DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY LUTHER MANOR	1500 W 38TH ST , SIOUX FALLS, South Dakota, 57105

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F0000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/31/26 through 4/1/26. Areas surveyed included a significant medication error, elopement, and potential resident abuse. Good Samaritan Society Luther Manor was found not in compliance with the following requirement: F689 and had past noncompliance with F760.	F0000		
F0689 SS = E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, South Dakota Department of health (SD DOH) facility-reported incident (FRI) review, and policy review, the provider failed to ensure: *The front door code was changed following an elopement (when a resident who needs supervision leaves the premises or safe area without authorization or necessary supervision) from the facility for one of one sampled resident (2) who knew that door code and remained outside unsupervised for about 18.5 hours on 3/28/26 through 3/29/26. *Three of four sampled newly admitted residents (3, 4, and 5) were assessed for their elopement risk per provider policy.	F0689	1. Resident 2 has Discharged from the facility. Elopement Risk Assessments for Residents 3, 4, and 5 were completed on 4/2/2026. 2. All residents are at risk for not having an elopement risk assessment. Admissions nurse or designee will complete the Elopement Risk Assessment UDA upon admission or readmission, and resident's will be reassessed Quarterly and with any significant change. All residents will be assessed for Elopement Risk quarterly and with any significant change. Residents that are identified as an elopement risk, have minimal cognitive impairment, and refuse to wear a wander guard will have Nurse Charting in the TAR to document location and time resident observed. The time frame for documentation will depend on the risk level of the resident as it could be scheduled for every hour or less. The nurse completing the admission will put in the order for the charting. 3. Morning clinical meetings that are held Monday through Friday. The nurse managers review new admissions and readmissions to ensure the Elopement Risk assessment has been completed and will verify the documentation order has been triggered for a resident that is found to be identified as an elopement risk, have minimal cognitive impairment, and refuse to wear a wander guard. Every 3-hour rounding will be improved with the implementation of the nurse charting as the nurse will document location of the resident and the exact time they see the resident. 3-hour Rounding is not a policy, and the timing will be decided upon by the team to ensure the safety of the resident. Nurse managers and charge nurses will be educated via email, text, and OnShift message that all residents require the Elopement Risk assessment to be completed quarterly, annually and with any significant change or event.	4/25/26

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other afeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 ays 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 llowing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program articipation.

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE TC Fraser	(X6) DATE 4/24/26

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F0689 SS = E	Continued from page 1 Findings include: 1. Review of the SD DOH FRI initial report received on 3/28/26 revealed that resident 2 had been reported missing to director of nursing (DON) B at 8:00 p.m. on 3/28/26. Dietary staff told DON B that resident 2 was not at the evening meal which was unusual for him, and the last he was reported seen was by registered nurse (RN) F at approximately 5:30 p.m. that day when she offered him a diet coke. The building and grounds were searched by staff, but resident 2 was unable to be located. 2. Review of the provider's camera check timeline summary for resident 2's elopement investigation revealed that resident 2 had exited the building on 3/28/26 at 5:04 p.m. Earlier that day at 12:49 p.m., resident 2 can be seen in his wheelchair approaching the front door, pushing numbers on the keypad, watching the door open and close, then returning to his room. 3. Review of resident 2's electronic medical record (EMR) revealed that he was admitted to the facility on 10/28/25 and was assessed as a risk for elopement from his admission elopement risk screening. Resident 2 had a Brief Interview for Mental Status (BIMS) score of 11 meaning he had mild cognitive impairment. He had refused to have a wander guard (a wearable door alarming device) placed for his safety, so his care plan (personalized plan that addresses a resident's care needs, goals, and interventions) was updated for staff to perform and document rounding (checking on residents' status and assistance needs) on him every three hours to verify his whereabouts. His last documented three-hour check on 3/28/26 was at 12:00 p.m. that day. He returned to the facility on 3/29/26 at 11:30 a.m. in a private vehicle. 4. Observation on 3/31/26 at 4:33 p.m. in the hallway near the front door revealed that a keypad was protruding from the wall to the right of the front door. A visitor was seen reading the top of the keypad, then entered a number to that keypad. The front door opened and that visitor exited the building. The laminated paper on top of the keypad read "7092 (BACKWARDS)". 5. Interview on 3/31/26 at 4:42 p.m. with resident 2 in his room revealed that his room was the closest resident room located near the front door. Resident 2	F0689	Yellow clip boards at the front office and nurses' station will now include high risk for elopement residents along with residents who have wander guards. Nurse managers are responsible for updating the yellow clip boards. The Maintenance Director will change door code monthly or immediately after an event. 4. DON or Designee will audit 5 new admissions to ensure elopement risk assessment has been completed. Audits will be weekly for 4 weeks, biweekly for 1 month, monthly for 3 months. Audits will continue until compliance has been sustained for 3 months. DON or designee will audit all residents that are identified as an elopement risk, have minimal cognitive impairment, and refuse to wear a wander guard upon admission or event to ensure rounding is being completed timely. Audits will be with every new admission or event weekly for 4 weeks, bi-weekly for 1 month, and monthly for 6 months. Administrator or designee will audit door code monthly for 6 months. Elopement drills will be continue monthly for 1 year and will include all shifts to ensure all staff are able to respond appropriately to the yellow code. Results of the audits will be discussed by the DON or designee at the monthly QAPI meeting with the medical director and IDT for analysis and recommendation for continuation, discontinuation, or revision of the audits based on findings. 5. Compliance date: 4/25/2026	

