STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435044	A. BUILDING _____ B. WING _____	C 10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY LUTHER MANOR	1500 W 38TH ST SIOUX FALLS, SD 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
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 10/15/24 through 10/17/24. Good Samaritan Society Luther Manor was found not in compliance with the following requirements: F657, F689, and F812. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 10/15/24 through 10/17/24. Areas surveyed included resident neglect as it related to timely resident assessment. Good Samaritan Luther Manor was found in compliance.	F 000	*Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.*	
F 657 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. (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	F 657	Resident 73's care plan was revised on 10/16/24 to remove the reference to the discontinued Foley catheter. Audit of residents who have or have previously had an order for a catheter was conducted 11/7/24. Audit was to verify these residents' care plans were updated following the discontinuation of catheter use. Any residents found out of compliance will have their care plans updated by DNS or designee by 11/12/24. To ensure systemic change, all nurses will be educated by DNS or designee by 11/12/24 on what changes to a resident's plan of care constitute an update to the care plan, and how to ensure the care plan is updated based on those changes.	11/12/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelli Arndt, WHA — TITLE: Administrator — (X6) DATE: 11/08/24

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 657	Continued From page 1 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, and policy review, the provider failed to ensure the care plan for one of two sampled residents (73) was updated after her catheter was removed. Findings include: 1. Observation and interview on 10/16/24 at 8:20 a.m. with resident (73) while in her room revealed: *She confirmed she had no catheter. *Resident 73 denied she had a catheter. 2. Review of resident 73's electronic medical record (EMR) revealed: *Her care plan indicated she required Enhanced Barrier Precautions (EBP, the use of gowns and gloves) for an indwelling medical device - Foley Catheter initiated 05/28/24. *A progress note (PN) dated 5/28/24 indicated "the resident will communicate understanding of need for EBP by the review date." *There was no current physician order for a Foley catheter. *Her 6/03/24 Minimum Data Set (MDS) assessment indicated she had a catheter at that time. *Her 8/20/24 MDS indicated she did not have a catheter at that time. *A PN dated 8/12/24 indicated her Foley catheter	F 657	To monitor our performance to ensure that solutions are sustained, the DNS or designee will conduct focus audits on 5 residents that have or have had orders for a catheter to ensure their care plan accurately reflects their current use bi-weekly X 2, and monthly X 2. The results of these audits will be reviewed and reported at the monthly Quality Committee meeting.	

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F 657	Continued From page 2 was discontinued. *Her 8/20/24 Brief Interview for Mental Status (BIMS) assessment score was 10 which indicated she was moderately cognitively impaired. 3. Review of resident 73's paper medical record revealed: *On 6/20/24 the 14 French (FR) catheter was removed. 4. Interview on 10/16/24 at 8:30 a.m. with registered nurse (RN) E revealed: *Resident 73 did not have a catheter. *She stated, "She may have had a catheter when she first came in." 5. Interview on 10/16/24 at 2:30 p.m. with certified nurse assistant (CNA) H revealed: *"[Resident 73] does not have a catheter." *She indicated she would have looked at the resident's care plan or MDS to know if a catheter was present. *She stated, "The nurse is who updates the care plans, and the nurse manager is who overlooks the care plans/MDS." 6. Interview on 10/16/24 at 2:53 p.m. with RN/MDS nurse D revealed: *She stated, "I do 75 percent of the care plans." *She reviewed the resident chart and the records provided by the admitting facility. *"[RN C's name] should have updated that care plan." *The nurse manager on the unit that the resident lived on, would then have notified her of the changes at their "stand-up" morning meeting or by email. Review of the provider's Care Plan policy	F 657		

