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 03/05/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/3/26 through 3/5/26. Good Samaritan Society Luther Manor was found not in compliance with the following requirements: F554, F609, F641, F657, F686, and F699. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/3/26 through 3/5/26. Areas surveyed included quality of care and potential abuse related to a resident who fell from a mechanical lift, a resident who fell when a gait belt was not used while he was walking, a resident who eloped from the facility, staff to resident verbal abuse, failure to care for a resident's wounds, misappropriation of property related to alleged theft of a resident's medications, and a medication error that resulted in a resident's hospitalization. Good Samaritan Society Luther Manor was found not in compliance with the following requirements: F689 and F755.	F0000	The plan of correction is prepared an/or executed soley because it is required by provisions of federal and state law	
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure one of one sampled resident (100) who waas left alone in his room with his nebulizer (a device that converts liquid medication into an inhalable mist) machine administered by certified medication aide(CMA) (EE), was assessed for the resident's ability to safely sefl-adminster that medicaiton. Findings include:	F0554	1.Resident 100 was assessed on 3/24/26 by Nurse Manager and was deemed inappropriate for self-administration of inhaled medications. 2.All other residents who are self-administering medications are at risk of not having an assessment and/ or physician orders. Residents have been reviewed by clinical managers in conjunction with nurse and MA's who pass medications to determine those residents self-administering. Those residents have had an assessment completed and order obtained from the provider. With each resident that can self-administer medications after supervision, the Medication Administration Record (MAR) has been updated to identify which medications are approved for self-administration. 3.New admissions desiring to complete self-administration will be assessed by a nurse using the Self-Administration UDA to determine appropriateness, and a physician order will be obtained. Resident self-administering medications will be assessed quarterly and with any significant change in condition to determine continued appropriateness.	4/1/2026

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 reverse for further 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 TC Fraser	(X6) DATE 3/31/26

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 03/05/2026

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F0554 SS = D	Continued from page 1 1. Observation on 3/5/26 at 7:56 a.m. revealed resident 100 was alone in his room, lying on his back in his bed. He had a nebulizer mask positioned on the right side of his face without covering his nose and mouth while the nebulizer machine was on and administering the breathing treatment(nebulized medication). 2. Observation, interview, and electronic medication administration record (EMAR) review on 3/5/26 at 8:00 a.m. with CMA EE revealed she was standing at the medication cart and stated she put the nebulizer mask on resident 100. When she entered his room she stated, "Oh, you knocked the cup (container that held the medication) off." -She removed the nebulizer mask and turned off the nebulizer machine. -She stated she was not sure if the resident could have that nebulizer treatment without supervision. -She looked at the resident's (EMAR) but could not find a physician's order for him to self-administer that medication. 3. Interview on 3/5/26 at 9:17 a.m. with registered nurse (RN) J revealed she thought that resident 100 could self-administer his nebulizer treatments in his room by himself. 4. Interview on 3/5/26 at 4:00 p.m. with director of nursing (DON) B revealed: *Resident 100 did not have a doctor's order to self-administer his medication. *He did not have an assessment for his ability to safely self-administer medication completed. *She expected a resident's self-administration assessment to be completed and to have a physician's order before a resident was left in their room unattended. 5. Review of resident 100's electronic medical record (EMR) revealed: *He had a physician's order for Ipratropium-Albuterol	F0554	Certified medication aide (CMA) EE has been educated on the process and requirements to determine if a resident has been deemed appropriate to self-administer medications. All other CMA's and Nurses will receive education by DON or designee on the process of self-administration of medication by 4/1/2026. New hires will be educated during their orientation process during their allotted time with the DON. Those not in attendance due to illness, vacation, leave or casual work status will not be allowed to work until the education has been completed prior to their next scheduled shift. 4.DON or designee will observe a medication pass three times a week and focus on 5 random residents to determine if residents are self-administering medications. If they are self-administering, their EMR will be checked to ensure completion of the self-administration assessment and physician's order. Audits will be done weekly for 6 weeks, bi-monthly for 2 months, and then monthly for 3 months. Audits will continue until all residents have been reviewed during medication pass and no concerns of self-administering medication without a proper assessment and physician's order. Audits will continue until compliance has been sustained for 3 months. 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 audits based on findings. 5.Compliance Date: 4/1/2026.	

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F0554 SS = D	Continued from page 2 Inhalation Solution 0.5-2.5 (3) MG (milligram)/3ML (milliliter) (Ipratropium-Albuterol 1 vial inhale orally via nebulizer four times a day related to Quadriplegia (the paralysis in all four limbs and the torso). *He was readmitted to the facility on 2/19/26. *He did not have a brief Interview of Mental Status (BIMS) assessment score completed and he was nonverbal. *His diagnoses included: -Traumatic subdural hemorrhage with loss of consciousness (a type of bleeding near the brain), unspecified intracranial injury with loss of consciousness, cognitive communication deficit, facial weakness, psychomotor deficit, and convulsions. *His care plan indicated that he had limited physical mobility and interventions were initiated on 7/10/25 that included a private room to accommodate for his specialized larger wheelchair, the use of a Total body lift (a mechanical lift and sling used to lift a person's full body), and two staff members to assist him with all his cares. *His care plan indicated he had an altered respiratory status related to his obstructive sleep apnea. The intervention that was initiated on 7/10/2 was to monitor for signs and symptoms of respiratory distress and to report to a health care provider as needed. 6. Review of the provider's 10/31/58 resident self-administration of medication policy revealed: *"Purpose: To determine if the resident can safely self-administer medications." *"To identify which mediations may be safely self-administered." *"To assist the resident who is self-administering medications to manage his or her prescribed medications in a safe manner" *"To provide residents who can do so safely with the opportunity to self-administer medications"	F0554		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F0609	1.For facility reported incidents of resident 10, resident 49, and resident 44 the reports have been submitted reviewed and accepted.	4/1/26

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F0609 SS = D	Continued from page 3 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. 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 report incidents to the SD DOH within the required time frame, for one of one sampled resident (10) who fell on the floor while being transferred with a sit-to-stand mechanical lift (a mechanical lift used to assist from a seated to a standing position) by certified nursing assistant (CNA) N without the assistance of another staff member, one of one sampled resident (49) related to allegations of having been verbally abused by CNA K, and one of one sampled resident (44) related to allegations of having been verbally abused by CNA E. Findings include: 1.Review of the provider's 12/1/25 submitted FRI regarding resident 10 revealed: *On 12/1/25, the provider completed a review of a fall incident for resident 10 that had occurred on 11/28/25	F0609	2.All residents are at risk for facility reported incidents not being reported in a timely manner. All resident events for the last 3 months have been reviewed by the Administrator to determine appropriate reporting. 3.Events or incidents that require reporting will be identified during review of resident, family and/or staff concerns that are brought forward using guidelines from the Department of health reporting guidelines and the facility Abuse policy. DON or Administrator will complete a reporting checklist at time of submission of an initial incident to ensure timeliness of reporting. DON or Administrator will complete the Facility reported incidents (FRI) log in the Shared file to track time of event, time of reporting and will be discussed in QAPI. There will be a binder that will have the FRI initial and final report printed out, the audit sheets per plan of correction or education required. FRI's will be kept in the binder until audits and/or education have been completed and then will be removed and put in a red file labeled by the resident name in the DON office. Nurse Managers will review all calls as a potential for a FRI that may need to be reported during their weekend of call. The DON and/or the Administrator will review calls as a potential for a FRI during the week. Certified Nursing Assistant (CNA) N was educated regarding following care plan for all resident transfers and completed Safe Resident Handling competencies on 3/26/26 by Administrator and Clinical Learning and Development Specialist (CLDS) CNA K and CNA E have completed their required education regarding the verbal abuse allegations. DON and Administrator received and completed education on 3/9/2026. All staff will receive education regarding the timeliness of reporting, what needs to be reported along with a quiz to validate knowledge and understanding by 4/1/2026. Abuse posters identifying events that need to be reported and timeframes, who to notify right away, and next steps have been posted in breakrooms, bathrooms, nurses station, and by the time clock. Those not in attendance due to illness, vacation, leave or casual work status will not be allowed to work until the education has been completed prior to their next scheduled shift. New Hires receive Abuse reporting education via learning centers during their new hire orientation and annually thereafter. 4.Audits will be conducted weekly of the above events by the Administrator for the need to report, the accuracy of reporting, and if it was reported in the allotted time frame. Audits will be weekly for 2 months, monthly for 4 months. Audits will continue until compliance has been sustained for 3 months. Results of the audits will be discussed by the Administrator or designee at the monthly QAPI meeting with the medical director and IDT for analysis and recommendation for continuation, discontinuation, or revision of audits based on findings. 5.Compliance Date: 4/1/2026.	

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F0609 SS = D	Continued from page 4 at 11:30 a.m. *Resident 10 was assisted to the restroom and back to his wheelchair by CNA N with the use of a sit-to-stand mechanical lift. *During the transfer, resident 10 slipped and slid from the sling to the floor onto his bottom and then rolled onto his right side. *CNA N called for assistance and licensed practical nurse (LPN) HH immediately came to the room. *Resident 10 was assessed by the nurse and was not injured as a result of the fall. *The investigation revealed CNA N failed to follow resident 10's care plan, which stated he was to be transferred with the use of a sit-to-stand mechanical lift and the assistance of two staff members. *CNA N was immediately re-educated by director of nursing (DON) B after the incident to ensure she checked a resident's care plan before she provided resident care. *The incident was not reported to the SD DOH until 12/1/25, which was past the 24-hour required timeline. 2. Review of the provider's 2/26/26 submitted FRI regarding resident 49 revealed: *On 2/20/26 at 8:15 p.m. DON B was notified that CNA D left her scheduled 2/20/26 shift 30 minutes after reporting to work. *CNA D stated she did not feel comfortable working until she spoke with the scheduler and DON B on Monday (2/21/26). *CNA D called DON B and texted the scheduler, which prompted administrator A and DON B to investigate CNA D's report of quality of care concerns. *On 2/20/26 administrator A and DON B went to the facility and interviewed residents and staff. *Resident 49 reported that CNA K told her "not to sing and to shut up" and "Sit Up or I am not going to help you". -Resident 49 could not provide a date or time when CNA K had said that to her.	F0609		

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F0609 SS = D	Continued from page 5 *During resident interviews there were two other residents who stated CNA K made "rude and inappropriate" comments such as, "You would not have these issues if you went out to the dining room" and "Don't be Cocky". *No resident had reported feeling unsafe or having received poor care from the staff during those resident interviews. *CNA K denied having made rude or inappropriate comments to residents. *The FRI was reported to the SD DOH on 2/26/26 at 1:06 p.m., six days after DON B was notified of the allegations of verbal abuse. *DON B indicated in the report, "This report is late as the Administrator felt that with all residents stating they do not feel abused, no care issues of abuse were raised, and all residents interviewed stated they felt safe we did not feel [it] would require reporting. After speaking with [the] Regional Nurse consultant and explaining the details of the investigation she stated that both [investigations involving residents 44 and 49] needed to be reported...We have learned that any and all allegations of verbal, psychological, physical, or emotional abuse will be reported first and investigated second." 3. Review of the provider's FRI on 2/27/26 at 12:46 p.m. regarding resident 44 revealed: *On 2/20/26 at 8:15 p.m. director of nursing (DON) B was notified that CNA D left her scheduled 2/20/26 shift 30 minutes after reporting to work. *CNA D stated she did not feel comfortable working until she spoke with the scheduler and DON B on Monday (2/21/26). *CNA D called DON B and texted the scheduler, which prompted administrator A and DON B to investigate CNA D's report of quality of care concerns. *CNA E reported that resident 44 had used her call light several times during the night on 2/19/26 regarding leg pain and needed to be repositioned. *CNA E reported to the charge nurse that resident 44 could not get comfortable. The nurse assessed resident 44 and provided care and medications ordered by her doctor.	F0609		

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F0609 SS = D	Continued from page 6 *CNA E stated she did not use profanity toward residents or while providing them care, but she did use profanity at times when talking with other staff members about a resident, as an expression of how she felt, not towards the resident. *CNA E was assigned the following training: Abuse and Neglect of Vulnerable Adult Abuse, Neglect and Exploitation, and Creating a Restraint – Free Environment, which was to be completed by 3/4/26. 4. Interview on 3/5/26 at 5:43 p.m. with DON B revealed: *The reports of resident abuse and neglect were to be reported to the SD DOH within two hours of being reported to herself or another staff member. *All other reportable events were to be reported to the SD DOH within 24 hours. *DON B acknowledged she did not report the allegations of verbal abuse, related to residents 44 and 49, within the required two-hour time frame to the SD DOH. *DON B stated she did not recall the 12/1/25 FRI regarding the 11/28/25 incident that involved resident 10's fall from a mechanical lift or that it was not reported within the required 24-hour time frame. 5. Review of the provider's 4/7/25 Abuse and Neglect policy revealed: *"If there is an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident/client property, and/or there is serious bodily injury, then it will be reported immediately, but not later than two hours after the allegation is made." *"If there is an allegation that does not involve abuse and there is no serious bodily injury, then it will be reported no later than 24 hours after the allegation is made."	F0609		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's	F0641	1.Resident 11's Minimum Data Set (MDS) was corrected to remove the areas of inaccuracy of being coded for an invasive mechanical ventilator and a non-invasive mechanical ventilator and the modification was submitted prior to the surveyor leaving RN J's office on 3/3/2026 during the survey process.	4/1/26

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F0641 SS = D	Continued from page 7 status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 October 2025 review, the provider failed to ensure one of one sampled resident's (11) Minimum Data Set (MDS) assessments, a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs, were accurately coded in the areas for an invasive mechanical ventilator (a device that delivers air into the lungs through a hole in the neck into the windpipe or a flexible tube inserted in the mouth or nose through the windpipe) and a non-invasive mechanical ventilator (positive air pressure delivered through a mask into the lungs to treat severe breathing difficulties).	F0641	2.All other residents have the potential to have inaccuracy of coding in their MDS assessment. MDS assessments will be reviewed prior to submission for any inaccuracy to prevent inaccurate coding in the future. 3.MDS/wound nurse F received education from Lila Blair Senior Clinical Reimbursement Analyst on 3/30/2026 regarding the importance of ensuring that the accuracy of the MDS has been reviewed prior to submission. Education was completed by Lila Blair Senior Clinical Reimbursement Analyst on 3/30/2026. MDS coordinator and DON present for education as well. 4.The MDS nurse will review each MDS prior to submission to verify that each section of the MDS has been accurately coded to reflect the residents health status and individual plan of care. If a MDS is found to be inaccurate, the errors will be corrected prior to submitting the MDS. The MDS coordinator of designee will audit the most recent MDS submitted for 10 residents a week for 4 weeks, then monthly for 5 months. Audits will continue until compliance has been sustained for 3 months. Results of the audits will be discussed by the MDS coordinator or designee at the monthly QAPI meeting with the medical director and IDT for analysis and recommendation for continuation, discontinuation, or revision of audits based on findings. 5.Compliance Date: 4/1/2026.	

