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	435044	A. BUILDING _____ B. WING _____	C 01/23/2025

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 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/21/25 through 1/23/25. Areas surveyed included nursing services quality of care and treatment. Good Samaritan Society Luther Manor, Sioux Falls was found not in compliance with the following requirement: F684	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 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI) review, record review, observation, interview, and policy review the provider failed to ensure Buprenorphine (pain medication) transdermal (TD) (delivered through the skin) patch was removed before a second Buprenorphine patch was applied to one of one sampled resident (1) whose altered mental state required evaluation at a hospital. Findings include: 1. Review of the SD DOH FRI dated 1/17/25 revealed: *There was concern regarding nursing services	F 684	Resident 1's order for Buprenorphine patch was reviewed by DON on 1/17/25 for accuracy to include medication, order type, route of administration, schedule, administration time, supplementary documentation and whether the order contained information to apply and remove patch. A 2nd order was written on 1/17/25 by DON to check placement of Buprenorphine patch 3x/day, with site documentation required as part of the order. All new changes would now be attached to the MAR. A 3rd order was written on 1/17/25 by DON to remove the previous Buprenorphine patch prior to applying a new one, with supplemental documentation added to the order in yes/no format for nurse to document that patch was indeed removed. Order was attached to the MAR.	2/15/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelli Aschoff — TITLE: Administrator — (X6) DATE: 2/14/25

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 684	Continued From page 1 and the quality of care provided to resident (1) who had two Buprenorphine patches on his skin when he was evaluated at a hospital for his altered mental state. *He had an order to apply one Buprenorphine patch every 7 days. *He had a patch applied to his skin on 1/3/25 and a second patch applied on 1/11/25 because it was not available when it was due on 1/10/25. *The patch was delivered on 1/11/25. The nurse applied the patch and was not aware the previously applied patch had not been removed from the resident's skin. *The doctor at the hospital suspected the cause of resident 1's altered mental status was from having two Buprenorphine patches on his skin. *Further investigation was pending. 2. Review of resident 1's electronic medical record (EMR) revealed: *Diagnosis of a neurogenic bladder, history of urinary tract infections (UTI) and he had a super pubic catheter. *Pain level from 1/3/25-1/15/25 revealed it was between 2-5/10. 3. Observation and interview on 1/22/25 at 7:38 a.m. with licensed practical nurse (LPN) C revealed: *TD patches were to be signed out on the medication administration record (MAR) and the narcotic book was to be signed. *She would have removed the old patch and applied the new patch. -She would have kept the patch she removed and had another nurse destroy it with her. *She would have signed the time and date on the patch placement form . *If a medication wasn't available, she would notify	F 684	Audit of all current residents who have orders for Buprenorphine patches was performed on 1/17/25 by DON. Any order found to not include a "remove patch" as part of the order was either rewritten or corrected and updated. The order descriptions were reviewed and corrected as necessary, additional orders written to remove old patch prior to applying new patch, checking placement times were changed to TID, supplemental documentation added to order if needed and all orders were attached to MAR. Any changes that required a new order to be written were obtained, reviewed and signed by Provider. To ensure systemic change, every order for a Buprenorphine patch will specify removal of old patch prior to application of a new patch and include TID "check placement" orders. All nurses will have received education by 2/15/25 from the DON regarding how to enter, and the new system, for Buprenorphine patch orders. To monitor our performance to ensure that solutions are sustained, the DNS or designee will conduct focus audits on 3 residents that have orders for a Buprenorphine patch to ensure their orders contain a remove or check placement of patch weekly X 4, bi-weekly X 2, and monthly X 1. The results of these audits will be reviewed and reported at the monthly Quality Committee meeting.	

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F 684	Continued From page 2 clinical care leader (CCL) D. -She would have called the pharmacy if a medication was not availabl to check if it was waiting on a doctor's order or for a doctor's signature. *She would let the nurse manager know what was going on while she checked on the missing medication. 4. Interview on 1/22/25 at 7:50 AM with CCL D revealed:. *If there wasn't a medication available, they would have checked to determine if it was waiting for pharmacy delivery, if the order had changed, or if it had not been faxed to the pharmacy. *Their pharmacy delivered at 10:00 am., and had tow to four hours to deliver their orders for newly admitted residents. *Pharmacy would deliver for a stat (as soon as possible) order within one hour. 5. Interview on 1/22/25 at 10:52 a.m. with LPN C regarding the narcotic patch placement form revealed resident 1's form for his Buprenorphine TD patch had areas the placement had not been signed off as verified. 6. Interview on 1/22/25 at 2:30 PM with LPN C regarding resident 1's TD patch revealed: *Before she left her shift on 1/10/25 resident 1's TD patch had not been delivered from the pharmacy. - Pharmacy had said the TD patch was ordered Wednesday and should be delivered 1/10/25. -She reported to oncoming LPN E and instructed him to put the TD patch on resident 1 when it came in. -It was reported to her when she came to work 1/12/25 that the patch had been delivered on	F 684		