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F 657	Continued From page 3 revealed: *"The purpose of the care plan is to provide a centralized coordination of the services that will be provided to each resident, based on his or her individual needs, abilities, and preferences."	F 657		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: A. Based on interview, observation, record review, and policy review the provider failed to ensure the safety of one of one sampled resident (14) who required the assistance of two staff during transfers with a sit-to-stand mechanical lift. Findings include: 1. Interview and observation on 10/15/24 at 3:45 p.m. with resident 14 revealed: *He had gone to the hospital because he had been dropped from a lift in the shower room and hit his head. *He pointed to his head and said, "that's what this bump is from." *He had a raised area on his left forehead and a brace on his left foot. 2. Review of resident 14's electronic medical record (EMR) revealed a progress noted dated	F 689	A. CNA I was re-educated on the Kardex and provided coach and counseling by DNS on 10/30/24. B. LPN K no longer works at facility as of 11/2/24. Following resident 39's undocumented fall, the week of 5/12/24 nurse manager did educate LPN K that a fall without injury and/or fall when lowered to the floor requires fall documentation. Summary of final investigation for resident 39's fibula fracture was submitted to DOH on 10/18/24 by Administrator. A. All resident transfers were audited comparing how the staff transfer the residents to what is care planned, and updates/education based on the audit will be complete by DNS or designee by 11/12/24. B. All residents have the potential to be affected by the deficient practice. All other initial state reports submitted	11/12/24

were reviewed by Administrator on 11/8/24 to ensure a final report was also submitted and accepted by DOH.

To ensure systemic change, all nursing staff will receive education by DNS or designee by 11/12/24 on the following:

- The proper assessment to complete for new admissions, re-admissions, quarterly, and as needed for changes in condition to determine appropriate transfer status.
- How to ensure the care plan reflects the accurate transfer status and the expectation that staff adhere to the care plan.
- The definition of a fall which is "unintentionally coming to rest on the ground, floor, or other lower level, but not as the result of an overwhelming external force (e.g., resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught hi/herself, is considered a fall. A fall without injury is still a fall..."
- The required post-fall documentation and assessments for potential injury or change in needs.

On 11/4/24 Administrator implemented inclusion of the above training for all new nursing staff hires and new nursing agency staff during general orientation. New nursing staff/agency nursing staff will be required to pass a competency test upon start at facility regarding these topics.

On 10/23/24 Administrator initiated a tracking tool of state reports to ensure timely completion and submission of the final 5-day investigation.

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F 689	Continued From page 4 9/9/24: *"CNA [certified nursing assistant] called nurse to tub room res laying on the floor, skin tear to left arm above elbow, measures 5x5x5 triangle shaped area, also has a bump on left forehead with abrasion resident right leg is turned inward resident c/o [complaints of] pain when tried to move right leg. Resident stated "I was standing up to get on bath chair and I fell." VS [vital signs] and Neuro check done, d/t [due to] pain and leg turning inward PCP [primary care provider] call and sending res to ER [emergency room] via ambulance, will wait to transfer res from floor when EMS [emergency medical service] arrives, EMS arrived approximately 0815." 3. Interview on 10/16/24 at 1:40 p.m. with resident 14 revealed, he had stopped this surveyor in hall and asked what was found out about the lift and stated, "That thing [the lift] is going to kill me." 4. Interview on 10/16/24 at 1:44 p.m. CNA O regarding resident 14's transfers revealed: *She would check his Kardex for changes in how they were to help him transfer, but he used the sit- to-stand mechanical lift with the assistance of two staff. *She stated he didn't like to use the lift and could be "ornery or stubborn" about using it. *She stated she would report to the nurse if he had trouble with the lift and maybe they would maybe get therapy to reevaluate him. 5. Interview on 10/16/24 at 1:50 p.m. with licensed practical nurse (LPN) F regarding resident 14 revealed: *She was aware resident 14 did not like to use the sit-to-stand lift. *She thought it was safer than a pivot transfer	F 689	To monitor our performance to ensure that solutions are sustained, the DNS or designee will conduct randomized focus audits on 5 residents to verify 1) Care planned transfer statuses are reflected in how staff are transferring the resident and 2) That resident falls are properly documented per facility's policy/procedure weekly X 4, bi-weekly X 2, and monthly X 3. Facility will also audit completion and acceptance of final reports to DOH of state reportable incidents bi-weekly X 2 and monthly X 3. The results of these audits will be reviewed and reported at the monthly Quality Committee meeting.	