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F0641 SS = D	Continued from page 8 Findings include: 1. Observation and interview on 3/3/26 at 10:22 a.m. with resident 11 in her room revealed: *She was sitting in her recliner with oxygen administered through a nasal cannula (flexible tubing with prongs that delivers oxygen through the nose). *There was no invasive or non-invasive ventilator in the room. *Resident 11 denied that she was on a ventilator. 2. Review of resident 11's electronic medical record (EMR) revealed: *She was admitted to the facility on 9/26/24. *Her 12/16/25 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. *Her diagnoses included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), shortness of breath, mild intermittent asthma (a lung disease characterized by inflamed, narrow airways that produce excess mucous and cause wheezing and shortness of breath), and chronic respiratory failure with hypoxia (a long-term progressive condition where the lungs cannot adequately transfer oxygen into the blood). *There was no physician's order for an invasive mechanical ventilator or non-invasive mechanical ventilator such as a Continuous Positive Airway Pressure (continuous air pressure administered through a mask to keep the airway open) (CPAP) machine or a Bilevel Positive Airway Pressure (delivers pressurized air through a mask at two different pressures) (BiPAP) machine. *Her 3/5/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) did not indicate she used an invasive or a non-invasive mechanical ventilator. *Item O0110 F1 of resident 11's 12/16/25 quarterly MDS assessment was coded to reflect that she was on an invasive mechanical ventilator within the last 14 days before the completion of that MDS assessment. *Item O0110 G1 of resident 11's 12/16/25 quarterly MDS assessment was coded to reflect that she was on a	F0641		

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F0641 SS = D	Continued from page 9 non-invasive mechanical ventilator within the last 14 days before the completion of that MDS assessment. -It did not identify if resident 11 had used CPAP or BiPAP machine as the non-invasive mechanical ventilator. 3. Interview on 3/5/26 at 7:58 a.m. with registered nurse (RN) J revealed: *She had worked as a nurse at the facility for eight years. *No resident had used an invasive mechanical ventilator in the facility during those eight years. 4. Interview and review of resident 11's 12/16/25 MDS assessment on 3/5/26 at 11:55 a.m. with MDS/wound nurse F revealed: *The provider did not admit residents to the facility who needed invasive mechanical ventilators. *She completed resident 11's 12/16/25 quarterly MDS assessment. *She verified that item O0110 F1 of resident 11's 12/16/25 quarterly MDS assessment was coded that she was on an invasive mechanical ventilator within the last 14 days before the completion of that MDS assessment. -She acknowledged that section O0110 F1 was coded incorrectly. *She verified that item O0110 G1 of resident 11's 12/16/25 quarterly MDS assessment was coded that she was on a non-invasive mechanical ventilator within the last 14 days before the completion of that MDS assessment and did not indicate if resident 11 had used a CPAP or BiPAP machine. -She acknowledged that section O0110 G1 was coded incorrectly. *MDS/wound nurse F felt that the incorrect MDS coding was due to human error. 5. Interview on 3/5/26 at 5:43 p.m. with director of nursing (DON) B revealed: *She expected the MDS assessments to be coded accurately.	F0641		

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F0641 SS = D	Continued from page 10 *The provider did not have the ability to care for residents on invasive mechanical ventilators. *Resident 11 did not use an invasive or a non-invasive mechanical ventilator. *She acknowledged that resident 11's 12/16/25 quarterly MDS assessment was coded inaccurately in the areas related to the use of an invasive mechanical ventilator and a non-invasive mechanical ventilator. 6. Review of section O in the Centers for Medicare and Medicaid Services Long-Term Care Facility RAI 3.0 User's Manual Version 1.20.1 October 2025 revealed: *"The intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received or performed during the specified time periods." *"Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedure such as IV [intravenous] medications or ventilators." *"O0110F1, Invasive Mechanical Ventilator (ventilator or respirator) Code any type of electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the resident who is or who may become (such as during weaning attempts) unable to support their own respirations on this item. During invasive mechanical ventilation the resident's breathing is controlled by the ventilator." *"O0110G1, Non-invasive Mechanical Ventilator Code any type of CPAP or BiPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle."	F0641		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F0657	1.Resident 6, 7, and 29's care plans have been reviewed and revised to reflect their current care needs. 2.All residents are at risk for their care plans to not be reviewed and updated timely to reflect changes to their personalized care needs, goals, and interventions.	4/1/26

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F0657 SS = D	Continued from page 11 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure resident care plans (personalized plan to address a resident's care needs, goals, and interventions) were revised to reflect their current care needs for three of twenty-five sampled residents (6, 7, and 29). Findings include: 1.Observation and interview on 3/3/26 at 9:24 a.m. with resident 6 revealed: *She was currently on a liquid diet. *Her nasogastric (NG) tube (a flexible tube passed through the nose, down the esophagus, and into the stomach to provide nutrition and medication) was removed at the end of February. *She used a NG tube for receiving nutritional formula and medications, but that was removed.	F0657	3.Email communication from therapy, new interventions, changes in resident conditions will be updated within 72 hours of notification in the care plan as changes arise. Fall interventions will be updated at the time of Safe Event review which is completed Monday through Friday. Residents that are up for quarterly MDS review will have their care plans reviewed during the IDT Care Plan monthly meeting. All nursing staff have been educated regarding the importance of care plans by 4/1/2026. Those not in attendance due to illness, vacation, leave or casual work status will not be allowed to work until the education has been completed prior to their next scheduled shift. DON, Nurse Mangers, or desginee will update the care plan as needed. 4.Each nurse manager will review 4 resident care plans a week for 8 weeks, bi-monthly for 2 months, and then monthly for 3 months. Audits will continue until compliance has been sustained for 3 months. 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 audits based on findings. 5.Compliance Date: 4/1/2026.	

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F0657 SS = D	Continued from page 12 2. Observation on 3/3/26 at 11:57 a.m. of resident 6 in the dining room revealed she was drinking broth and eating Jello for lunch. 3. Interview on 3/5/26 at 7:51 a.m. with certified nursing assistant (CNA) I revealed: *The residents' diet orders were on their dietary meal tickets, and Kardex (a report of the resident's care needs and interventions). *The Kardex for resident 6 indicated she was NPO (nothing by mouth) and used an NG tube. 4. Observation and interview on 3/5/26 at 7:58 a.m. with licensed practical nurse (LPN) H revealed: *She had worked for the provider for seven and a half years. *The residents' diet orders were in their care plan and physician's orders. *Resident 6 takes her medications crushed with applesauce. *She agreed that her nursing cheat sheet (a compact report of resident needs and interventions for nurse's) indicated to administer resident 6's medications through her NG tube. *She agreed that resident 6's care plan stated that she was using an NG tube for eating. *She was able to update resident care plans. *If a resident received new diet orders, she would update the resident's care plan. 5. Observation and interview on 3/5/26 at 8:09 a.m. with resident 6 in the dining room revealed: *She was drinking broth, juice, water, and a Boost Breeze supplement drink for breakfast. *She thought her breakfast was good. *She was going to advance her diet to full liquids (foods that are liquid or melt at room temperature, plus strained cream soups, milkshakes, and pudding) in a couple of days.	F0657		

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F0657 SS = D	Continued from page 13 *She was tolerating the clear liquid diet well. 6. Review of resident 6's electronic medical record (EMR) revealed: *Her 11/25/25 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. *She had a 2/26/26 physician's diet order for clear liquids, with a thin consistency, which ended on 3/5/26. *She had a 3/6/26 physician's diet order for a full liquid diet, with a thin consistency, which would end on 3/13/26. *She had a 3/12/26 physician's diet order for a regular diet, with a minced moist texture with thin liquids. *She had diagnoses of: -dysphagia (difficulty swallowing). -gastro-esophageal reflux disease (GERD). *On 2/25/26 her NG tube was removed at her gastrointestinal (GI) appointment. *Her care plan indicated a focus area of activities of daily living (ADL) self-care performance deficit due to weakness, physical deconditioning, decreased balance, decreased activity tolerance. Decreased functional ambulation and mobility evidence by decreased independence with ADLs initiated on 7/23/25 and revised on 7/24/25. -Goal of she will improve current level of function in bed mobility, transfers, eating, dressing, toileting use and personal hygiene by the review date initiated on 11/24/25, revised on 11/24/25 with a target date of 4/30/26. -she had interventions of NPO, and received tube feedings. Those were initiated on 7/23/25 and revised on 7/24/25. *The 3/4/26 Kardex for resident 6 under eating/nutrition/hydration indicated she was NPO, and received tube feedings.	F0657		

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F0657 SS = D	Continued from page 14 7. Interview on 3/5/26 with assistant director of nursing (ADON)/infection preventionist (IP) G revealed: *All the nurses were to update care plans for the residents. *On 2/26/26 after resident 6's diet order changed the interdisciplinary team (IDT) reviewed her care plan, and they missed changing her diet and removing the NG tube on her care plan. *The residents' care plans are reviewed on admission, as needed, quarterly, when there are significant changes in their care, and when a resident is discharged from the facility. *The nurses try to be timely with resident care plan updates, to ensure they are accurate. *The CNAs refer to the resident's Kardex which generates its information from the resident's care plan. *He was responsible for updating the nursing cheat sheets. 8. Interview on 3/3/26 at 10:58 a.m. with resident 7 in his room revealed: *He had experienced "a lot" of trauma in his life. *He had spoken to a counselor about his trauma, but not for "quite a while". *He thought his post-traumatic stress disorder (PTSD) was under control, but he knew he could not turn on the television and see the conflict and bombing in the Middle East, or it might trigger his PTSD symptoms. 9. Review of resident 7's EMR revealed: *He was admitted to the facility on 1/10/25. *His 1/30/26 Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated his cognition was intact. *His diagnoses included PTSD, depression, insomnia (the inability to sleep), and mood disorder (a mental health condition characterized by long term extreme emotional states). *His 3/4/26 care plan did not include that he had PTSD,	F0657		

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F0657 SS = D	Continued from page 15 interventions to help him cope with his trauma history, or what the staff could do to prevent triggering a traumatic response. 10. Interview on 3/4/26 at 4:04 p.m. with resident 7 revealed he: *Had only spoken with his VA counselor about his past traumatic experiences. *Would have spoken with a facility staff member about those experiences if they had asked him. 11. Review of resident 29's EMR revealed: *She was admitted to the facility on 12/27/23. *Her diagnoses included depression, dementia (a group of symptoms affecting memory, thinking, and social abilities), and anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability). *She had a 3/27/25 physician's order for olanzapine (an antipsychotic medication) 5 mg (milligrams) at bedtime. *Her 3/5/26 care plan did not have a focus area related to her taking antipsychotic medications, monitoring identified behaviors that the antipsychotic medication was prescribed for, or non-pharmacological interventions for those behaviors. 12. Interview and record review on 3/5/26 at 11:55 a.m. with Minimum Data Set (MDS)/wound nurse F revealed: *She was responsible for updating the residents' care plans. *Care plans were to be updated anytime there was a change in that resident's care needs or a new class of medication prescribed. *She reviewed each resident's care plan quarterly, annually, as needed, and when a resident had a significant change MDS assessment completed. *She acknowledged resident 29's care plan did not indicate she was prescribed an antipsychotic medication, what her behaviors were or non-pharmacological interventions for those behaviors. *She stated that resident 29's use of antipsychotic medications, the potential side effects of that medication, her behaviors, and non-pharmacological	F0657		

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F0657 SS = D	Continued from page 16 interventions should have been included in the resident's care plan. *A resident with a diagnosis of PTSD was to have PTSD identified on the resident's care plan, along with potential triggers of the resident's PTSD, pharmacological, and non-pharmacological interventions to prevent re-traumatization and to provide interventions that were identified as potentially effective to cope with the resident's trauma. *She acknowledged that resident 7's care plan did not indicate he had PTSD, what his potential triggers may be, or the interventions for those triggers. *She expected a resident with a PTSD diagnosis to have the PTSD addressed in the resident's care plan, even if the resident's past trauma was not shared during the resident's trauma assessment, so staff would be aware that the resident may have unidentified trauma triggers and what the interventions may be tried. 13. Interview on 3/5/26 at 1:57 p.m. with CNA L revealed she would reference a resident's Kardex to identify that resident's potential behaviors and the interventions for those behaviors. 14. Interview on 3/5/26 at 2:30 p.m. with registered nurse (RN) C revealed she: *Was aware of resident 7's PTSD diagnosis because he had talked to her about some of his experiences. *Did not know if resident 7 had any potential triggers for his PTSD, but stated he was able to express his needs and concerns. *Expected a resident's PTSD triggers and interventions to be identified on that resident's care plan. *Expected the behaviors and interventions for those behaviors for a resident on an antipsychotic medication to be addressed in that resident's care plan. 15. Interview on 3/5/26 at 5:43 p.m. with director of nursing (DON) B revealed: *Care plans were to be updated by the unit managers, or the MDS nurse quarterly, annually, with a significant change in a resident's heath status and care needs, and anytime a resident's care needs changed. *She was aware that resident 7 was a military veteran and had a diagnosis of PTSD.	F0657		

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F0657 SS = D	Continued from page 17 *She stated resident 7 talked about the military and shared some of his experiences with the staff. *She was not aware that resident 7 had identified the conflict and bombing in the Middle East as a trigger for his PTSD and felt he could not watch about it on television. *She acknowledged that the failure to identify a resident's past exposures to traumatic events and identify those triggers in that resident's care plan for the staff to reference posed a risk for the resident to be exposed to potential triggers and be re-traumatized. *She expected the use of antipsychotic medications to be a focus area on a resident's care plan, with the behaviors the antipsychotic was being used for, the non-pharmacological interventions for that resident's behaviors, and any side effects of the antipsychotic medication that the nursing staff should monitor for. 16. Review of the provider's 12/1/25 Care Plan policy revealed: *"To develop a comprehensive care plan using an interdisciplinary team approach." *"To provide guidance to the interdisciplinary team in developing the initial care plan." *"Residents will receive and be provided with the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the residents' optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. Any problems, needs and concerns identified will be addressed through use of departmental assessments, the Resident Assessment Instrument (RAI) and review of the physician's orders." 17. Review of the provider's 12/9/25 Psychotropic Medications policy revealed: *"Individualized, non-pharmacolgical approach that are provided as part of a supportive physical and psychosocial environment and are directed toward understanding, preventing, relieving and/or	F0657		

