

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435104	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2025
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society New Underwood		STREET ADDRESS, CITY, STATE, ZIP CODE 412 South Madison New Underwood, SD 57761	

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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, and policy review, the provider failed to ensure the safety of one of one sampled resident (1) who fell as she walked to her room with the assistance of one of one certified nursing assistant (CNA) who had not used a safety device (gait belt) while assisting the resident. That fall resulted in resident 1's development of a hematoma (collection of blood outside blood vessels) to the back of her head and a fractured left femur (thigh bone). CNA C's failure to use a gait belt may have contributed to the accident.</p> <p>Findings include:</p> <p>1. Review of the provider's 3/28/25 SD DOH FRI regarding resident 1 revealed:</p> <p>*On 3/28/25, CNA C was walking with resident 1 to her room after lunch when resident 1 lost her balance and fell backwards.</p> <p>*CNA C was not using a gait belt (a waist strap gripped as support for safe mobility and transfers) while walking with resident 1, and was not able to intervene when resident 1 started to lose her balance.</p> <p>*Resident 1 fell, hit the back of her head and was sent to the emergency department (ED) for a head scan.</p> <p>*While resident 1 was at the ED, it was determined that she had a left femur fracture, which required pinning (a surgical procedure to repair the fracture).</p> <p>*Resident 1's care plan stated she needed the assistance of one staff member and the use of a gait belt and a walker while walking.</p> <p>*CNA C was suspended on 3/28/25 pending an investigation of the accident.</p> <p>2. Review of resident 1's electronic record revealed:</p> <p>*She was admitted on [DATE].</p> <p>*Her 4/3/25 Brief Interview for Mental Status (BIMS) assessment score was 1, which indicated she was severely cognitively impaired.</p> <p>(continued on next page)</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
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>*Her diagnoses included fracture of the left femur, acute kidney failure, altered mental status, osteoporosis (a condition that causes weak and brittle bones), hypertension (high blood pressure), fracture of the right femur, Alzheimer's, anterior dislocation of the right hip, fracture of the shaft of the right humerus (arm), and dementia.</p> <p>*Her care plan indicated she needed the assistance of one staff with the use of a gait belt and her walker when walking.</p> <p>*A progress note on 3/28/25 at 3:04 p.m. indicated:</p> <p>- ambulance here, when we moved resident she is expressing more pain [her] in left hip, added to note [her transfer] to ER [emergency room] and ambulance EMT [emergency medical technician] will bring [that information] to [the] ER [staffs] attention.</p> <p>*A progress note on 3/30/25 at 9:28 a.m. indicated:</p> <p>- Received fax from [surgical doctor] at [local hospital], with [an] assessment plan.</p> <ol style="list-style-type: none"> 1. Patient is weight-bearing as tolerated in the left lower extremity [leg]. 2. Continue Physical and occupational therapy. 3. Patient will need 30 days of DVT [deep vein thrombosis] prophylaxis [preventative treatment] after surgery. <p>*A progress note on 3/31/25 at 7:37 p.m. indicated:</p> <p>- Reason resident was hospitalized or received services at a hospital: LEFT HIP FX [fracture] ORIF [open reduction [and] internal fixation].</p> <p>3. Interview on 6/10/25 at 2:17 p.m. with director of nursing (DON) B regarding the 3/28/25 FRI for resident 1 revealed:</p> <p>*She stated that CNA C was walking with resident 1 without using a gait belt.</p> <p>*Resident 1 had lost her balance, CNA C was not able to prevent the fall, and resident 1 fell and hit her head.</p> <p>*Registered nurse (RN) F assessed resident 1 after the fall and discovered the resident hematoma on the back of her head.</p> <p>*RN F and CNA C assisted resident 1 to her bed by using a Hoyer lift (a mechanical lift and sling used to lift a person's full body).</p> <p>*RN F had obtained a physician's order to send resident 1 to the ED for evaluation.</p> <p>*DON B stated administrator A reviewed the camera footage of that hallway regarding the incident on 3/28/25.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>*She stated she had discussed safety issues with CNA C prior to the 3/28/25 incident with resident 1. That discussion included CNA C using her phone when she was assisting residents, not following residents' care plans, and not using gait belts with residents who needed them to support safe mobility.</p> <p>*She stated CNA C was suspended pending investigation of the 3/28/25 incident, due to her not using a gait belt with resident 1 while walking.</p> <p>*When she became aware that resident 1 had a fracture, the administration team discussed CNA C's multiple safety issues and decided to terminate her employment with the facility on 4/3/25.</p> <p>*DON B stated all CNAs had completed a gait belt competency when they started their employment and then every year after that.</p> <p>-She stated the online competency was called Safe Resident Handling.</p> <p>*She stated she has not provided a formal all-staff education since the 3/28/25 incident.</p> <p>-During huddles meeting with the CNAs and RN in the mornings at 10:30 a.m. she had discussed using gait belts, but she did not have a sign-in form to acknowledge that all CNAs and RNs had been provided the gait belt use education.</p> <p>-Gait belts use education was posted on a communication clipboard for all staff to see.</p> <p>--There was no sign-in form for staff to sign, acknowledging they had read that sheet.</p> <p>*She stated that when walked around the facility, she observed to ensure the staff were using gait belts appropriately, but did not document those observations to use them as an auditing tool for safe gait belt use to discuss in the QAPI (Quality Assurance and Performance Improvement) meetings.</p> <p>4. Interview on 6/10/25 at 3:28 p.m. with administrator A revealed:</p> <p>*He had reviewed the camera footage for the incident on 3/28/25 with resident 1 and CNA C but he would have to review his notes to remember everything he had seen.</p> <p>*He stated CNA C was very nice, but had not been following the residents' care plans.</p> <p>*He stated that the administration team determined that CNA C's employment would be terminated after the 3/28/25 incident.</p> <p>*He expected the staff to follow the residents' care plans and the facility's policies to ensure safety.</p> <p>5. Review of CNA C's personnel file revealed:</p> <p>*She was hired on 1/9/25.</p> <p>*She had completed the following online education classes:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Safe resident handling program on 1/22/25.</p> <p>-Fall prevention: What YOU can do on 1/27/25.</p> <p>*She had completed a Safe Resident Handling session on 2/3/25.</p> <p>*Her employment was terminated on 4/3/25.</p> <p>6. Interview on 6/10/25 at 4:03 p.m. with CNA E revealed:</p> <p>*She was hired on 9/27/22.</p> <p>*She worked day and evening shift.</p> <p>*She stated that staff were to use a gait belt every time they were walking with a resident.</p> <p>*She stated she remember receiving education from the DON regarding the gait belt use after resident 1 had fallen on 3/28/25.</p> <p>7. Interview on 6/10/25 at 4:30 p.m. with CNA D revealed:</p> <p>*She was hired on 1/3/24.</p> <p>*She usually worked night shifts.</p> <p>*She thought she had received online training for gait belt use after resident 1 had fallen on 3/28/25.</p> <p>*She stated that staff were to use a gait belt every time they were walking with a resident.</p> <p>8. RN F was unavailable for an interview at the time the survey was conducted.</p> <p>9. Review of the provider's 9/23/24 Gait Belt policy revealed:</p> <p>*Purpose:</p> <p>To promote safety with patient ambulation and transfers by providing guidance for gait belt use. 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.</p>		