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F 689	Continued From page 5 (spinning to move while bearing weight on one or both legs) and resident 14 thought he could still pivot. *She was not aware of him being dropped from a mechanical lift but resident 14 had told her he thought staff were going to drop him. *She stated she could put in a request for therapy to reevaluate him and the mechanical lift, but she had not placed one yet. *She later returned and informed this surveyor she had checked, and he was currently working with physical therapy and the use of the mechanical lift. 6. Interview on 10/16/24 at 1:56 p.m. with resident 14 revealed he stated: *His left leg and arm were weak from a stroke. *Only one staff would come in when they used the mechanical lift. *When staff used the lift it would pull his toes right into the stopper on the footrest toward the person that operated the machine. *He reported to staff he didn't like the mechanical lift and did not feel safe in it, but they still used it. 7. Interview on 10/16/24 at 2:10 p.m. with physical therapist assistant (PTA) Q regarding resident 14 revealed he stated: *Resident 14 had not been dropped from a lift by staff. *Resident 14 would lean back in the lift and not work well with staff about the lift being used. *He stated he would hate to go back to using a Hoyer full body mechanical lift (total body mechanical lift) when resident 14 could stand up. *Resident 14 was currently working with therapy and he would get their notes for the last few weeks.	F 689		

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F 689	Continued From page 6 8. Interview and observation on 10/17/24 at 7:32 with CNA I during resident 14's transfer revealed: *Resident 14 was laying in bed with his legs hanging off the edge of bed. *CNA I stated that she would know how to care for residents because their information was on a Kardex which contained information on how to care for a resident. -The Kardex was updated timely. *While resident 14 was seated on the edge of the bed, CNA I placed the lift sling behind him and explained she would get him up with a stand lift by herself. *This surveyor stopped CNA I before she hooked the sling up to the mechanical lift and asked her if he needed two staff to assist with the lift for safety. *CNA I said she thought he was one assist but she would check his care plan and left the room. -CNA I then re-entered resident 14's room at 7:44 a.m. with CNA P and stated resident 14 was to have two staff to assist with the mechanical sit-to-stand lift and stated his care plan must have recently changed. *She agreed she had been transferring resident 14 by herself with the sit-to-stand mechanical lift. 9. Observation on 10/17/24 at 8:06 a.m. in the nurse's station revealed a whiteboard hanging on the wall near the entrance dated 10/16/24 at the top and had instructions written on it in orange to "check Kardex daily." 10. Interview on 10/17/24 on 8:09 a.m. with LPN L regarding resident 14 when transferred with the mechanical lift revealed: *He was a fall risk and staff should use two people when using the mechanical lift. *He thought the Kardex was updated timely to	F 689		

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F 689	Continued From page 7 include that information. 11. Interview on 10/17/24 at 8:12 a.m. with director of nursing (DON) B regarding resident 14's fall and transfers with a mechanical lift revealed: *Resident 14 had fallen in the tub room while one staff was assisting, but he did not fall from the mechanical lift. *CNA I was not involved with that transfer and fall but CNA R was. *She was disappointed CNA I used the mechanical sit-to-stand mechanical lift without the assistance of an additional staff person for resident 14. *She stated, "That is a big deal we had recently done training on 9/19/24 because he had fallen." *CNA I was trained on 10/4/24 regarding transfers and Kardex's updated for transfers. *She stated, CNA R was not available for interview because she had called off work for the last two days. 12. Review of resident 14's 9/9/24 fall investigation revealed: *CNA R indicated resident 14, "Was going to get a w/p [whirlpool] bath. He stood up at the bars and turned to sit and his good leg gave out on him and down he went." -The root cause of resident 14's fall was indicated as, "Lost balance and fell, resident did not have a gait belt on when nurse entered room." -"Summary of meeting: Resident found to not have fracture after being sent to the emergency department for evaluation. Investigation revealed resident was being transferred via one assist versus care planned sit-stand lift, this was how all consistent care givers were transferring resident." -"Conclusion: Use sit-to-stand for all transfers,	F 689		