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F0689 SS = E	Continued from page 2 stated that he would watch people leave through that front door and was able to figure out the code for the door from watching it being pushed by others on the keypad. He recalled testing the door code earlier in the day on 3/28/26 and waited until a time that staff was busy to wheel himself out of the building in his wheelchair. He did not know if the door code had been changed after he left the facility on 3/28/26 evening, but he would continue to watch people and figure out the new code if it had been changed. 6. Interview on 4/1/26 at 9:34 a.m. with registered nurse (RN) I and licensed practical nurse (LPN) J at the nurses' station revealed that they both were aware that resident 2 was an elopement risk because he had made statements about leaving the facility on his own. They both stated that he was periodically confused but they both believed that he planned his elopement to a time when staff would be busy getting the other residents ready for the evening meal. 7. Interview on 4/1/26 at 10:10 a.m. with supervisor of ancillary services (SAS) G revealed that the same door code had been used for several years, and that administrator A asked him to change the code yesterday on 3/31/26. He confirmed that the code was the same from when resident 2 eloped on 3/28/26 until 3/31/26. SAS G stated that some residents knew the front door code and would use it to open the door and to sit outside on occasion, and that resident 2 was one of those residents. He acknowledged that a resident with intact cognition would be able to read the laminated door code sign and enter the code to leave the front door. 8. Interview on 4/1/26 at 11:26 a.m. with RN C revealed that she was responsible for performing the admission assessments on residents who were new to the facility. The provider used a system called Point Click Care (PCC) for the resident's electronic medical record (EMR). She stated that the elopement assessment for residents used to automatically open when a new resident admitted to the facility for the staff to complete in PCC. She explained that since the update to PCC in December 2025, the elopement assessment no longer automatically opened for the staff to complete for new resident admissions. RN C would only perform an elopement risk assessment if a resident verbally confirmed that they had a wish to leave the facility or if they had other clinical risk factors. RN C also explained that there was an admission checklist to	F0689		

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F0689 SS = E	Continued from page 3 perform on the admission assessment, but it was no longer accurate since the PCC upgrade, and she no longer filled out that checklist. 9. Interview on 4/1/26 at 1:48 p.m. with social services supervisor H revealed that resident 2 had been offered counseling previously for his wish to elope from the facility and declined it. His doctor wanted him to undergo a psychiatric evaluation (a series of tests to determine a person's decision-making ability) and he declined this as well. His discharge plan was to get a new pair of prosthetic legs and discharge either to the community or with his brother. 10. Interview on 4/1/26 at 2:29 p.m. with director of nursing (DON) B revealed that education on elopement risk residents was performed with staff after resident 2's elopement as well as at the March all-staff meeting. 11. Review of the residents admitted from 3/11/26 through 3/27/26 revealed that resident 4 was admitted on 3/11/26, resident 6 was admitted on 3/24/26, and residents 3 and 5 were both admitted on 3/27/26. There were no documented admission elopement screening assessments for residents 3, 4, and 5 found in their EMRs. 12. Further interview on 4/1/26 at 2:29 p.m. with DON B revealed that she was aware that the assessment in PCC for elopement screens on newly admitted residents no longer automatically opened for staff to complete after the December 2025 update for PCC. She acknowledged that staff were only performing this assessment if a resident voiced a history of trauma, substance abuse, or actively wanted to leave the facility. She agreed that their policy stated that all residents were to be screened for elopement risk on admission and that a history of trauma or substance abuse was not an elopement screen. 13. Interview on 4/1/26 at 3:41 p.m. with administrator A revealed that he was not aware that newly admitted residents were not being screened for their risk for elopement. Screening all newly admitted residents for elopement risk was the expectation to determine their risk and implement safety interventions. He agreed that not changing the door code immediately after the elopement could have put resident 2 at risk for another	F0689		