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F0657 SS = D	Continued from page 18 accommodating a resident's distress or loss of abilities, as well as maintaining or improving a resident's mental, physical or psychosocial well-being." *"Non-pharmacological interventions are recommended before medication interventions. Attempts should be documented in the resident medical record."	F0657		
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to monitor and implement pressure ulcer (skin and/or underlying tissue injury due to prolonged pressure) healing and prevention interventions for one of one sampled resident (7) who was identified at risk for developing pressure ulcers and developed a stage II (2; open wound or blister with partial-thickness skin loss) pressure ulcer to his coccyx (tailbone), right buttock, and left buttock and one of one sampled resident (7) who was identified at risk for developing a pressure ulcer developed a stage II pressure ulcer to his right buttock. Findings include: 1. Observation and interview on 3/3/26 at 10:58 a.m. with resident 7 in his room revealed: *He had a trapeze bar (a bar above the bed used to	F0686	1.Resident 7 and resident 83 have been assessed and have appropriate interventions in place to aide in the prevention of pressure ulcers and to aide in the healing of current pressure ulcers. Resident 83's pressure ulcer has been healed since 12/2025. 2.All residents are at risk for not being monitored or having healing and preventative measures implemented to protect them from acquiring pressure ulcers. 3.Current residents have been evaluated for skin concerns and the need of preventative measures have been implemented. Residents newly admitted or returning to the facility will be evaluated using the Braden score and the Pressure ulcer prevention document. Once the pressure ulcer prevention document has been completed, the admission nurse will ensure measures have been implemented. The Pressure Ulcer documents are given to the Wound Nurse and audits will be performed monthly to ensure all measures are in place and being utilized. Measures will be evaluated and updated as needed with quarterly reviews, appearance of a skin/wound concern, and any significant change in resident status. All nursing staff have been educated on Preventative Measures, the documentation and process for identifying. The Preventative Measure Plan will be implemented by 4/1/2026. Those not in attendance due to illness, vacation, leave or casual work status will not be allowed to work until the education has been completed prior to their next scheduled shift. Update white boards in nurses station for shifts to shift report and CNA's and nurses will communicate changes during shift to shift report. 4.DON or designee will audit 10 random residents weekly for 8 weeks, bi-weekly for 2 months and monthly for 3 months to ensure preventative measures are in place and/ or any new skin issues or concerns have been identified, measures have been put in place and are effective in the prevention of pressure ulcers. Audits will continue until compliance has been sustained for 3 months. 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 audits based on findings. 5.Compliance Date: 4/1/2026.	4/1/26

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F0686 SS = G	Continued from page 19 assist in repositioning and transfers) attached to his bed. *There was a pressure reduction cushion in his wheelchair and recliner. *He stated that he had a wound on his buttocks, but he thought it had healed. *He did not know if he had the trapeze bar attached to his bed or the pressure reduction cushions in his recliner and wheelchair before the wound developed on his buttocks. 2. Review of resident 7's electronic medical records (EMR) revealed: *He was admitted to the facility on 1/10/25. *His 1/30/26 Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated his cognition was intact. *His diagnoses included stage I (1; unopened non-blanchable skin redness, meaning the area remains red when pressed, caused by pressure) pressure ulcer and stage II pressure ulcer. *Resident 7's 1/10/25 Braden Scale for Predicting Pressure Sore Risk (a tool used to assess the risk of developing pressure ulcers) assessment score was 16, which indicated he had a mild risk for the development of a pressure ulcer. -The interventions recommended for that mild risk were, "Frequent Turning (e.g., q [every] 2 hours), Maximal Remobilization, Pressure-Reduction Support Surfaces if Bed- or Chair-Bound, Protect Heels, Manage Moisture, Manage Nutrition, Manage Friction and Shear *If other major risk factors are present (advanced age, poor dietary intake of protein, diastolic pressure below 60, hemodynamic instability), advance to [the] next level of risk." *His 1/24/25 wound assessment indicated that resident 7's facility acquired stage II pressure ulcer to his coccyx measured 1 centimeter (cm) in length by 0.5 cm in width. -Resident 7 indicated to staff that he had pain related to the wound. There was no description of his pain or what intervention was used to decrease his pain level.	F0686		

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F0686 SS = G	Continued from page 20 *His 1/28/25 wound assessment indicated that resident 7's facility acquired stage II pressure ulcer to his coccyx measured 1.0 cm in length by 1.3 cm in width by 0.1 cm in depth and that the surrounding tissues were red. It did not indicate that resident 7's physician was notified of the increased size of that pressure ulcer. *His 2/4/25 wound assessment indicated resident 7's pressure ulcer on his coccyx measured 1 cm in length by 0.5 cm in width by 0.1 cm in depth. *His 2/11/25 wound assessment indicated resident 7's pressure ulcer on his coccyx measured 1.2 cm in length by 2.2 cm in width by 0.1 cm in depth. It did not indicate that resident 7's physician was notified of the increased size of that pressure ulcer. *His 2/18/25 wound assessment indicated resident 7's pressure ulcer on his coccyx measured 3.1 cm in length by 3.6 cm in width by 0.1 cm in depth. It did not indicate that resident 7's physician was notified of the increased size of that pressure ulcer. *His 3/4/25 wound assessment documentation indicated resident 7's pressure ulcer on his coccyx measured 0.2 cm by 0.2 cm. *His 3/11/25 wound assessment indicated that resident 7 had a facility acquired stage II pressure ulcer to his left buttock. There were no measurements of that wound, and it indicated the current treatment plan was to continue. *His 3/18/25 wound assessment indicated that resident 7's facility acquired stage II pressure ulcer to his coccyx/left buttocks were healed. *His 3/25/25 wound assessment indicated that resident 7's facility acquired stage II pressure ulcer to his left buttock measured 0.9 cm in length by 0.9 cm in width by 0.1 cm in depth and was described as "dried scabs." *His 3/26/25 wound assessment indicated that resident 7 had a facility acquired stage II pressure ulcer to his left buttocks. There were no measurements of that wound, and it was described as "open". *His 4/8/25 wound assessment indicated resident 7's pressure ulcer on his coccyx measured 1.4 cm in length by 1.9 cm in width. It did not indicate that resident 7's physician was notified of the increased size of that pressure ulcer.	F0686		

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F0686 SS = G	Continued from page 21 *His 4/16/25 wound assessment indicated resident 7's pressure ulcer on his coccyx measured 0.2 cm in length by 0.8 cm in width. *His 4/29/25 wound assessment indicated resident 7's pressure ulcer on his coccyx measured 1.0 cm in length by 1.0 cm in width. It did not indicate that resident 7's physician was notified of the increased size of that pressure ulcer. *His 5/06/25 wound assessment indicated resident 7's pressure ulcer on his coccyx measured 1.2 cm in length by 1.0 cm in depth. *His 5/13/25 wound assessment indicated resident 7's pressure ulcer on his coccyx measured 0.7 cm in length by 1.0 cm in width by 0.1 cm in depth. *His 5/20/25 wound assessment indicated resident 7's pressure ulcer on his coccyx measured 0.4 cm in length by 0.2 cm in width. *His 5/27/25 wound assessment indicated resident 7's pressure ulcer on his coccyx measured 0.6 cm in length by 0.3 cm in width. *His 6/03/25 wound assessment indicated resident 7's pressure ulcer on his coccyx measured 1.6 cm in length by 1.5 cm in width by 0.1 cm in depth. It did not indicate that resident 7's physician was notified of the increased size of that pressure ulcer. *His 6/10/25 wound assessment indicated resident 7's pressure ulcer on his coccyx measured 0.6 cm in length by 0.5 cm in width. *His 6/17/25 wound assessment indicated resident 7's pressure ulcer on his coccyx measured 0.2 in length cm by 0.4 cm in width. *His 6/22/25 wound assessment indicated resident 7's pressure ulcer on his coccyx was red, dry, and intact with no open areas. *His 7/30/25 wound assessment indicated resident 7's pressure ulcer on his coccyx stated, "left side 0.1x1.2 [0.1 cm in length by 1.2 cm in width] right side 2.2x1.6 [2.2 cm in length by 1.6 cm in width], sang drng [sanguineous drainage; bloody fluid that leaks from wounds]". *His 8/05/25 wound assessment indicated resident 7's pressure ulcer on his "coccyx/upper bilateral buttocks"	F0686		

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F0686 SS = G	Continued from page 22 measured 2.2 cm in length by 2.4 cm in width. *His 8/19/25 wound assessment indicated resident 7's pressure ulcer on his coccyx measured 6.0 cm in length by 5.3 cm in width and was described as "slit in coccyx with shearing [deeper skin layers slide beneath the surface of the skin causing internal damage] off to both sides of [the] buttocks." *His 8/26/25 wound assessment indicated resident 7's pressure ulcer on his coccyx measured 7 cm in length by 5.6 cm in width by 0.1 cm in depth and described as, "large 'butterflies' over coccyx and bilateral buttocks." It did not indicate that resident 7's physician was notified of the increased size of that pressure ulcer. *His 9/02/25 wound assessment indicated resident 7's pressure ulcer on his coccyx measured 0.9 cm in length by 0.3 cm in width by 0.3 cm in depth. *Resident 7's 9/8/25 Braden Scale for Predicting Pressure Sore Risk assessment score was 19, which indicated he had no risk/low risk for the development of a pressure ulcer. -Resident 7 had a pressure ulcer on his coccyx at the time of this assessment and had two other pressure ulcers since his admission to the facility on 1/10/25. *His 9/9/25 wound assessment indicated resident 7's pressure ulcer on his coccyx was described as "'butterflies' to bilateral buttocks. Lt [left] buttocks: 0.3x0.2; rt [right] buttocks 0.2x0.1. coccyx wound closed. skin pink." *His 9/16/25 wound assessment documentation indicated resident 7's pressure ulcer on his coccyx described as, "Open area measuring 1.1x0.7 [1.1 cm in length by 0.7 cm in width] with two tiny openings below." The measurements were documented as 2.0 cm in length by 0.7 cm in width by 0.1 cm in depth. *His 9/19/25 wound assessment indicated resident 7's pressure ulcer on his coccyx was described as, "open slit with redness surrounding." *His 9/23/25 wound assessment indicated resident 7's pressure ulcer on his coccyx measured 0.9 cm in length by 0.3 cm in depth. *His 9/30/25 wound assessment indicated resident 7's pressure ulcer on his coccyx/upper bilat [bilateral] buttocks measured 0.4 cm in length by 0.3 cm in width.	F0686		

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F0686 SS = G	Continued from page 23 *His 10/06/25 wound assessment indicated resident 7's pressure ulcer on his coccyx was "skin intact/closed, pink". *His 10/13/25 wound assessment indicated resident 7's pressure ulcer on his coccyx described as "reddened and skin starting to break down." *His 10/14/25 wound assessment indicated resident 7's pressure ulcer on his coccyx measured 1.1 cm in length by 0.2 cm in width and was described as "re-opened, slit". *His 10/28/25 wound assessment documentation indicated resident 7's pressure ulcer on his coccyx was described as "skin intact; no open area noted". *A 12/14/25 physician's order for the staff to apply a Mepilex (a soft foam) dressing to resident 7's coccyx, and to change it every three days, related to a stage I pressure ulcer. *A 12/14/25 physician's order for staff to apply a zinc oxide cream, to resident 7's coccyx and red areas twice daily as needed related to a stage I pressure ulcer. *His 3/4/26 care plan did not indicate when the trapeze bar was attached to resident 7's bed. *A care plan focus area initiated on 3/2/26 indicated he had a potential for "impairment to skin integrity R/T [related to] weakness, decreased functional ambulation" with an 2/5/25 intervention of "Provide pressure relieving mattress on bed and/or cushion in wheelchair" and a 2/25/25 interventions of, "Monitor location, size and treatment of skin injury. Report abnormalities, failure to heal s/s [signs and symptoms] of infection, maceration, etc. to [the] health care provider." -It did not indicate if or when the pressure reduction cushion was placed in his wheelchair or recliner. 3. Observation and interview on 3/3/26 at 11:09 a.m. with resident 83 and his wife in his room revealed: *Resident 83 was sitting in his wheelchair. *There was no pressure reduction cushion in his wheelchair. *There was a pressure reduction cushion in his recliner.	F0686		

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F0686 SS = G	Continued from page 24 *Resident 83 stated that he had a wound on his buttocks before he was admitted to the facility. *Resident 83's wife stated that resident 83 was admitted to the facility with a pressure reduction cushion but it had gone flat, and the staff removed it from his room. *After resident 83 developed a wound on his buttocks, resident 83's wife demanded that he get another pressure reduction cushion. *A pressure reduction cushion was then provided to him at that time. *Resident 83's wife stated resident 83 spent most of his time in his recliner or in his bed. *The pressure reduction cushion in resident 83's recliner was flat. 4. Review of resident 83' EMR revealed: *He was admitted to the facility on 6/4/25. *His 1/2/26 BIMS assessment score was 12, which indicated his cognition was moderately impaired. *His diagnoses included: Adult failure to thrive, pain, malnutrition, dementia, and muscle spasms. *A care plan focus area initiated on 6/4/25 indicated he had a potential for "impairment to skin integrity R/T physical conditioning and decreased mobility, and history of pressure injury to buttock" with an 11/5/25 intervention of "Monitor location, size and treatment of skin injury. Report abnormalities, failure to heal s/s of infection, maceration, etc. to [the] health care provider" and "Provide pressure relieving mattress on bed and/or cushion in wheelchair". -It did not indicate if or when the pressure reduction cushion was placed in his wheelchair or recliner. *His 11/05/25 wound assessment indicated that resident 83's facility acquired stage II pressure ulcer to his right buttocks was not measured. -The physician was notified of the newly developed pressure ulcer. *There was no further documented pressure ulcer measurements until 11/25/25 and it was documented as 0	F0686		