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F 689	Continued From page 8 ensure appropriate room arrangement to accommodate lift use." -"Additional Care Plan/Nurse aide assignment updates, CNA received coaching by the DON on 9/12/24, education provided to CNAs and nurse re: use of Kardex and how to request that transfer status be updated, Resident noted to have concerns about sit-to-stand lift and request part B therapy to work with resident on safe transfers in the lift." 13. Interview on 10/17/24 at 10:20 a.m. with DON B revealed: *DON B verified at the time of resident 14's fall incident on 9/9/24 resident 14 was transferred with the assistance of one staff and did not use a gait belt and she did not use the sit-to-stand mechanical lift. -She stated CNA R admitted to all of that. 14. Review of resident 14's care plan regarding transfers between surfaces revealed it was updated on 9/16/24 and instructed staff to use a mechanical sit-to-stand for transfers with assistance of two staff. Resident 14's transfer information on his Kardex matched those instructions. 15. Review of resident 14's 9/23/24 - 10/21/24 physical therapy evaluation and treatment plan revealed he would work with therapy to imporve his strength his left hip and knee and upper extremities needed to assist with transfers. 16. Review of the provider's 7/29/24 Fall Prevention and Management policy revealed: *"Purpose:" -"To promote resident well-being by developing and implementing a fall prevention and	F 689		

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F 689	Continued From page 9 management program." -"to identify risk factors and implement interventions before a fall occurs." -"To give prompt treatment after a fall occurs." -"To provide guidance for documentation." *"Falls - refers to unintentionally coming to rest on the ground floor or other lower level, but not as a result of an overwhelming external force. An episode where a resident lost his/her balance and would have fallen if not for employee intervention, is considered a fall. A fall without injury is still a fall." *"Proactive Approach before a Fall Occurs procedure: -"3. Care Plan the appropriate interventions, including personalizing all "(SPECIFY)" areas." -"4. Communicate fall risks and interventions to prevent a fall before it occurs per Fall Committee meetings." -"12. If appropriate, contact the physician for a referral to therapy and communicate this to resident an family.' -"14. Communicate that a fall has occurred during shift change and daily stand-up meetings in the preferred method of communication. The PCC Shift and 24 Hour report are available options." -"16. Review and update the Care Plan with any changes/new interventions." B. Based on observation, interview, record review, and policy review, the provider failed to ensure the safety of one of one sampled resident (39) who received a bodily injury from an undocumented fall. Licensed practical nurse (LPN) K failed to identify and accurately document and report timely to facility leadership an incident when one of one sampled resident (39) was lowered to the floor after her legs had buckled. A fibula fracture was determined later.	F 689		

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F 689	Continued From page 10 Findings include: 1. Observation and interview on 10/15/24 at 5:15 p.m. with resident 39 in her room revealed: *The room was free from clutter and potential injury hazards. *She was sitting in her recliner watching TV with her legs not elevated and her call light was within reach. *She could not remember if she had fallen recently. 2. Review of resident 39's electronic medical record (EMR) revealed: *Her diagnoses included hypothyroidism, other amnesia, history of falling, and type 2 diabetes. *Physician progress notes on 5/17/24 at 10:30 a.m. indicated: -She complained of increased right knee pain. -She reported she had a previous fall and was concerned for injury to her knee. -Her knee appeared swollen and had tenderness. -A nurse reported she was having difficulty with ambulation. *Her nursing progress notes indicated: -On 5/17/24 at 3:19 a.m. administration of, "acetaminophen oral tablet for pain related to her legs." -On 5/17/24 at 5:36 p.m. new orders from physician for, "ice pack/cold pack to right knee 15 min on and then 2 hours off as needed for pain." -On 5/17/24 at 5:37 p.m. new orders from physican for, "Biofreeze External Gel 4% (Menthol (Topical Analgesic)) Apply to knees topically four times a day for pain." -On 5/18/24 the X-ray results of her right knee shown, "osteoarthritis, and unremarkable examination of tibia and fibula." -On 5/20/24 the X-ray results of her right knee	F 689		

