologic assessment (evaluation of nerve function, reflexes, coordination, motor skills, sensation, and mental status) with slight delayed response, which was normal for resident 1.*Resident 1's vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) were within normal limits (WNL). *The local ambulance was notified and resident 1 was transferred to the ED.*His family was notified of the fall.*His primary care provider (PCP) was notified of the fall.*Resident 1 returned from the ED on 7/8/25 with a diagnoses of a fall, contusion (bruise) to the face, laceration of an eyebrow that was repaired with tissue glue, and subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain).*Orders: cold pack to left cheek TID (three times a day) x15 minutes until swelling resolves.Glue to left eyebrow laceration to remain in place until starts falling off on its own. 2. 2. Review of resident 1's electronic medical record revealed:*He admitted to the facility on [DATE].*His diagnoses included hypertension (high blood pressure), paranoid schizophrenia (symptoms of paranoia including delusions and hallucinations), peripheral vascular disease (narrowed blood vessels reduce blood flow to the limbs), hypoxemia (low level of oxygen), heart failure, atherosclerotic heart disease (damage or disease in the heart's major blood vessels), dysphagia (difficulty swallowing), and major depressive disorder.*His Brief Interview for Mental Status (BIMS) assessment score on 5/13/25 was 14, which indicated he was cognitively intact.*A 7/8/25 progress note: [Resident 1 was] Laying in prone position with [his] nose touching [the] floor with [a] pool of blood noted and gurgling breathing sounds noted, grabbed a towel and raised [resident 1's] head just enough to get my hand between [his] forhead [forehead] and floor so he could breathe, his eyes were open, and [he] responded to [the] 2nd [second] nurse whom rolled him onto his left side and then ambulance [was] called for emergent [emergency] transfer to nearest hospital via T.O.R.B. [telephone order read back]. [Local doctor] for evaluation. 2nd nurse checked his pupils and the O.D. [right eye] is 4mm [millimeters] and reactive, unable to open O.S. [left eye] d/t [due to] swelling around eye and left cheek bone. He did squeeze CNA's [certified nursing assistant] hands [he was] not strong but [he was] able to follow command and he did slightly move his right leg and his left leg just a little. Ambulance crew of 2 arrived and [a] cervical collar made from rolled towels were applied to neck and he was slid onto transfer board and then 4-5 people [assisted] to lift him onto the gurney. VS [vital signs] WNL @ [at] 134/66, [blood pressure] 73, [pulse] 18, [respirations] 98.2. [temperature]*A 7/9/25 progress note: FALL F/U [follow up] VS [vital signs] and Neuro's [neurological assessment] WNL, only able to check [NAME]] pupil as O.S. is swollen shut. [Resident 1 was] Able to move all extremities on command, hand grasps weak, per baseline. Purplish black and red ecchymosis pbruising] to O.S and cheek bone. C/O [complains of] 10/10 [ten out of ten]pain in my back what part lower, he just received his scheduled 650 mg [milligrams] of Tylenol. Will continue to monitor.*A 7/10/25 progress note: Fall f/up: [Resident 1] Continues to have bruising and swelling to left eye. No bleeding or drainage noted to [left] eye brow. Neuro's intact. Complains of pain, Tylenol given per MAR [medication administration record] Moves all extremities per self.*He had lift chair safety assessments completed on 2/4/2024, 7/9/25 and 7/11/25.-The 7/9/25 and 7/11/25 indicated the lift chair would be used for repositioning and would not be a restraint for resident 1.-No documentation identified that resident 1 would be safe to use the lift chair. 3. Observation and interview on 7/16/25 at 4:15 p.m. with resident 1 revealed he:*Was lying in bed, with his legs elevated on a pillow. He had a bruise above his left eye and bruising on his neck.*Was unsure how he fell out of his lift chair on 7/8/25.*Since that fall on 7/8/25, he has not used his lift chair. 4. Interview on 7/17/25 at 8:33 a.m. with CNA E regarding the 7/8/25 FRI involving resident 1 revealed:*She had found resident 1 face down on the floor and immediately called for the nurse on duty.*She put on gloves and supported his head to ensure he could breathe.*The emergency department was called promptly.*It took five staff members to roll resident 1 onto his back.*A cold compress was applied to resident 1's head while an RN