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F0686 SS = G	Continued from page 25 cm in length by 0 cm in width by 0 cm in depth. *The right buttocks wound continued to be documented as a pressure injury until 12/7/25 when it was documented as a scab. *The pressure ulcer was documented as a facility acquired wound from 11/5/25 through 12/7/25 without measurements or documentation of characteristics. 5. Interview and EMR review on 3/5/26 at 11:55 a.m. with Minimum Data Set (MDS)/wound nurse F revealed: *She confirmed resident 7 and 83's pressure ulcers were facility-acquired. *Resident 7's "PRN [as needed] Mepilex" was not documented as applied for prevention before the development of his pressure ulcer. The Triad cream was ordered by his physician the day after his coccyx pressure ulcer was discovered and documented by the staff. 6. Interview on 3/5/26 at 1:57 p.m. with CNA L revealed: *Pressure ulcer prevention interventions included repositioning the residents every two hours, using pressure reducing cushions to offload pressure, and some residents used specialized mattresses. *She documented in the residents' EMR when she repositioned residents, who were on a repositioning schedule. -The repositioning documentation section would not be available in the residents' EMR if it was not scheduled. *She documented the residents' barrier cream application if the residents' EMR prompted the staff to document it. *She confirmed that residents 7 and 83 did not have repositioning schedules or barrier cream documentation sections in their EMRs. 7. Interview on 3/5/26 at 2:30 p.m. with RN C revealed: *She was aware that resident 83 had a pressure ulcer. *Resident 83 had a pressure reduction cushion in his chair, and he had the standard pressure reduction mattress.	F0686		

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F0686 SS = G	Continued from page 26 *She expected the staff to move the cushion from the wheelchair to the recliner if they were transferring the resident. *The residents' EMR should reflect pressure ulcer interventions and prevention measures. 8. Interview on 3/5/26 at 5:43 p.m. with DON B revealed: *She designed a "pressure ulcer prevention sheet" that was supposed to be referenced by the nurses to determine what interventions needed to be implemented for the residents. -That sheet was used for about a month but was no longer being used. *If a resident was hospitalized, the interventions from the hospital should have been continued upon the resident's readmission to the facility. *She expected either the care plan or the physician's orders to indicate any pressure ulcer interventions and prevention measures. *She confirmed she was aware that the pressure reducing cushion that resident 83 had when he arrived was flat. -Another pressure-reducing cushion was acquired for him, but she was not aware if the new cushion was provided before or after he developed the pressure ulcer. *She acknowledged there was no documentation of the pressure ulcer preventative measures for both residents 7 and 83 before they developed the pressure ulcers. *She was not aware that the staff could document barrier cream applications and each time they repositioned residents in the electronic medical record. She was not aware that those tasks had to be triggered in the resident's medical record for the staff to be able to document each time those tasks were completed. 9. Continued interview on 3/5/26 at 3:02 p.m. with MDS/wound nurse F revealed she confirmed there was no documentation to support any pressure ulcer prevention measures were implemented before residents 7 and 83 developed their pressure ulcers. 10. Review of the provider's 2/17/25 Pressure Ulcers	F0686		

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F0686 SS = G	Continued from page 27 policy revealed "Based on the resident's comprehensive assessment, the location will use prevention and assessment interventions to assure that a resident entering the location without pressure ulcers does not develop a pressure ulcer unless the individual's clinical condition demonstrates that this was unavoidable." 11. Review of the provider's 12/8/25 Skin Assessment Pressure Ulcer Prevention and Documentation policy revealed: *"Any resident at risk [for developing a pressure ulcer] will be placed on a pressure redistribution surface as determined appropriate." *"When a pressure ulcer is present, complete the Wound Data Collection UDA [user defined assessment] daily, documentation should include the following: -An evaluation of the ulcer, if no dressing is present... -The presence of possible complications, such as signs of increasing area of ulceration or soft tissue infection". *"If the pressure ulcer is not determined to be clinically unavoidable, the ulcer should show signs of improvement within two to four weeks. Signs of improvement might include decrease in size of the wound (length times width), decrease in the amount of exudate [drainage] and improvement in the tissue type". *"Observations of the ulcer's characteristics may be documented by a licensed nurse and should include at least the following: -Measurements - length, width, depth -Characteristics of the ulcer – including wound bed, undermining, and tunneling, exudate, surrounding skin, etc. -Presence of pain -Current treatments".	F0686		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F0689	1.Incidents involving resident's 100, 36, 10, and 93 have been reported, initial and final reports have been accepted. Resident 93 no longer resides in the facility.	4/1/26

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F0689 SS = G	Continued from page 28 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 interview, record review, policy review, South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, and staffs' training records review, the provider failed to ensure the residents were protected from risk of injury or harm by staff members failing to safely use lift devices and to provide supervision for: *One of one sampled resident (100) who sustained a skin injury to his buttocks after a total body lift (a mechanical lift and sling used to lift a person's full body) was pulled out from under him by registered nurse (RN)/former director of nursing (DON) DD. *One of one sampled resident (36) identified as unable to safely operate a lift recliner chair and sustained a skin laceration to his head when he fell from that chair onto the floor after being left unsupervised. *One of one sampled resident (10) identified as needing to be transferred by two members with the use of a sit-to-stand lift (a mechanical device used to assist from a seated to a standing position) and fell after certified nursing assistant (CNA) (N) transferred the resident with that lift, without the assistance of another staff member. *One of one sampled resident (93) identified at risk for elopement (leaving the facility without staff knowledge) who eloped and remained outside unsupervised for about five minutes on 9/12/25. Findings include: 1. Interview on 3/4/26 at 1:59 p.m. with certified nurse assistant (CNA) X revealed: *Resident 100 had a wound on his right buttocks area that had healed, then it opened back up. *He thought he was repositioned every 2 hours (hrs) and	F0689	2.All residents are at risk of not being protected from risk of injury or harm by staff members failing to safely use lift devices and supervision being provided for accidents and hazards. 3.Pressure Ulcer Prevention Plan as discussed in F0686 has been implemented as of 4/1/26. Lift Chair assessments, observations and education implemented as of 4/1/2026. Hall Care Sheets have been created to assist in quick guide for resident transfer status. Elopement drills continue monthly and are completed on a various shifts. CNA N received education on 3/26/26 Regarding safe resident handling by CLDS. Former DON DD no longer works at the facility and cannot be educated. DON B and Administrator A have reviewed the policy and competency regarding safe resident handling, Abuse and Neglect, elopement and assisted in creating the plan for lift chair assessments in the facility. All Nursing staff will be educated by 4/1/2026 by Administrator, DON or designee upon the use of care plan, Kardex, Hall care sheet, or white board (in rooms where available) to verify current transfer or ambulation status. Will be educated on lift chairs and where remote is removed or placed to ensure that residents are safe when left in the lift chair. How to properly remove bedding, sling, turn sheet, soaker pad or any other type of linen/material from under a body to prevent shear that could result in harm or injury to a resident. All nursing staff have received Safe Resident Handling Education and competency verified – this education includes safe and proper use of all mechanical lifts the facility uses. And the importance of being involved in the Elopement drills and participating as it is a live event to ensure the safety of all residents who are at risk for wandering or elopement. Policy for Elopement was given to all staff. Policy for Safe Resident Handling was given to nursing staff by 4/1/2026. Transfer status will be clearly identified in the EMR and CNA's assignment sheets. 4.Care plans are being audited for F0657, 3 random transfer audits will be done monthly to review residents and observe the use of each mechanical lift during cares to ensure proper use are performed monthly by the DON or designee, Lift Chair assessment audit will be completed monthly to verify that residents are being assessed quarterly or with significant change and to ensure that all residents with a lift chair have been assessed. DON or designee will audit 3 random residents a week that have lift chairs for 4 weeks, then bi-weekly for 1 month and monthly for 4 months to ensure that residents with a Lift Chair are following care plan. Elopement drills will be conducted monthly for 1 year and will include all shifts to ensure all staff are able to respond appropriately to a code yellow. Audits will continue until compliance has been sustained for 3 months	

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F0689 SS = G	Continued from page 29 his incontinence brief was changed every hour. 2. Interview on 3/4/26 at 2:06 p.m. with CNA W regarding resident 100's wound revealed: *He stated he had wound on his buttock that had a wound vac (a device that uses negative pressure to remove excess fluid and debris from a wound to promote wound healing). *He stated that resident 100 developed the wound while he was on the rehab unit. *He stated that resident 100 had a mechanical lift sling placed underneath him for a transfer, and it scraped him when they removed it. CNA W stated the sling caused a rash, then it opened. *He thought that the wound was avoidable. 3. Interview on 3/5/26 at 9:17 a.m. with RN J regarding resident 100 revealed: *She had finished checking his wound, which involved making sure the wound vac was working, monitoring for redness, swelling, warmth, and that the dressing was secure. *She stated wound care was completed by the wound care clinic on Mondays, Wednesdays, and Fridays, and the floor nurses checked it daily. *She stated that he had the wound when he was admitted, and he had no other wounds. 4. Interview on 3/5/26 at 11:58 with assistant director of nursing (ADON) G regarding resident 100's wound revealed: *Resident 100 had an abscess (confined pocket of pus, bacteria, and dead tissue) while he was in the hospital, which had opened. *He stated that the wound was not from a sling while he was in the rehab unit. 5. Interview on 3/5/26 at 2:00 p.m. with minimum data set (MDS)/wound nurse RN F regarding resident 100's wound revealed:	F0689	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 audits based on findings. 5.Compliance Date: 4/1/2026.	

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F0689 SS = G	Continued from page 30 *She was the wound nurse. *She was present in the residents room when he acquired the wound to his right buttock. *She stated registered nurse (RN)/former director of nursing (DON) DD attempted to pull a mechanical lift sling from under the resident and caused that wound. *She stated the wound was not from pressure, it was from shearing, and the wound was avoidable. *She stated he was sent to the hospital for an unrelated issue and the staff discovered the resident was septic. She stated that after further investigation and scans they discovered the wound was deeper than they thought and was tunneling (wound that extends from the skin surface into deeper tissue layers, forming narrow channels or passageways). *She stated the resident returned from the hospital with a wound vac. 6. Review of resident 100's electronic medical record (EMAR) revealed: *He was readmitted to the facility on 2/19/26. *He did not have a Brief Interview of Mental Status (BIMS) assessment score completed and he was nonverbal. *His diagnoses included: -Quadriplegia (paralysis of all four limbs and he torso), Unspecified open wound of right Buttock sequela. *His care plan revealed he had a focus area of impairment to skin integrity related to a shearing injury to the right buttock that was initiated on 8/12/25. *His care plan interventions regarding his right buttock were identify potential causative factors and eliminate/resolve where possible, turn and reposition him in bed every two to three hours, weekly skin observations by a licensed nurse, provide a pressure-relieving/reducing mattress on his bed and/or cushion in his wheelchair. *His 8/8/25 wound assessment indicated that the wound was caused by friction/shearing. It was an open area that measured 0.9 cm (centimeters) in length by 0.2 cm	F0689		

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F0689 SS = G	Continued from page 31 in width by 0.1 cm in depth, and it was not present on admission/readmission to the facility. The physician was notified, and the wound was cleansed, and a barrier cream was applied to it. The assessment was signed as completed on 8/10/25 by RN Z. 7. Interview on 3/5/26 at 2:00 p.m. with DON B regarding resident 100's wound revealed: *She was not aware that the wound was caused by shearing related to the removal of the mechanical lift sling from under the resident. *She was not sure what policy would address accident hazards regarding that incident. 8. Interview on 3/5/26 at 4:15 p.m. with administrator A regarding resident 100's wound revealed: *He did not have an accident hazards policy regarding mechanical lift slings. *He was not aware that resident 100 had a facility acquired wound from a mechanical lift sling. 9. Review of the provider's 12/12/25 Safe Resident Handling Program (SRHP) Overview revealed: *"Good Samaritan's goal is to maintain a safe living and working environment for residents and employees. The Safe Resident Handling Program (SRHP) supports this goal. Each location will follow SRHP practices when performing mobilization and other care tasks that require employee assistance." 10. Interview on 3/4/26 at 3:14p.m. with resident 36's family member revealed: *He was informed resident 36 was transferred to his lift chair (recliner) by the staff after they completed his personal cares. After the staff left the room the chair control somehow activated and lifted him all the way up, and he fell on the floor, and had hit his head. 11. Interview on 3/5/26 at 10:32 a.m. with occupational therapist registered and licensed (OTR-L) AA, revealed: *She would have completed resident 36's lift chair safety assessment, but she did not work for the	F0689		

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F0689 SS = G	Continued from page 32 provider at that time. She stated that the nursing staff also completed lift chair assessments. *She was not aware of a resident's fall that involved a lift chair. 12. Interview on 3/5/26 at 9:17 a.m. with RN J revealed: *Resident 36 had one fall in the last two months. *She thought that he may have slipped out of his wheelchair, but he had no injuries. 13. Interview on 3/5/26 at 2:30 p.m. with DON B revealed: *She stated that resident 36 did not have any falls regarding the requested fall information. *She stated that she would look further when this surveyor verbalized that he had fallen, and one fall involved a lift chair. *She stated that resident 36 had one lift chair safety assessment completed 12/27/25. 14. Review of resident 36's (EMR) revealed: *He was admitted to the facility on 9/7/24. *His diagnoses included dementia (a group of symptoms affecting memory, thinking, and social abilities) and Parkinson's Disease without Dyskinesia (a movement disorder characterized by erratic and uncontrollable muscle movements). *He had a BIMS assessment score of 3, which indicated his cognition was severely impaired. *His care plan indicated on 9/27/24 that he had an activities of daily living (ADL) self-care performance deficit related to Parkinson's Disease, pain, shortness of breath, and dementia. His interventions indicated that a lift chair assessment was completed on 10/1/25 and 12/27/25, which indicated he was unable to demonstrate the safe use of the lift chair/remote, and that the remote was to be placed out of his reach. *His 12/27/25 lift chair assessment revealed he was unable to demonstrate safe use of the lift chair and	F0689		

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F0689 SS = G	Continued from page 33 needed his wife or son to operate it for him. 15. His 9/22/25 progress indicated: Resident 36 was found lying on his right side on the floor. He had a cut on his skin above his right eyebrow that measured 2 cm in length by 0.2 cm in width, and was bleeding. He was conscious, alert, able to move all four limbs, denied having pain, and answered the staff's questions. The staff checked his vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate), which were not documented, and his neurological evaluation (assessment of nerve function, reflexes, coordination, motor skills, sensation, and mental status) was completed. RN Y placed a bandage on his cut above his right eyebrow and notified the resident's family and physician of his fall. Before his fall, resident 36 was sitting in his recliner and had the remote tucked over the recliner. 16. Review of the providers 9/22/25 Fall Scene Huddle Worksheet regarding resident 36 revealed: *Resident 36 was found on the floor. *A CNA had transferred him to his recliner five minutes before his fall. *He had diarrhea that day, and last went to the bathroom at 9:00 a.m. *Resident 36 seemed alert and oriented before and after his fall. *His range of motion (measurement of movement around a joint or body part) was within normal limits, and he had a skin tear above his right eyebrow. 17. Review of the provider's 9/23/25 fall interdisciplinary review for resident 36 revealed: *He had a skin laceration to his right eyebrow. *His fall was not reported to the South Dakota Department of Health. *They were unsure of his last fall occurred. *The staff were to complete a lift chair assessment for resident 36. 18. Review of the provider's 9/12/25 submitted FRI regarding resident 93 revealed:	F0689		