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F 689	Continued From page 11 shown, "she has arthritis." -On 5/22/24 at 11:15 a.m. the resident was sent to hospital for, "right lower extremity (RLE) concerns of cellulitis." -On 5/22/21 at 7:17 p.m. the hospital called, "resident is going to be admitted for broken fibula [calf bone]." *There was no documentation found in her EMR of a fall that occurred from 5/9/24 through 5/22/24. *Her careplan indicated her fibula fracture was a result of a fall that occured on 5/11/24. *Interventions for falls in her care plan initiated on 11/29/23 included staff were to: -Educate resident/family/IDT as to causes of fall. -Remind resident not to bend over to pick up dropped items. Encourage the use of a grabber or to ask for assistance. *Interventions for falls in her care plan updated on 5/28/24 included she was to work with physical therapy/occupational therapy for strengthening, endurance, and safety awareness. *Kardex as of 10/17/24 indicated: -She needed one staff assist with a walker and gait belt for ambulation. -She needed the assistance of two staff with a full body lift and an extra-large sling for transfers between surfaces. -Staff were to elevate feet when sitting up in chair to help prevent dependent edema. 3. Review of resident 39's 3/4/24 Sit-Stand-Walk Data Collection Tool assessment revealed: *She could bear weight on at least one leg. *She could extend at least one leg at the knee, flex her ankle and point her toes. *There was no indication of how she could pull herself to a standing position and maintain her position.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435044	A. BUILDING _____ B. WING _____	C 10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY LUTHER MANOR	1500 W 38TH ST SIOUX FALLS, SD 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
F 689	Continued From page 12 *Interventions for ambulation and transfers between surfaces indicated the assistance of one staff member, walker, and gait belt. 4. Review of resident 39's 5/28/24 Sit-Stand-Walk Data Collection tool assessment revealed: *She could bear weight on at least one leg. *She could extend at least one leg at the knee, flex her ankle, and point her toes. *She could not pull herself to a standing position and maintain the position. *She would need the sit-to-stand equipment for transfers. *She was unsafe to ambulate. *Interventions for ambulating and transfers between surfaces indicated assistance of one staff member, walker, and gait belt. 5. Interview on 10/16/24 at 4:21 p.m. with certified nursing assistant (CNA) J regarding resident 39 revealed: *She needed the assistance of a sit-to-stand lift for transfers between surfaces prior to her fracture. *She always had ace wraps on her legs during the day for edema. *She was non-weight bearing when she had returned from the hospital. *She was in a boot that went up to her kneecap. 6. Interview on 10/17/24 at 7:32 a.m. with CNA G regarding resident 39 revealed: *She needed the assistance of a sit-to-stand lift between surfaces prior to going to the hospital because she had difficulty transferring because of pain. *She was sent out for X-rays after a potential injury was discussed. *She was in a boot and non-weight bearing status	F 689		

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

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F 689	Continued From page 13 when she came back from the hospital. *Physical therapy had worked with her for a while, but she was not getting any better. *She was changed to use a full body lift for transfers. 7. Interview on 10/17/24 at 8:01 a.m. with administrator A regarding resident 39 revealed: *She was aware that there was no documentation of a fall that occurred. *She was on maternity leave when the fibula fracture was found. *She stated that agency LPN K had been with her when the fall occurred on 5/12/24. *LPN K had told her that she lowered resident 39 to the floor in the bathroom when her legs buckled. *When administrator A had asked LPN K why she had not documented the fall, LPN K stated she was not aware it was considered a "fall." *Administrator A stated her expectation would be if she was there, she would have looked into the fibula fracture of unknown origin and started an investigation. *She was aware that a final report was not submitted to the Department of Health. 8. Interview on 10/17/24 at 8:21 a.m. with LPN K regarding resident 39's fall revealed: *She was not aware that the facility considered lowering a resident to the ground as a "fall." *She had thought the resident needed the assistance of one staff with transfers. *Once the resident had been lowered to the ground, she needed multiple people to get her back up. *She did not believe the resident was hurt at the time of the incident. *Resident 39 needed a total body lift for transfers	F 689		

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F 689	Continued From page 14 after her fracture and she cannot walk anymore. 9. Review of providers 7/29/24 Fall Prevention and Management policy revealed: *Purpose: - "To promote resident well-being by developing and implementing a fall prevention and management program." - "To identify risk factors and implement interventions before a fall occurs." - "To give prompt treatment after a fall occurs." - "To provide guidance for documentation." * "Fall-refers to unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force. An episode where a resident lost his/her balance and would have fallen, if not for employee intervention, is considered a fall." *"e. Notify the physician and resident representative of the incident." * "f. Complete Fall Scene Huddle Worksheet." * "16. Review and update the Care Plan with any changes/new interventions." * "17. Report to the state regulatory agency when appropriate."	F 689		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812	The corkboard above the toaster in the kitchen was found to have papers that were curled and not in protective sleeves. On 11/5/24 the corkboard was raised away from the toaster and protective sleeves were added to papers.	11/12/24

Soiled binder found in kitchen on 10/15/24 was replaced with a new binder on 10/16/2024.