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F0689 SS = E	Continued from page 4 elopement. 14. Review of the provider's 4/7/25 Elopement policy revealed that all residents would be assessed for their risk of elopement through the "pre-admission and/or admission process" to "put measures in place to minimize the risk of elopement that are individualized to the resident needs and identified on the care plan." The staff would complete the elopement risk user defined assessments (UDA) (customizable electronic forms used for clinical documentation such as assessments) in PCC. That UDA would include resident/family education about needing to sign in and sign out of the building or to let a staff member know that a resident is leaving. During the resident's stay, elopement risk UDA would be completed again periodically, and the resident's care plan would be updated as needed.	F0689		
F0760 SS = G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI) review, record review, interview, and policy review, the provider failed to ensure that one of one sampled resident (1) was free from a significant medication error when his baclofen (a primary medication for managing involuntary muscle stiffness and muscle spasms in quadriplegia) was discontinued by registered nurse (RN) C without a physician's order which resulted in the resident being transferred to the emergency department (ED) for evaluation and treatment, and had a subsequent three-night hospitalization for observation of his condition. This citation is considered past non-compliance based on a review of the corrective actions the provider implemented following the incident. Findings include: 1. Review of the provider's 3/21/26 SD DOH FRI regarding resident 1 revealed that on 3/20/26, he had a "change in [his] mental status, face turning red, and was not acting himself." He was sent to the ED for	F0760	"Past Noncompliance - no plan of correction required"	

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F0760 SS = G	Continued from page 5 evaluation at approximately 9:00 p.m. and was then admitted to the hospital from the ED at 10:52 p.m. He was diagnosed with acute encephalopathy (a critical syndrome characterized by rapid changes in brain function), "likely due to baclofen withdrawal after abrupt discontinuation." The facility's investigation into the incident revealed that RN C received a "Consultant Pharmacist Communication to Physician," in which the pharmacist asked the physician for clarification about the date that baclofen should be discontinued. The communication read, "Baclofen and duonebs [an inhaled medication to treat lung diseases] have a stop date of 2/1/2027 on the MAR [medication administration record] – please clarify if these are supposed to be discontinued at that time or if they are ongoing." RN C did not notice the year 2027 and thought the medications should have been discontinued on 2/1/26. She did not wait for the physician's verification before discontinuing the order. RN C stopped resident 1's baclofen on 3/18/26. DON B provided education to RN C about the process of monthly pharmacy recommendations immediately after the incident was identified upon RN C's return to work on 3/23/26. The education included an explanation that pharmacy recommendations could not be acted upon without the physician's order to agree or disagree. RN C was encouraged to maintain "a questioning attitude" and was advised to seek clarification if she was unsure whether a medication had been discontinued. She was also instructed to use her unit manager and DON B as resources if she was ever unsure about a pharmacy recommendation or what action to take. RN C had no previous disciplinary actions or performance issues. The facility's plan to prevent future significant medication errors involves reporting the issue to its Quality Assurance and Performance Improvement (QAPI) committee. There was a process change, and moving forward, the QAPI nurse will be assigned to review monthly pharmacy recommendations as a second RN check and to serve as a resource for questions. Interview on 4/1/26 at 11:26 a.m. with RN C confirmed that DON B had recently provided her with education related to her role in the monthly pharmacy recommendation process, and she felt more confident in that role. She was also educated about the change in the process involving the QAPI nurse serving as a second RN check and as a resource. Interview on 4/1/26 at 11:50 a.m. with medical director K, who was resident 1's primary physician, revealed	F0760		

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F0760 SS = G	Continued from page 6 that she would have expected to be contacted before a medication was discontinued. She would have expected a nurse to get clarification on how a medication like baclofen should be discontinued to ensure it was done safely. Interview on 4/1/26 at 2:29 p.m. with DON B revealed she was providing oversight and reviewing the monthly pharmacy recommendations for all residents until the transition of those duties to the QAPI nurse was complete. She confirmed the incident was a significant medication error for resident 1 and stated it was discovered on Saturday, 3/21/26. On Monday, 3/23/26, she and clinical care leader (CCL) D and RN E reviewed all of the monthly pharmacy recommendations that RN C had been responsible for to ensure accuracy, and no additional errors were found. She stated that although not all nursing staff are responsible for handling monthly pharmacy recommendations, they will provide education to all nursing staff as an additional precaution in case they need to assist with coverage for that task. Interview on 4/1/26 at 3:41 p.m. with administrator A revealed that he expected a nurse to have a physician's order before discontinuing a resident's medication. The provider's implemented actions to ensure the deficient practice does not recur were confirmed onsite on 4/1/26 after record review confirmed the facility had followed their quality assurance process and: *DON B provided education to RN C about the monthly pharmacy recommendation process. *Interview confirmed that RN C understood the education provided. *RN C had no prior disciplinary actions or performance issues. *DON B implemented a new process to provide a second RN check by the QAPI nurse for monthly pharmacy recommendations. *DON B created an audit tool to be used to monitor monthly pharmacy recommendations. *DON B ensured monthly pharmacy recommendation audits will be reported at the next monthly QAPI meeting. Based on the above information, non-compliance at F760 occurred on 3/18/26, and based on the provider's implemented corrective actions on 3/23/26, for the	F0760		

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F0760 SS = G	Continued from page 7 deficient practice confirmed on 4/1/26, the non-compliance is considered past non-compliance.	F0760		