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F0689 SS = G	Continued from page 34 *On 9/12/25 at 2:00 p.m. resident 93 had eloped from the front door entrance of the facility. *Resident 93 was not observed leaving the facility and was missing approximately five minutes before staff intervened according to the video footage that was reviewed by the facility leadership. *When approached by the staff, resident 93 stated she wanted to go home and refused to come back into the facility. *The resident eventually agreed to go to the hospital for an examination after much encouragement and a phone conversation from her brother. *Resident 93 was examined at the hospital emergency department and discovered to have a urinary tract infection. -She was hospitalized and returned to the facility with her family transporting her back on 9/17/25. *The resident had no prior elopements from the facility. *Resident 93's family planned to move her to a facility in another state to be near her family members by 10/1/25. *Following the incident, the provider immediately provided re-education to the staff who were on duty of the provider's elopement policy and procedure, and planned to re-educate all other staff by 10/2/25. *Weekly elopement drills were to be conducted for one month, bi-weekly for one month, then monthly for four months. *All residents with a WanderGuard (a wearable door alarming device) would be checked for proper function each shift by nursing staff and recorded on the resident's treatment administration record. *DON or designee would audit one resident WanderGuard per week for one month, bi-weekly for one month, then monthly for four months. 19. Review of resident 93's EMR revealed: *She was admitted to the facility on 8/6/25. *Her BIMS score was 7, which indicated her cognition	F0689		

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F0689 SS = G	Continued from page 35 was severely impaired. *Her diagnoses included dementia (cognitive communication deficit), anxiety, depression, and a history of a femur and cervical spine level two fractures. *She required the assistance of one staff member for bathing, bed mobility, dressing, and personal hygiene, but was independent with ambulation (walking) around the facility. *She wore a C-collar (a type of brace used to stabilize the neck). *Resident 93's revised 8/28/25 care plan revealed: -A focus area: "The resident has impaired thought processes R/T [related to] cognitive communication deficit/dementia." --Goal: "Resident will be safe in their own environment as evidenced by: not eloping, not wandering into other resident rooms, etc." --Identified interventions for that goal included that staff were to ask yes/no questions to determine her needs, cue, reorient, and supervise as needed. A WanderGuard was to be used to alert the staff to her movements and help monitor her, and the staff was to offer her assistance by calling her brothers, helping her shower, or offering her a Diet Coke or candy. 20. Interview on 3/4/25 at 8:40 a.m. with RN C revealed: *She was working in the facility the day of resident 93's elopement. *RN C observed staff sitting, interacting, and attempting to keep resident 93 occupied on 9/12/25 because she made statements that she wanted to leave and to go home. *When resident 93 eloped, the staff stayed with her to ensure that she remained safe. *Education was provided to the staff following the elopement incident on 9/12/25 of the provider's elopement process to follow. *A code yellow is called over the intercom system in the event a door alarm goes off.	F0689		

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F0689 SS = G	Continued from page 36 *The door alarms are loud and easily heard by the staff. *A list of current residents with a WanderGuard was kept at the nurse station in the event a door alarm sounded, which indicated a possible resident elopement. *Nursing would take the lead with giving out resident assignments to the staff. *Each staff completed a head count for the residents on their list, and they reported back to nursing. *All residents needed to be accounted for before the nurse in charge would give an all clear to resume normal activities. *Education was initiated by leadership and provided to all staff members following that elopement incident. -Elopement drills were held to ensure the staff knew the process to follow in the event a door alarmed. -Nurses were to check every shift for the resident's WanderGuards and document them on the resident's treatment administration record (TAR) to ensure each resident's WanderGuard functions properly. The device used to check the WanderGuard functions was kept in the locked medication cabinet. 21. Interview on 3/4/26 at 1:40 p.m. with RN Nurse Manager R revealed: *She was the nurse manager in charge of the rehabilitation unit. *Resident 93 was admitted to the facility on 8/5/25 for rehabilitation services. *Her room was located on the long-term care side of the facility and not in the regular rehabilitation services hallway which was not unusual. *An elopement assessment was completed with her admission, and resident 93 was not identified as an elopement risk at that time. *The family had let the facility staff know they were interested in a permanent placement for resident 93, but the resident stated she did not want to stay at the facility long term and wanted to return to her apartment. *After resident 93 became aware of the family plan for	F0689		

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F0689 SS = G	Continued from page 37 her to stay long term, she started to make statements about not wanting to be there and that she wanted to go home. *An updated elopement risk assessment was completed after those statements began and a WanderGuard was added on 8/27/25 as an intervention and added to her care plan. -The family agreed with the proposed WanderGuard intervention, and a physician's order for it was obtained on 8/27/25. *On days resident 93 had made statements about wanting to go home or to leave the facility, the staff were usually able to distract her from those thoughts by offering to call her family or to talk about her dog. *The day that she eloped from the facility she was near the front entrance area and making statements that she did not want to be there. *The staff were keeping a close eye on her due to those statements and interacted with her to help distract her thought process from wanting to leave. *RN nurse manager R was aware that resident 93 eloped that day but was not involved with the incident. *No other resident elopements occurred since resident 93's incident on 9/12/25. 22. Interview on 3/4/26 at 2:02 p.m. with administrator A revealed: *He was working inside his office on 9/12/25 at the time resident 93 eloped from the facility. *Resident 93 was making statements earlier in the day that she wanted to go home. *Administrator A believed he was the first staff member to find resident 93 when he saw her outside of his office, which was located next to the front door entrance. *Resident 93 was seated on a bench outside of the building which was next to his office window, and he recognized that she was to have staff supervision. *He thought only a few minutes had passed before her discovery and he had approached her. *While resident 93 was seated on the bench, he	F0689		

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F0689 SS = G	Continued from page 38 attempted to reason with her to come back inside, but she refused. *She then got up and walked away toward a nearby car because she believed it was her personal car and stated she was going to use it to leave and go home. *Resident 93 became angry and suspicious of administrator A at this time because he had tried to talk her out of entering the car. *She refused to go back into the building, but she walked back and sat on the same bench again. *Several other staff members attempted to intervene with resident 93 but were unsuccessful in bringing her back inside. *Resident 93's brother and power of attorney (someone designated on a legal document to act on behalf of a resident) was contacted by telephone and had a conversation with resident 93, but he was also unable to talk her into going back inside the building. *Eventually she agreed with the staff to be evaluated at the emergency department and was transported by a facility vehicle with two staff members. *She was hospitalized with a urinary tract infection and remained at the hospital for treatment and then returned to the facility. *The family decided to discharge resident 93 to another facility near them in Illinois and she was discharged on 10/1/25. *As a result of resident 93's elopement, the provider had implemented door audits to ensure alarms functioned correctly, nursing checked all residents with a WanderGuard for proper function each shift, elopement drills were conducted, and all the staff were re-educated on the provider's elopement policy and procedure. 23. Interview on 3/5/26 at 8:00 a.m. with clinical learning and development specialist S and DON B revealed: *Clinical learning and development specialist S was responsible for training new staff members and ensuring that all the staff were up to date with the required ongoing training. *The majority of the facility training was assigned and	F0689		

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F0689 SS = G	Continued from page 39 provided online. *He could run reports for all the staff to see what training they had to complete. *Each staff member was assigned the required training, and he checked to ensure that their training was completed on time. *If a staff member did not complete the training as assigned and it was near the required completion date, he was alerted and would then contact that staff member by email to remind them to do the training before the completion date passed. *If there were continued issues, DON B received alerts and would also contact the staff member with reminders. *The elopement training that was conducted after the 9/12/25 incident was completed in person by the staff with DON B and administrator A. *The staff who were educated had signatures on a sign in sheet to indicate they completed the elopement training. *He was not aware that there were staff who did not attend that training. *He stated administrator A and DON B did not communicate to him that he was to ensure all the staff had completed that training, but he would have if he was informed. 24. Interview and audit review on 3/5/26 at 9:15 a.m. with maintenance supervisor T revealed: *The maintenance department was responsible for conducting the audits for the door alarm function when a resident's WanderGuard was triggered. *The audits were completed weekly after resident 93's 9/12/25 elopement and were currently being done once a month. *The audits included the use of a WanderGuard to ensure that the door alarm triggered appropriately when the WanderGuard was near an exit door. *The surveyor verified that these audits were completed. *No resident had eloped from the facility since the 9/12/25 incident.	F0689		

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F0689 SS = G	Continued from page 40 *He believed he was working the day of the 9/12/25 elopement but was not directly involved. *He stated a staff member stationed at the front desk was assisting the family of a resident who had a WanderGuard on to leave the building for an outing. *When the door alarmed, the staff thought it was due to the resident who was leaving who also had a WanderGuard. -The same staff member did not notice resident 93 near the front door entrance when the family and other resident were leaving the facility. -She turned to reset the alarm and did not notice resident 93 follow the family and resident outside of the building. *Resident 93 was out of the building for a few minutes before she was discovered and the staff had intervened. 25. Interview on 3/5/26 at 9:20 a.m. with CNA U revealed: *The staff were provided with re-education on the procedure to follow when a resident eloped from the facility. *She had heard about resident 93's elopement but was not involved with the incident. *Elopement drills were being conducted regularly so the staff would be familiar with what to do in the event a door alarmed. *In the event of a suspected resident elopement, a code yellow would be called over the intercom system to alert the staff. *The staff would report to their unit nurse station for instructions and resident assignments. *Once the resident assignments were given, the staff would conduct room-to-room searches ensure every resident was accounted for. *When the resident assignments were completed, the staff would check in at the nurse station. *After all the residents were accounted for, the designated person in charge would give an all clear on the overhead intercom system to resume regular facility	F0689		

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F0689 SS = G	Continued from page 41 activities. *She was not aware of any other resident elopements taking place after the 9/12/25 incident with resident 93. 26. Review of the staff re-education completion sheets regarding the provider's elopement policy and procedure revealed: *The elopement training was completed over several days according to the dates listed next to the staffs' signatures on the completion sheets. *There were ten staff members on the re-education completion sheets who did not receive the required elopement training. 27. Interview on 3/5/26 at 10:30 a.m. with administrator A revealed: *Administrator A and DON B had conducted the elopement policy and procedure re-training for their staff. *The elopement policy and procedure did not change. *He was not aware there were ten staff members who had missed the elopement re-education training but expected all staff to receive the training. *He expected the clinical learning and development specialist to have checked to ensure all staff had received the elopement training, but that did not happen. *He agreed he was responsible for ensuring all staff were trained. *No further documentation was provided to indicate that those ten employees had received the elopement re-education training. 28. Interview on 3/5/26 at 2:00 p.m. with DON B and administrator A revealed: *The resident WanderGuard audits of the TAR that were to be conducted by the DON or designee as reported in the 12/1/25 FRI submitted for resident 93 were not completed and should have been. *They both agreed the elopement re-education training was not completed for all staff and should have been. *DON A stated administrator A and she had been working	F0689		

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F0689 SS = G	Continued from page 42 on their follow-up of facility incidents. *They did not complete all interventions for resident 93's elopement as they had planned and recognized they had issues with the completion of documentation to ensure that future incidents did not occur. 29. Review of the provider's revised 4/7/25 Elopement policy and procedure revealed: *"The SNF [skilled nursing facility] location and each Adult Day Program will be responsible for maintaining a system that clearly defines the mechanisms and procedures for monitoring residents/clients at risk for elopement. These include identifying, evaluating and analyzing environmental hazards and risks; and implementing, monitoring and modifying interventions as needed. All SNF residents will be assessed for risk of elopement through the pre-admission and/or admission process and as needed. All Adult Day clients will be screened for risk of elopement through the intake process and as needed. Each SNF location and Adult Day Program will put measures in place to minimize the risk of elopement that are individualized to resident/client needs and identified on the care plan. When an elopement occurs, immediate efforts to locate the resident/client will be taken. All occurrences will be documented, and follow-up will be completed as required by state and federal regulations." 30. Review of the provider's 12/1/25 FRI regarding resident 10 revealed: *On 12/1/25, a post-fall huddle [when the staff gathered to discuss information available related to a resident's fall] form review was completed by the provider leadership, and it was determined that a report would be submitted to the SD DOH regarding resident 10's fall. -The fall report was not reported to the SD DOH within the required 24-hour reporting window. *On 11/28/25 at 11:30 a.m. CNA N was transferring resident 10 with a sit-to-stand mechanical lift (a mechanical lift used to assist from a seated to a standing position) from the toilet to his wheelchair. *Before the resident was able to be positioned and lowered into the wheelchair, he slipped and slid out of the sling and onto the floor on his bottom, then rolled onto his right side.	F0689		

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F0689 SS = G	Continued from page 43 *The nursing staff came to the room immediately and completed a physical assessment of resident 10. *The resident indicated he bumped his head and Neurological evaluation (assessment of nerve function, reflexes, coordination, motor skills, sensation, and mental status) (neuros) and vitals were completed and within normal limits. *Notifications were made to the family and resident 10's medical provider. *CNA N was educated regarding the need for a second staff member when completing transfers with the sit-to-stand with resident 10. *The provider's investigation of the fall revealed that the sit-to-stand lift was functioning properly, the correct sling size was used, but CNA N had failed to follow resident 10's care plan, which indicated he was to be transferred using the sit-to-stand mechanical lift with the assistance of two staff members. *The provider planned to implement education to all CNAs regarding resident transfer status and to follow the residents' care plans. *Safe resident handling audits were to be completed by DON B or designee including: -The review of five random residents' care plan per week observing the resident transfers, weekly for eight weeks, biweekly for two months, and monthly for two months. -All resident care plans were to be reviewed by 12/9/25 to ensure their resident transfer status was correct. 31. Review of resident 10's EMR revealed: *He was admitted to the facility on 7/3/13. *His Brief Interview of Mental Status (BIMS) assessment score was 00, which indicated he could not be interviewed. -Resident 10 was able to make his needs known by gesturing with his hands and with a head shake or nod. *His diagnoses included aphasia (a language disorder commonly caused by stroke or injury that impairs the ability to speak, understand, read, and write), and hemiparesis (weakness of one side of the body)	F0689		