All food items named to be not dated, out of date, or not properly stored have been discarded.

Wall above the food preparation sink has been addressed by maintenance so there is no longer peeling paint.

Named soiled kitchen equipment and spaces, such as areas on and around grease trap, oven, and stove have been cleaned and sanitized.

All residents have the potential to be affected by the deficient practice.

To ensure systemic change, cleaning logs have been reviewed/revised by Dining Services Manager to ensure deficient areas are included. Dining Services Manager will provide training to all dining services staff by 11/12/24. Training includes proper cleaning and sanitizing procedures, food storage practices, and cleaning logs. These trainings will be reviewed annually and with new staff during general orientation.

To monitor our performance to ensure that solutions are sustained, the Dining Services Manager or designee will audit weekly X 4, bi-weekly X 2, and monthly X 1. This audit will include review of:

- Foods being covered, labeled, and dated with an expiration date (use-by) in all refrigerators, freezers, and/or dry storage to ensure no expired or spoiled foods.
- Cleaning schedules being followed by staff.
- Handwashing sinks having soap.

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	435044	A. BUILDING _____ B. WING _____	C 10/17/2024

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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F 812	Continued From page 15 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, cleaning log review, and policy review, the provider failed to ensure food items were appropriately stored and labeled and to maintain a clean and sanitary food service environment in one of one kitchen and one of one kitchenette. Findings include: 1. Observation of the kitchen on 10/15/24 at 10:23 a.m. revealed: *At least six cardboard boxes were piled on a metal cart with a blue bucket that contained a hardened brown and white substance. *A plastic bin with a blue lid that contained cookies and was not labeled or dated. *The floor, wall, and metal grease trap box under the three-compartment sink was covered with a brown and black substance. -There was unidentifiable debris between the sink and the grease trap. *There was no soap in the dispenser at the hand-washing sink. *The wall above the food preparation sink had areas of white peeling paint. *The base of the Magic Bullet, used to puree small portions of food, contained crumbs and a tan, brown, and pink substance. *A tub contained butter covered in crumbs that was not labeled or dated.	F 812	• The floor being clean and free of spilling including under/behind equipment and around baseboards/table legs. • Kitchen equipment being clean and sanitized. The results of these audits will be reviewed and reported at the monthly Quality Committee meeting.	

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F 812	Continued From page 16 *A container of peanut butter that was not labeled or dated. *A corkboard above the toaster contained at least six pieces of paper that were not in protective sleeves that were stained and curled at the edges. -One paper was touching the hot toaster. *A binder labeled "What to do when a team member calls in" was soiled with a brown substance and touched the toaster. *The areas between the oven and the stove, the stovetop, and the backsplash were splattered with a brown, black, and white substance. *A plate of cookies was in the pantry closet and was not labeled or dated. *The walk-in refrigerator contained: -A bag of celery that was visibly spoiled and was not labeled or dated. -An open bag of salad that was not labeled or dated. -A tub of cottage cheese labeled "Discard by 10/07/24." -A box of cottage cheese labeled "Best if used by 10/14/24." The walk-in freezer contained: -An open package of breaded chicken strips that were not labeled or dated. -An open package of french fries that was not labeled or dated. -An open package of carrots that was not labeled or dated. 2. Observation of the serving area located outside of the kitchen on 10/15/24 at 10:47 a.m. revealed: *The area between the steam table and the plate storage was soiled with food crumbs and debris. *A tray of cookies above the steam tables that were not labeled or dated. *The refrigerator contained:	F 812		