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F0689 SS = G	Continued from page 44 following cerebral infarction (stroke) affecting the right side. *He required the assistance of one staff member for bed mobility, dressing, oral care and personal hygiene. *He required the use of a sit-to-stand mechanical lift with the assistance of two staff members for transfers. *He was dependent upon the staff to ensure his care plan was implemented and followed. Resident 10's care plan revised on 12/17/25 revealed an identified problem of, "The resident has an ADL [activities of daily living] self-care performance deficit R/T [related to] obesity, pain/osteoarthritis, stroke with hemiparesis, expressive and receptive aphasia, OA [osteoarthritis], RUE/RLE [right upper extremity/right lower extremity] paralysis, LICA [left internal carotid artery] and RICA [right internal carotid artery] stenosis, low back pain and arthritis, and vitamin D deficiency E/B [evidenced by] assist needed with ADLs." -Identified interventions for that problem area included: "Transfer between surfaces: mechanical sit to stand assist of 2 [staff members]. Sling size XL [extra-large], staff to assist right arm on bar." Initiated: 9/15/25. 32. Interview on 3/3/26 at 11:55 a.m. with CNA I revealed: *CNA I had worked at the facility for 13 years and was a CNA for 30 years. *Usually, she was scheduled to work in restorative, but also worked as a CNA when needed. *When the staff were working with the residents, the expectation was that they would consult the Kardex (a report of the resident's care needs and interventions), the whiteboard (a dry erase board used for communication) within the resident room, or use their computer tablets to ensure the residents care plan was followed. There were several resources that were available to the CNAs in each hallway of the facility. *The gait belts and slings for mechanical lift transfers were hung on the backside of the entrance door in each resident room. -Each resident's sling size was indicated in their individual care plan.	F0689		

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F0689 SS = G	Continued from page 45 *There were to be two staff members to assist with all full body lift (a mechanical lift and sling used to lift a person's full body) transfers. *If a sit-to-stand mechanical lift was used, it could either be one or two staff members involved, depending on the resident's needs. *The facility expectation was that CNAs would check the resident's care plan before assisting a resident to ensure their care plan was being followed correctly. *Resident 10 was known to need two staff to assist him with sit-to-stand mechanical lift transfers. 33. Interview on 3/4/25 at 8:40 a.m. with RN C revealed: *She had worked at the facility for 27 years. *Care plans were initiated by the MDS coordinators or the admissions nurse. *When there were care plan updates, the nursing leadership usually made those changes. *She expected the CNAs to ask nursing if there were any questions or concerns about the residents. *The CNAs should check the resident care plans for the correct way to care for and assist the resident. 34. Interview on 3/4/26 at 11:35 a.m. with CNA N regarding resident 10 revealed: *She was a CNA for a year but was hired by the facility on 11/4/25. *During her orientation training at the facility she thought she remembered other CNAs transferring resident 10 alone, and not with two staff members. *On 11/28/25 she answered resident 10's call light. -She did not check his transfer status before assisting with his needs. *She used the sit-to-stand mechanical lift to assist resident 10 to the bathroom to use the toilet. *After the resident was finished, she raised him off of the toilet using the sit-to-stand mechanical lift, changed his brief and pulled up his pants.	F0689		

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F0689 SS = G	Continued from page 46 *She then transferred the resident using the sit-to-stand mechanical lift from the bathroom and placed him next to his wheelchair by his bed to be positioned and lowered into a seated position in the wheelchair. *The resident's left hand slipped off of the left-hand grip of the mechanical lift, his left arm went above his head, he slid out of the sling and landed on his bottom and rolled onto his right side. -He was unable to catch himself with his right hand due to right sided weakness from a prior stroke. *CNA N immediately called nursing to the room and an assessment of resident 10 was completed to check for any injuries. *The nurse who responded was a contracted licensed practical nurse (LPN). *No injury was identified, but the resident was able to indicate he bumped his head. *Neuros and vitals were completed per the facility fall protocol and remained within normal limits. *Notifications were made to the family and resident 10's medical provider. *Resident 10 remained in the facility and sustained no injury from the fall. *DON B educated CNA N immediately after the incident to ensure safe use of the sit-to-stand mechanical lift with a demonstration. 35. Review of the facility's documentation following resident 10's fall revealed that documentation was not provided to confirm that all residents care plans were reviewed by 12/9/25. 36. Interview on 3/5/26 at 2:00 p.m. with DON B revealed: *DON B stated resident 10's care plan was not followed by CNA N on 11/28/25 when he fell. *CNA N was immediately educated after the incident by DON B that resident 10 required the assistance of two staff members with transfers using the mechanical sit-to-stand lift, and to check the resident's care plan to ensure all resident care plans were followed	F0689		

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F0689 SS = G	Continued from page 47 before assisting them. *CNA N was educated by DON B regarding the safe use of the sit-to-stand mechanical lift with return demonstration. *Additionally, all staff were re-educated after this incident to follow resident care plans before assisting with resident needs to ensure safe transfers with mechanical lifts to prevent future fall incidents. *DON B stated she expected all direct care staff to follow the resident care plans. The facility used change of shift huddles, resident whiteboards, pocket care plans (a document that identifies residents' care needs and interventions), the Kardex, and computer tablets as resources available for the staff to ensure the residents are assisted with their individual needs. *She confirmed they did not have documentation that all resident care plans were reviewed as listed in the 12/1/25 FRI submitted for resident 10's fall as a part of their fall prevention plan. -This was an area that leadership was working on, to ensure documentation was completed to show what they were doing to prevent future incidents from occurring.	F0689		
F0699 SS = D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and policy review, the provider failed to identify and implement specific care approaches that addressed the mental and psychosocial needs of one of two sampled residents (7) with diagnosed post-traumatic stress disorder, a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event (PTSD) to mitigate trauma triggers and prevent re-traumatization. Findings include:	F0699	1.Resident 7's care plan has been updated to reflect his PTSD diagnosis to include interventions, possible triggers, and ways to prevent re-traumatization. 2.All residents with the diagnosis of PTSD or who express feelings of trauma at some point in their life are at risk for not having specific care approaches that address the mental and psychosocial needs that result from this trauma. 3.New/return admissions will be assessed at time of admission during their clinical evaluation by the admitting nurse for areas of Trauma or if have a diagnosis of PTSD. If a presiding resident receives a diagnosis of PTSD or Trauma during their life at the facility the resident will be asked the questions pertaining to the trauma, potential triggers, interventions, and ways to prevent re-traumatization quarterly or as concerns arise by the Social worker and the care plan will be reviewed and revised as needed. Social Worker BB was educated on the importance of identifying care approaches that address the mental and psychosocial needs of a resident with trauma or a diagnosis of PTSD, and that the care plan should have a personalized focus related to intervention, possible triggers, and ways to prevent re-traumatization.	4/1/26

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F0699 SS = D	Continued from page 48 1. Interview on 3/3/26 at 10:58 a.m. with resident 7 in his room revealed: *He had experienced "a lot" of trauma in his life. *He had spoken to a counselor about his trauma, but not for "quite a while". *He thought his post-traumatic stress disorder (PTSD) was under control, but he knew he could not turn on the television and see the conflict and bombing in the Middle East, or it might trigger his PTSD symptoms. 2. Review of resident 7's EMR revealed: *He was admitted to the facility on 1/10/25. *His 1/30/26 Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated his cognition was intact. *His diagnoses included PTSD, depression, insomnia (the inability to sleep), and mood disorder (a mental health condition characterized by long term extreme emotional states). *The focus area related to depression on his 3/4/26 care plan had interventions of, "Resident talks with VA Mental Health Counselor every 6 months or more often if needed by phone" and "Resident states he has had this counselor many, many years and likes this set up." *His last documented visit with his VA counselor was on 12/3/24. *He had a 1/10/25 physician's order for "Psych [psychological] services as needed", duloxetine (an antidepressant) 60 mg (milligrams) daily for depression, and mirtazapine (an antidepressant) 7.5 mg daily for insomnia. *His 1/10/25, 4/17/25, and 7/30/25 trauma assessments indicated resident 7 answered "No" to "Have you ever experienced some form of trauma or stressful event, (i.e., serious accident or fire, a natural disaster, a physical or sexual assault or abuse, torture, a war, seeing someone be killed or seriously injured or loss of a loved one)?" *There were no trauma assessments documented since 7/30/25 in resident 7's EMR. 3. Interview on 3/4/26 at 4:04 p.m. with resident 7	F0699	MDS nurses, Nurse Managers, and Admission nurse's were also educated as they now complete the Trauma section of the Clinical Admission/Readmission UDA where those questions are asked in hopes of identifying Trauma or PTSD. All staff were educated regarding the diagnosis of PTSD or Trauma and that those residents will have an individual and personalized focus for the resident to allow staff the knowledge of possible triggers, interventions, and ways to prevent re-traumatization by 4/1/2026. Those not in attendance due to illness, vacation, leave or casual work status will not be allowed to work until the education has been completed prior to their next scheduled shift. 4.The DON or designee will audit High Priority Progress notes daily for 4 weeks, weekly for 1 month, bi-weekly for 1 month and monthly for 3 months to ensure residents are not having mood/behaviors that could be a result of their trauma. Social Worker or designee will audit 5 care plans a month to ensure that all areas of a resident having Trauma or PTSD are documented in the care plan. Audits will continue until compliance has been sustained for 3 months. Audits will be discussed by the Social Worker or designee at the monthly QAPI meeting with the medical director and IDT for analysis and recommendation for continuation, discontinuation, or revision of audits based on findings. 5.Compliance Date: 4/1/2026.	

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F0699 SS = D	Continued from page 49 revealed he: *Had only spoken with his VA counselor about his past traumatic experiences. *Would have spoken with a facility staff member about those experiences if they had asked him. 4. Interview and record review on 3/5/26 at 11:55 a.m. with Minimum Data Set (MDS)/wound nurse F revealed: *All residents were to be assessed on admission, quarterly, and with a significant change in condition to determine if they had experienced a traumatic event. *A resident with a diagnosis of PTSD was to have PTSD identified on the resident's care plan, along with potential triggers of the resident's PTSD, pharmacological, and non-pharmacological interventions to prevent re-traumatization and to provide interventions that were identified as potentially effective to cope with the resident's trauma. *She stated she knew resident 7 had a diagnosis of PTSD but was not aware his trauma assessments indicated he did not experience trauma. *She stated resident 7 had experienced trauma during his time in the military. *A resident with a diagnosis of PTSD was to have PTSD identified on the resident's care plan, along with potential triggers of the resident's PTSD, pharmacological, and non-pharmacological interventions to prevent re-traumatization and to provide interventions that were identified as potentially effective to cope with the resident's trauma. *She acknowledged that resident 7's care plan did not indicate he had PTSD, what his potential triggers may be, or the interventions for those triggers. *She expected a resident with a PTSD diagnosis to have the PTSD addressed in the resident's care plan, even if the resident's past trauma was not shared during the resident's trauma assessment, so staff would be aware that the resident may have unidentified trauma triggers and what the interventions may be tried. 5. Interview on 3/5/26 at 2:30 p.m. with registered nurse (RN) C revealed: *Was aware of resident 7's PTSD diagnosis because he had talked to her about some of his experiences.	F0699		

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F0699 SS = D	Continued from page 50 *Did not know if resident 7 had any potential triggers for his PTSD, but stated he was able to express his needs and concerns. *Expected a resident's PTSD triggers and interventions to be identified on that resident's care plan. 6. Interview on 3/5/26 at 5:43 p.m. with director of nursing (DON) B revealed: *All residents were to be assessed to determine if they had experienced trauma on admission, quarterly, and with a significant change in condition. *Trauma assessments used to be completed by social services, but with the new updates within the EMR system, nursing also assessed residents for trauma during the completion of a resident's admission assessment. **She was aware that resident 7 was a military veteran and had a diagnosis of PTSD. *She stated resident 7 talked about the military and shared some of his experiences with the staff. *She was not aware that resident 7 had identified the conflict and bombing in the Middle East as a trigger for his PTSD and felt he could not watch about it on television. *She was not aware that resident 7's 3/4/26 care plan indicated he was seeing a VA counselor. *She stated he did not see a VA counselor since she had been in the facility (3/18/25). *She was not aware that his trauma assessments indicated he did not experience trauma. -She acknowledged that those assessments did not accurately reflect resident 7's past exposure to traumatic events. *She acknowledged that the failure to identify a resident's past exposures to traumatic events and identify those triggers in that resident's care plan for the staff to reference posed a risk for the resident to be exposed to potential triggers and be re-traumatized. 7. Social worker BB was not in the facility or available for interview during the survey.	F0699		

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F0699 SS = D	Continued from page 51 8. Review of the provider's 12/31/25 Trauma Informed Care policy revealed: *"Moving from the community into a long-term care facility, for an individual with a history of trauma or PTSD, can be a very difficult transition and cause worsening or reemergence of symptoms. Additionally, the structured environment of the rehab [rehabilitation] /skilled care facility can trigger memories of traumatic events. Trauma-informed care means being intentional by anticipating and avoiding institutional processes and practices that are likely to re-traumatize a resident who has a history of trauma." *"Trauma-informed care- an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact, and signs and symptoms of trauma in residents, and incorporates knowledge about trauma to avoid re-traumatization." *"Staff will ensure that residents who experience trauma receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization." *"1. The Trauma Assessment is required: a. Within five days of admission for all new residents; b. PRN [as needed]. 2. The Trauma Assessment is completed by Social Services while interviewing the resident/representative."	F0699		
F0755 SS = E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F0755	1.The FRI involving the medication diversion and insulin administration have both been reported; initial and final reports have been accepted. 2.All residents are at risk for insulin medication errors or having their narcotic medication diverted.	4/1/26

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F0755 SS = E	Continued from page 52 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), observation, interview, record review, and policy review, the provider failed to ensure the staff completed and documented controlled medications (medications at risk for abuse and addiction) supply counts for five of five medication carts (Mystic Ranch, Park View, Focus, East, and Luther Lane), failed to prevent the theft of one of one sampled resident's (94) controlled pain medication (oxycodone) by registered nurse (RN) FF, and failed to ensure insulin was administered according to the physician's order for one of one sampled resident (10) who was evaluated at an emergency room after being administered the wrong insulin by licensed practical nurse (LPN) CC. Findings include: 1. Review of the provider's 12/18/25 FRI involving resident 10's medication error revealed: *On 12/17/25 at 8:45 p.m. LPN CC administered the incorrect insulin to resident 10. *His insulin medication orders were to inject Novolog) a fast-acting insulin according to the sliding scale:	F0755	3.Resident 10's insulin is labeled and in a bin with only his insulin. Resident 94 is no longer a resident at the facility. LPN CC was educated at the time of the error. RN FF no longer works for the facility. Insulins are stored in the cart in a bin for each resident with labels indicating long or short acting. All narcotic medications are in bubble packs and dosed according to the providers order to prevent the need for staff to score or cut medications. A list of Insulins has been laminated and put in the front of the Narcotic book for ease of reference for the nurses if they should have questions about what insulin they are giving. All nursing staff will be educated by 4/1/2026 on the importance of signing and counting narcotics and the importance of the 6 rights of medication before administering insulin. Nurses will have a list at the med cart to help identify insulins. The list will include the type of insulin and other names used. 4.DON or designee will audit medication carts for insulin to be stored in individual bins. DON or designee will audit narcotic count sheets to verify nurses are signing on and off shift counts and will audit all Narcotic sheets in the narcotic book to verify two nurses have acknowledged the count and medication arriving to the facility. Audits will be conducted weekly for 6 weeks, biweekly for 2 months and monthly for 3 months. Audits will continue until compliance has been sustained for 3 months. 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 audits based on findings. 5.Compliance Date: 4/1/2026.	

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 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0755 SS = E	Continued from page 53 *Novolog sliding scale order indicated if his blood sugar was: -between 60 and 150, to inject zero units. -between 201 and 250, to inject two units. -between 251 and 300, to inject four units. -between 301 and 350, to inject six units. -between 351 and 400, to inject eight units. *The physician was to be notified if his blood sugar level was less than 70. *He was to be given 18 units of Novolog with his breakfast meal and 15 units daily with his noon and evening meals. *He was to receive 38 units of Tresiba (a long -acting insulin) one time a day. *LPN CC noticed she injected the resident with Novolog and not the Tresiba. *The resident's primary provider was called immediately and requested that the resident be sent to the emergency room (ER) for overnight observation. *The resident was alert, non-verbal, and easy to arouse. *The resident's wife was notified of the insulin error. *His blood sugar was 234, and no other vital signs were obtained. *Resident 10's blood sugar levels remained stable in the ER, with the lowest level of 100. *Resident 10 returned to the facility on 12/18/25 at 4:16 a.m., and he had no adverse effects from that incident. *There were no new physician's orders or orders to hold any of his medications. *The facility's investigation revealed that the resident's insulin pens were stored in one bulk container on the medication cart. *LPN CC stated she did not realize which insulin she	F0755		

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F0755 SS = E	Continued from page 54 had until she was administering the units to the resident. *The insulin medications were now stored in the medication drawer in the medication cart, and every resident had their own container of their insulin medications. *Insulin education was provided to LPN CC and for all nurses by 1/1/26. 2. Observation and Interview on 3/3/26 at 11:24 a.m. with resident 10 revealed: *He was in a wheelchair with headphones on and was watching television (TV). *He took his headphones off, indicated he was non-verbal and shook his head to respond yes or no to questions asked. *He acknowledged that he received good care from the staff, and that he did not have problems with his insulin. *He indicated that he received good care from the staff, and that he did not have problems with his insulin. 3. Review of resident 10's electronic medical record (EMR) revealed: *He was admitted to the facility on 7/1/13. *Diagnoses included: hyperglycemia (high blood sugar) and Type 2 Diabetes Mellitus with Diabetic Neuropathy. 4. Interview and observation of the medication care on 3/4/26 at 4:20 p.m. with LPN CC regarding resident 10's incident above and insulin storage revealed: *When she went to administer resident 10 his Tresiba , she took his Tresiba and Novolog insulin pens to his room. *She dialed the insulin dose and while she was injecting him with that insulin, she realized it was the Novolog pen, which was the wrong insulin. *She stated she stopped the injection, but she had already administered the resident a significant amount	F0755		

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F0755 SS = E	Continued from page 55 of the incorrect medication. *She called director of nursing (DON) B to discuss the error and was directed to call 911. *She explained to resident 10 that she had given him too much insulin and she would send him to the ER. She contacted his wife regarding the medication error. *She stated that resident 10 had done well and returned to the facility within a few hours, but not during her shift. *Before that incident, all residents' insulin pens were stored together in one container in the medication cart. *The insulin pens were stored in the medication cart in separate containers for each resident and were labelled with their names. *She did not remember being educated regarding storing the insulin pens in individual containers, but noticed the resident-specific insulin containers during the next shift she worked. 5. Observation of the medication carts and interview on 3/5/26 at 10:08 a.m. with registered nurse (RN) C revealed: *The medication carts had separate containers in them that were labelled with each resident's name and contained their individual insulin pens. *She stated the new insulin storage containers process was started two to four months ago. She received education to keep the residents' insulin pens stored separately. 6. Interview on 3/5/26 at 2:00 p.m. with DON B regarding the 12/17/25 incident with resident 10 and insulin storage revealed: *She was called right away regarding the insulin error involving resident 10 by LPN CC. *She stated the resident did not have a negative outcome from receiving the wrong insulin and had been monitored in the ER. *She stated LPN CC had been educated regarding medication errors but DON B did not have documentation	F0755		

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F0755 SS = E	Continued from page 56 to support that had occurred. *She stated each resident had a container in the medication cart that was labelled and contained their insulin pens. 7. Review of the provider's 3/3/26 Medication Error policy revealed that medication errors were defined as: *"The observed or identified preparation or administration of medications or biologicals which are not in accordance with prescriber's order, manufacturer's specifications (not recommendations) regarding the preparation and administration of the medication or biological or accepted professional standards and principles which apply to professionals providing services..." 8. Review of the provider's 9/18/25 FRI regarding resident 94 revealed: *On 9/17/25 at approximately 6:10 a.m. DON B was notified that the Mystic Ranch hall medication cart had a discrepancy in its controlled drug (medications with risk for abuse and addiction) count. *Resident 94's bottle of oxycodone (a controlled pain medication) 5 milligram (mg) tablets were counted by the on-coming and off-going nurses and was found to have 84 halved tablets, but the Controlled Drug Count Record sheet indicated there was supposed to be 90 halved tablets in the bottle. *DON B removed the bottle of oxycodone from the Mystic Ranch medication cart and initiated an investigation into the oxycodone that could not be accounted for. *The bottle of oxycodone had arrived at the facility from the pharmacy on 9/11/25. *The Individual Resident's Narcotic Record for resident 94 did not have a signature of the nurse who received that bottle of oxycodone and verified the bottle contained the correct amount of oxycodone in it. *DON B identified through her investigation that RN FF had cut the oxycodone 5 mg tablets in half to equal the 2.5 mg dose that was ordered to be given to resident 94 on 9/11/25. *Resident 94's oxycodone tablets were not counted after they were cut by RN FF and put into the locked	F0755		

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F0755 SS = E	Continued from page 57 medication drawer in the medication cart. *The 9/11/26 evening nurse placed a piece of tape over the top of the bottle of oxycodone without counting the pills in that bottle to prevent staff from using that bottle of oxycodone. *That bottle of oxycodone was not counted until 9/17/25, when the discrepancy was found. *On 9/17/25 at 2:33 p.m. DON B and administrator A spoke with RN FF on the telephone. -RN FF denied that she had cut resident 94's oxycodone tablets in half, stating she was allergic to oxycodone. *DON B reviewed the facility's video footage from 9/11/25 at the west nurses' station where she identified RN FF putting a pill in her hand, placing the pill in her mouth, and then she took several drinks of water. *On 9/23/25 at 8:51 a.m. administrator A, DON B, and human resources lead GG called RN FF on the telephone to discuss the events on 9/11/25 when RN FF was on video surveillance cutting resident 94's oxycodone tablet in half. -RN FF stated she "had a problem" and human resources lead GG ended the phone conversation by telling RN FF she was terminated for theft related to consuming medications that did not belong to her. *DON B determined there were six halved tablets of oxycodone 5 mg that could not be accounted for. *All medication carts were audited for controlled medications and it was determined that there were no other controlled medications that were not accounted for. *DON B started audits on the controlled drugs in the medication carts and the Controlled Drug Count Record sheets and began educating staff on controlled medication counts and the cutting of medications. 9. Observation on 3/4/26 at 1:32 p.m. of the three-ring binder on the Park View medication cart revealed that on 3/3/26 at 11:00 p.m. the on-coming nurse did not sign the Controlled Drugs Count Record sheet to indicate a count of the controlled medications were completed with no discrepancies. 10. Interview on 3/5/26 at 2:30 p.m. with RN C	F0755		

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F0755 SS = E	Continued from page 58 revealed: *The controlled drugs were to be counted by the on-coming and off-going nurses at the change of each shift, or if the keys to the medication cart are exchanged between nursing staff members and then documented on the Controlled Drugs Count Record. *The off-going nurse was to review the Individual Resident's Narcotic Record while the on-coming nurse counted the medications. *She did not recall being educated on the controlled drug count process. She stated process was the same for years. *The nursing staff was educated during a nurses' meeting to remember to count the controlled medications between each shift and sign the Controlled Drugs Record to indicate the drug count was completed and accurate. 11. Review of the December 2025 Controlled Drugs Count Record sheets on the Mystic Ranch medication cart revealed: *There were three headings labeled 7-3 Shift (7:00 a.m. to 3:00 p.m.), 3-11 Shift (3:00 p.m. to 11:00 p.m.), and 11-7 Shift (11:00 p.m. to 7:00 a.m.). *Below those headings were columns labeled Nurse Off, Nurse On, and Card or prescription count. *The controlled drug count was not signed as completed with no discrepancies by the on-coming nurse under the 7-3 shift heading and the off-going nurse under the 11-7 shift heading on 12/4/25. *The controlled drug count was not signed as completed with no discrepancies by the 7-3 shift off-going nurse and the 3-11 shift on-coming nurse on 12/14/25 and 12/22/25. *The controlled drug count was not signed as completed with no discrepancies by the 3-11 shift off-going nurse and the 11-7 shift on-coming nurse on 12/1/25, 12/3/25, and 12/28/25. 12. Review of the December 2025 Controlled Drugs Count Record sheets on the Focus medication cart revealed: *There were three headings labeled 7-3 Shift (7:00 a.m. to 3:00 p.m.), 3-11 Shift (3:00 p.m. to 11:00 p.m.), and 11-7 Shift (11:00 p.m. to 7:00 a.m.).	F0755		

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F0755 SS = E	Continued from page 59 *Below those headings were columns labeled Nurse Off, Nurse On, and Card or prescription count. *The controlled drug count was not signed as completed with no discrepancies by the on-coming nurse under the 7-3 shift heading and the off-going nurse under the 11-7 shift heading on 12/3/25 and 12/31/25. *The controlled drug count was not signed as completed with no discrepancies by the 7-3 shift off-going nurse and the 3-11 shift on-coming nurse on 12/12/25. *The controlled drug count was not signed as completed with no discrepancies by the 3-11 shift off-going nurse and the 11-7 shift on-coming nurse on 12/30/25 and 12/31/25. 13. Review of the December 2025 Controlled Drugs Count Record sheets on the East medication cart revealed: *There were three headings labeled 7-3 Shift (7:00 a.m. to 3:00 p.m.), 3-11 Shift (3:00 p.m. to 11:00 p.m.), and 11-7 Shift (11:00 p.m. to 7:00 a.m.). *Below those headings were columns labeled Nurse Off, Nurse On, and Card or prescription count. *The controlled drug count was not signed as completed with no discrepancies by the on-coming nurse under the 7-3 shift heading and the off-going nurse under the 11-7 shift heading on 12/3/25 and 12/27/25. *The controlled drug count was not signed as completed with no discrepancies by the 3-11 shift off-going nurse and the 11-7 shift on-coming nurse on 12/2/25 and 12/29/25. 14. Review of the December 2025 Controlled Drugs Count Record sheets on the Park View medication cart revealed: *There were three headings labeled 7-3 Shift (7:00 a.m. to 3:00 p.m.), 3-11 Shift (3:00 p.m. to 11:00 p.m.), and 11-7 Shift (11:00 p.m. to 7:00 a.m.). *Below those headings were columns labeled Nurse Off, Nurse On, and Card or prescription count. *The controlled drug count was not signed as completed with no discrepancies by the on-coming nurse under the 7-3 shift heading and the off-going nurse under the 11-7 shift heading on 12/4/25, 12/6/25, 12/15/25, and 12/27/25.	F0755		

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F0755 SS = E	Continued from page 60 *The controlled drug count was not signed as completed with no discrepancies by the 7-3 shift off-going nurse and the 3-11 shift on-coming nurse on 12/14/25, 12/22/25, 12/26/25 and 12/27/25. *The controlled drug count was not signed as completed with no discrepancies by the 3-11 shift off-going nurse and the 11-7 shift on-coming nurse on 12/5/15, 12/14/25, 12/18/25, 12/23/25, 12/24/25, and 12/31/25. 15. Review of the December 2025 Controlled Drugs Count Record sheets on the Luther Lane medication cart revealed: *There were three headings labeled 7-3 Shift (7:00 a.m. to 3:00 p.m.), 3-11 Shift (3:00 p.m. to 11:00 p.m.), and 11-7 Shift (11:00 p.m. to 7:00 a.m.). *Below those headings were columns labeled Nurse Off, Nurse On, and Card or prescription count. *The controlled drug count was not signed as completed with no discrepancies by the on-coming nurse under the 7-3 shift heading and the off-going nurse under the 11-7 shift heading on 12/4/25 and 12/27/25. *The controlled drug count was not signed as completed with no discrepancies by the 7-3 shift off-going nurse and the 3-11 shift on-coming nurse on 12/9/25, 12/17/25, and 12/31/25. 16. Review of the January 2026 Controlled Drugs Count Record sheets on the East medication cart revealed: *There were three headings labeled 7-3 Shift (7:00 a.m. to 3:00 p.m.), 3-11 Shift (3:00 p.m. to 11:00 p.m.), and 11-7 Shift (11:00 p.m. to 7:00 a.m.). *Below those headings were columns labeled Nurse Off, Nurse On, and Card or prescription count. *The controlled drug count was not signed as completed with no discrepancies by the 3-11 shift off-going nurse and the 11-7 shift on-coming nurse on 1/6/26 and 1/22/26. 17. Review of the January 2026 Controlled Drugs Count Record sheets on the Luther Lane medication cart revealed: *There were three headings labeled 7-3 Shift (7:00 a.m. to 3:00 p.m.), 3-11 Shift (3:00 p.m. to 11:00 p.m.), and 11-7 Shift (11:00 p.m. to 7:00 a.m.).	F0755		