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F 812	Continued From page 17 -A carton of thickened water labeled "Best used by 10/8/24." -A dish that contained blueberries that was not labeled or dated. -A salad labeled [resident name] that was visibly spoiled and was not dated. 3. Observation on 10/15/24 at 12:05 p.m. of the 500-wing kitchenette revealed: *A tub of peanut butter with a lid had peanut butter smudged on the outside of the container and it was not labeled or dated. *A tub of butter that was not labeled or dated that contained significant food crumbs. A refrigerator contained: -Thickened cranberry juice labeled "Discard by 10/11/24." -Thickened water labeled "Discard by 10/8/24." -Three individual prune juice containers labeled "Discard by 10/8/24." -Four slices of cheese in plastic wrap that was not labeled or dated. -Open packages of waffles, pancakes, and French Toast that were not labeled or dated. 4. Observation of the main kitchen on 10/17/24 at 9:15 a.m. again revealed: *The cardboard boxes and the blue bucket that contained a hardened brown and white substance remained on the metal cart. *The floor, wall, and metal grease trap box under the three-compartment sink were covered with the same brown and black substance. *There was no soap in the dispenser at the hand-washing sink. *The base of the Magic Bullet contained the same tan, brown, and pink substance. 5. Review of the Weekly Cleaning Assignments	F 812		

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F 812	Continued From page 18 Logs revealed: *The September 2024 log was divided into five weeks each with 49 tasks. -Week one had 10 of the 49 tasks marked completed. -Week two had 22 of the 49 tasks marked completed. -Week three had 18 of the 49 tasks marked completed. -Week four had 6 of the 49 tasks marked completed. -Week five had 1 of the 49 tasks marked completed. *The October 2024 log was divided into five weeks each with 49 tasks. -Week one had 35 of the 49 tasks marked completed. -Week two had 21 of the 49 tasks marked completed. -Week three had 16 of the 49 tasks marked completed. 6. Interview on 10/17/24 at 9:47 a.m. with director of dining services M revealed she: *Stated that she had asked staff to dispose of the "trash" on the metal cart. *Had not been aware that the soap dispenser was empty and replaced the soap. *Confirmed that the area under the sink was dirty and needed to be cleaned. *Indicated the kitchen was to receive new counters and expected the areas around the sinks to be updated with the remodel. *Stated, "That's gross," when she looked inside the Magic Bullet base. *Indicated that the butter and peanut butter containers are typically left on the counter and should have been labeled. *Expected items in the refrigerator and freezer to	F 812		

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F 812	Continued From page 19 have been labeled and dated with the open date and the discard date when they were first opened. -Items were to have been discarded by the discard date on that sticker. *Confirmed that the Weekly Cleaning Assignments logs were incomplete. 7. Review of the provider's 4/3/24 Date Marking-Food and Nutrition policy revealed: *"When TCS [Time/Temperature Control for Safety Foods] has been opened but remain in storage, employees: Ensure that ready-to-eat TCS foods opened at the location are clearly date marked for: 1) The date/time the original container is open. 2) The date or day by which the food shall be consumed on the premises, sold or discarded." *"A food item is discarded when: the TCS item is beyond the USE by date." 8. Review of the provider's 11/27/23 Cleaning Schedule-Food and Nutrition Services policy revealed: *"To promote a system that identifies cleaning tasks to be completed." *"Employees will initial the schedule after completing his or her cleaning duties each day." *"The DFN, food and nutrition supervisor, senior living dining director, senior living manager or person in charge is responsible for monitoring employees to ensure that cleaning duties are completed in a satisfactory and timely manner."	F 812		

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E 000	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 10/15/24. Good Samaritan Society Luther Manor was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelli Ann, LNHA — TITLE: Administrator — (X6) DATE: 11/08/24

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

South Dakota Department of Health

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	10681	A. BUILDING: _____ B. WING _____	10/17/2024

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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 10/15/24 through 10/17/24. Good Samaritan Society Luther Manor was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 10/15/24 through 10/17/24. Good Samaritan Society Luther Manor was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelli Arey, LNHA — TITLE: Administrator — (X6) DATE: 11/08/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435044	A. BUILDING 01 - MAIN BUILDING 01 (INCLUDES 1990 ADDITION) B. WING _____	10/15/2024

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K 000	INITIAL COMMENTS A recertification survey was conducted on 10/15/24 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Good Samaritan Society Luther Manor was found in compliance.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelliann, NHA

TITLE: Administrator

(X6) DATE: 11/08/24

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.