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F0755 SS = E	Continued from page 61 *Below those headings were columns labeled Nurse Off, Nurse On, and Card or prescription count. *The controlled drug count was not signed as completed with no discrepancies by the on-coming nurse under the 7-3 shift heading and the off-going nurse under the 11-7 shift heading on 1/30/26. *The controlled drug count was not signed as completed with no discrepancies by the 3-11 shift off-going nurse and the 11-7 shift on-coming nurse on 1/2/26. 18. Review of the January 2026 Controlled Drugs Count Record sheets on the Park View medication cart revealed: *There were three headings labeled 7-3 Shift (7:00 a.m. to 3:00 p.m.), 3-11 Shift (3:00 p.m. to 11:00 p.m.), and 11-7 Shift (11:00 p.m. to 7:00 a.m.). *Below those headings were columns labeled Nurse Off, Nurse On, and Card or prescription count. *The controlled drug count was not signed as completed with no discrepancies by the on-coming nurse under the 7-3 shift heading and the off-going nurse under the 11-7 shift heading on 1/2/26, 1/14/26, and 1/21/26. *The controlled drug count was not signed as completed with no discrepancies by the 7-3 shift off-going nurse and the 3-11 shift on-coming nurse on 1/14/26 and 1/15/26. *The controlled drug count was not signed as completed with no discrepancies by the 3-11 shift off-going nurse and the 11-7 shift on-coming nurse on 1/1/26 and 1/6/26. 19. Review of the January 2026 Controlled Drugs Count Record sheets on the Mystic Ranch medication cart revealed: *There were three headings labeled 7-3 Shift (7:00 a.m. to 3:00 p.m.), 3-11 Shift (3:00 p.m. to 11:00 p.m.), and 11-7 Shift (11:00 p.m. to 7:00 a.m.). *Below those headings were columns labeled Nurse Off, Nurse On, and Card or prescription count. *The controlled drug count was not signed as completed with no discrepancies by the on-coming nurse under the 7-3 shift heading and the off-going nurse under the 11-7 shift heading on 1/25/26.	F0755		

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F0755 SS = E	Continued from page 62 *The controlled drug count was not signed as completed with no discrepancies by the 7-3 shift off-going nurse and the 3-11 shift on-coming nurse on 1/23/26 and 1/25/26. *The controlled drug count was not signed as completed with no discrepancies by the 3-11 shift off-going nurse and the 11-7 shift on-coming nurse on 1/1/26, 1/2/26, 1/3/26, 1/5/26, 1/21/26, 1/24/26, and 1/28/26. 20. Review of the February 2026 Controlled Drugs Count Record sheets on the Mystic Ranch medication cart revealed: *There were three headings labeled 7-3 Shift (7:00 a.m. to 3:00 p.m.), 3-11 Shift (3:00 p.m. to 11:00 p.m.), and 11-7 Shift (11:00 p.m. to 7:00 a.m.). *Below those headings were columns labeled Nurse Off, Nurse On, and Card or prescription count. *The controlled drug count was not signed as completed with no discrepancies by the on-coming nurse under the 7-3 shift heading and the off-going nurse under the 11-7 shift heading on 2/5/26, 2/7/26, 2/10/26, and 2/19/26. *The controlled drug count was not signed as completed with no discrepancies by the 7-3 shift off-going nurse and the 3-11 shift on-coming nurse on 2/6/26, 2/10/25, 2/20/26, 2/21/26, and 2/22/26. *The controlled drug count was not signed as completed with no discrepancies by the 3-11 shift off-going nurse and the 11-7 shift on-coming nurse on 2/2/26, 2/4/26, 2/18/26, and 2/21/26. 21. Review of the February 2026 Controlled Drugs Count Record sheets on the Luther Lane medication cart revealed: *There were three headings labeled 7-3 Shift (7:00 a.m. to 3:00 p.m.), 3-11 Shift (3:00 p.m. to 11:00 p.m.), and 11-7 Shift (11:00 p.m. to 7:00 a.m.). *Below those headings were columns labeled Nurse Off, Nurse On, and Card or prescription count. *The controlled drug count was not signed as completed with no discrepancies by the 7-3 shift off-going nurse and the 3-11 shift on-coming nurse on 2/25/26, and 2/27/26. 22. Review of the February 2026 Controlled Drugs Count	F0755		

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 03/05/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0755 SS = E	Continued from page 63 Record sheets on the Park View medication cart revealed: *There were three headings labeled 7-3 Shift (7:00 a.m. to 3:00 p.m.), 3-11 Shift (3:00 p.m. to 11:00 p.m.), and 11-7 Shift (11:00 p.m. to 7:00 a.m.). *Below those headings were columns labeled Nurse Off, Nurse On, and Card or prescription count. *The controlled drug count was not signed as completed with no discrepancies by the on-coming nurse under the 7-3 shift heading and the off-going nurse under the 11-7 shift heading on 2/5/26. *The controlled drug count was not signed as completed with no discrepancies by the 3-11 shift off-going nurse and the 11-7 shift on-coming nurse on 2/3/26. 23. Review of the February 2026 Controlled Drugs Count Record sheets on the Mystic Ranch medication cart revealed: *There were three headings labeled 7-3 Shift (7:00 a.m. to 3:00 p.m.), 3-11 Shift (3:00 p.m. to 11:00 p.m.), and 11-7 Shift (11:00 p.m. to 7:00 a.m.). *Below those headings were columns labeled Nurse Off, Nurse On, and Card or prescription count. *The controlled drug count was not signed as completed with no discrepancies by the on-coming nurse under the 7-3 shift heading and the off-going nurse under the 11-7 shift heading on 2/5/26, 2/7/26, 2/10/26, and 2/19/26. *The controlled drug count was not signed as completed with no discrepancies by the 7-3 shift off-going nurse and the 3-11 shift on-coming nurse on 2/6/26, 2/10/25, 2/20/26, 2/21/26, and 2/22/26. *The controlled drug count was not signed as completed with no discrepancies by the 3-11 shift off-going nurse and the 11-7 shift on-coming nurse on 2/2/26, 2/4/26, 2/18/26, and 2/21/26. 24. Review of the February 2026 Controlled Drugs Count Record sheets on the East medication cart revealed: *There were three headings labeled 7-3 Shift (7:00 a.m. to 3:00 p.m.), 3-11 Shift (3:00 p.m. to 11:00 p.m.), and 11-7 Shift (11:00 p.m. to 7:00 a.m.). *Below those headings were columns labeled Nurse Off,	F0755		

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 03/05/2026

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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F0755 SS = E	Continued from page 64 Nurse On, and Card or prescription count. *The controlled drug count was not signed as completed with no discrepancies by the 7-3 shift off-going nurse and the 3-11 shift on-coming nurse on 2/27/26. 25. Interview and review of the Controlled Drugs Count Records on 3/5/26 at 5:43 p.m. with DON B revealed: *Education was provided to the nursing staff related to controlled medication counts to ensure all controlled medications were accounted for after resident 94's oxycodone could not be accounted for on 9/17/25. *Resident 94's oxycodone was changed to be supplied by a local pharmacy so it would arrive in half tablets and in a bubble pack to prevent the need to cut the pills and to be easier to count to ensure they were accounted for. *DON B reviewed the Controlled Drugs Count Record sheets intermittently, but she was not auditing them routinely. *She expected the controlled drugs were counted by the on-coming and off-going nurse at each shift change and any time the keys to a medication cart were exchanged. *The signatures on the controlled drug count record indicated that the count was completed and accurate. *She acknowledged there were missing signatures on the Controlled Drug Count Records. 26. Review of the provider's revised 10/20/25 Medication: Missing/Diversion of Medication – R/S, LTC, AL policy revealed: *"Upon discovery of a medication that may be missing or diverted, notify the Director of Nursing/AL Nurse. Document the incident in SAFE Event Reporting application." *"If controlled medication is discovered missing during perpetual count, consider: Recount, Checking addition and subtraction from previous activity, check the outdated medications." *"Nursing employees with access to the medication cart are asked to search the cart, their pockets and surrounding areas for the missing medications." *"An investigation of the situation is performed by the investigation team."	F0755		

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 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0755 SS = E	Continued from page 65 *"Notify the administrator, the state survey and certification agency, law enforcement, and other designated agencies in accordance with state law of a medication diversion." 27. Review of the provider's revised 3/4/25 Medications: Acquisition, Receiving, Dispensing, and Storage – R/S, LTC policy revealed: *"It Is preferred that a licensed nurse receive and verify the medications. Once the medications are received, they will be secured in the appropriate storage area (i.e., medication cart or medication room). Licensed nurses and medication aides (when allowed by state law) are responsible for reconciling medications received." *"Disposal will be done in accordance with state/pharmacy regulations." *"Controlled drugs (Schedule II) and other drugs subject to possible abuse will be stored in separate, locked, permanently fixed compartments, except when a single unit package drug distribution is used. These drugs will be reconciled daily through an appropriate system of records of receipt and disposition established by the licensed pharmacist."	F0755		

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 03/03/2026

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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E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 3/3/26. Good Samaritan Society Luther Manor was found in compliance.	E0000		

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 reverse for further 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 TC Fraser	(X6) DATE 3/31/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 03/03/2026

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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K0000	INITIAL COMMENTS A recertification survey was conducted on 3/3/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Good Samaritan Society Luther Manor was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K321 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0321 SS = B Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons)	K0321	1. By 4/4 the 300 Crawl space and the main utilities room have adjust made to the doors so meet NFPA compliance. 2. By 4/4 all hazardous areas will be audited to ensure compliance with NFPA requirements. 3. Training will be provided to the maintenance staff on the NFPA requirements for Hazardous Areas by 4/1/26 4. All Hazardous areas will be audited Quarterly and brought to QAPI for results. 5. Substantial completions will be achieved by 4/1/26	4/1/26

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 reverse for further 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 TC Fraser	(X6) DATE 3/30/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 03/03/2026

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K0321 SS = B* Bldg. 01	Continued from page 1 e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to maintain self-closing doors for two rooms (300 crawl space and shut off room for main utilities) in the lower level. Findings include: 1. Observation on 3/3/26 beginning at 1:40 p.m. revealed the following: The 300 crawl space room and the shut off room for the main utilities were both over 100 square feet in area and held copious amounts of combustible items (cardboard boxed items and wood dressers) kept in the rooms. Interview with the maintenance director at the time of the observations confirmed those findings. The deficiency could affect 100% of the smoke compartment occupants.	K0321		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10681	A. BUILDING: _____ B. WING _____	03/05/2026

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

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/3/26 through 3/5/26. Good Samaritan Society Luther Manor was found not in compliance with the following requirement: S236.	S 000		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare personnel or residents are as follows: (1) Each new healthcare personnel or resident shall receive an initial individual TB risk assessment and the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within twenty-one days of employment or admission to a facility. The qualified personnel must record the assessment and the test in the employee's record or the resident's medical record. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of admission or employment is considered a two-step test. A TB blood assay test completed within a twelve-month period prior to the date of admission or employment is an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare personnel or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin testing having been completed within the prior twelve months. Skin testing or a TB blood assay test is not necessary if documentation is provided by the transferring healthcare facility, healthcare personnel, or resident, of a previous	S 236	1.Certified Nursing Assistant (CNA) D no longer works at the facility. CNA E received TN skin test on 12/5/26 and 2 test on 12/12/25. Result were negative 2.All other employees are at risk of not receiving their two-step tuberculin (TB) skin test within twenty-one days of hire. Employees Hired in the past 3 months will be reviewed by the Infection Preventionist by April 1st to ensure all the appropriately received TB testing. 3.New Hire TB tests will be logged by the IP nurse or designee into the TB Tracking shared document upon hire and reviewed every morning in Clinical Stand up. Discussing and tracking the TB skin tests as a team. A copy of the TB skin test sheet for the new employee will be kept in a binder for tracking purposes until both skin tests have been completed. New employees will not be allowed to work on the floor until step one has been completed and read by a nurse. 4.DON or designee will audit all new employee TB skin tests during their first 21 days of hire to ensure that the process has been completed within the allotted time frames. Audits will continue until 100% compliance has been reached and maintained for 3 months. Results of the audits will be discussed by the Infection Prevention nurse or designee at the monthly QAPI meeting with the medical director and IDT for analysis and recommendation for continuation, discontinuation, or revision of audits based on findings. 5. Completion Date of 4/1/2026	4/1/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE TC Fraser | (X6) DATE 3/31/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10681	A. BUILDING: _____ B. WING _____	03/05/2026

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GOOD SAMARITAN SOCIETY LUTHER MANOR	1500 W 38TH ST SIOUX FALLS, SD 57105

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S 236	Continued From page 1 positive reaction to either test. Any new healthcare personnel or resident who has a newly recognized positive reaction to the skin test or TB blood assay test must have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Based on employee review, interview, and policy review the provider failed to ensure two of five employees (certified nursing assistant D and E) reviewed had received the two-step tuberculin (TB) skin test within twenty-one days of their employment. Findings Include: 1. Review of certified nursing assistant (CNA) D's employee record revealed: *She was hired on 2/10/26. *She had no documentation of TB skin tests being completed. 2. Review of CNA E's employee record revealed: *She was hired on 11/4/25. *She had received her TB skin tests on 12/5/25 and 12/12/25, both test results were negative. *That testing was outside the twenty-one-day requirement. 3. Interview on 3/4/326 at 3:25 p.m. with assistant director of nursing (ADON)/Infection preventionist (IP) G revealed: *He was responsible for ensuring the TB skin testing was completed for new employees. *He agreed that CNA D had no documentation of TB testing in her employee file. *He agreed that CNA E's TB skin tests had not been completed within twenty-one days of hire.	S 236		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10681	A. BUILDING: _____ B. WING _____	03/05/2026

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S 236	Continued From page 2 *He expected all staffs TB skin tests to be completed within twenty-one days of hire. 4. Review of the April 4, 2022 provider's Tuberculosis Control Plan and Screening for Employees policy revealed: *"To provide early identification of employee infected with Mycobacterium tuberculosis (TB) to prevent the spread of TB through appropriate screening and treatment of employees with TB or exposure to TB." -"If using TST [tuberculin skin test], a two-step Mantoux method should be used for testing. This involves administering the initial test upon hire, which is read 48 to 72 hours by a nursing professional or physician/practitioner. If the first TST is negative, the second test should be placed one to three weeks after the placement of the first test per state regulations. The second test is read 48 to 72 hours after administration."	S 236		