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F 684	Continued From page 3 1/11/25. -Resident 1's TD patch was signed out on 1/11/25 Saturday night at 3:00 p.m. as placed on the residents skin. *LPN C stated medications were ordered from the label they pulled from the medication label on the narcotic count sheet. That label was faxed to the pharmacy. *The pharmacy would send a response back as "complete" if they received it. If the fax return sheet indicated "no response" that meant the pharmacy had not received the reorder request for the medication. 7. Interview on 1/22/25 at 2:35 p.m. CCL D regarding resident 1's TD patches revealed: *She stated transdermal patches had four refills and would automatically go to the doctor for renewal and doctor signature. -Pharmacy would receive those orders, fill the order and send the medications to the facility *Resident 1's order needed to be signed by the doctor on Friday 1/10/25 the day the patch was due. *The order did not get filled until Saturday 1/ 11/25 in the morning and delivered in the afternoon. *When the order came in the nurse put the patch on resident 1. 8. Interview on 1/22/25 at 1:33 p.m. with administrator A regarding resident 1's TD patch and hospital visit revealed: *He had been positive for kidney stones and bacteria in his urine. *There had been communication on 1/10/25 questioning that resident 1 had a UTI and were waiting for more results. *Resident 1 had white blood cells in his urine, and he was ordered Keflex at the hospital.	F 684		

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F 684	Continued From page 4 *Resident 1's daughter stated the signs and symptoms of altered mental status were the same symptoms that he had in the past with his urinary tract infections that often had required hospitalization. 9. Interview on 1/22/25 at 2:30 p.m. with licensed practical nurse (LPN) E regarding the incident of two Buprenorphine TD patches found on resident 1 at the hospital revealed: *He remembered hearing that a patch had not come in and when it did come in it was to be put it on the resident right away. *He normally worked the 2-10 p.m. shift. *If a patch was not available, he would fax the pharmacy or call the pharmacy. -Pharmacy delivered between 7:00 p.m. and 7:30 p.m. Monday through Friday. *He stated pharmacy would deliver on Saturdays but not on Sundays. - He would get the medications he needed from the pharmacy deliverd medications and check- in the rest later when he had time. *If a medication not available, he would sign not available on the MAR. *He stated that on 1/11/25 when the patch was delivered he put the patch on resident 1. *He thought it was a new order and there was none available per the report he had received. *He stated there was no form in the book to see where the last patch would have been placed on resident 1. *He applied the Buprenorphine patch on resident 1 but did not check if he had an old patch on his skin. *He stated a couple of days later resident 1 went to the hospital. *LPN E stated he had applied TD patches on residents but not for resident 1 generally.	F 684		

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F 684	Continued From page 5 - He said he liked to try to get them done before residents went to bed and were asleep so he didn't have to wake them up or bother them. *He had been educated on the safeguards for patches, to sign on the MAR for the placement and removal of the old patch which was new process. 10. Interview on 1/23/25 at. 8:20 a.m. with registered nurse (RN) F revealed: *Had worked at the facility since 1/9/25. *Stated the clinical nurse manager advised RN F to call the daughter. *Stated TD patches were to be changed per the doctor's order. -Remove the old patch and destroyed it with a 2nd nurse, applied the new patch on a different site. *Thought the resident had signs and symptoms of a UTI when he was sent out to the hospital. *Buprenorphine TD patches came in their own box and each box had their own count and placement forms . -Stated the old forms would be pulled out of the book and replaced with the new ones. *Stated there had not been any new education since that incident and was not aware of a different process. 11. Observation and Interview on 1/23/25 at 8:14 a.m. with LPN C regarding resident 1's Buprenorphine patch placement revealed: * He was to receive 15 micrograms per hour (mcg/hour) every week on Thursdays on the a.m. shift. *The hospital had a 10 and 5 mcg/hour patches, so they put one on each of resident 1's arms *At 8:22 AM she went to resident 1's room to apply a new patch for resident 1 for the surveyor	F 684		

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F 684	Continued From page 6 to observe. -Resident 1 was in his wheelchair in his room, he appeared sleepy but would open his eyes occasionally when spoken to. -She stated those were the same symptoms he had the day he went out to the hospital. *His vital signs were taken and were within normal limits, his blood sugar was 129. *She removed the patches that the hospital had placed on him: - The patch removed from his left arm was 5 micrograms and the patch removed from the right arm was a 10 micrograms. -She stated that was the doses the hospital had versus one patch of 15 micrograms. *These patches were destroyed with CCL D. *She did not place the new one patch on resident 1 because she was going to call to the doctor. -She stated resident 1's nurse practitioner was coming in to see him for normal rounds that morning and would see the resident in person and labs had been ordered. -This did not occur before the end of survey. 12. Interview on 1/23/25 5 at 8:47 a.m. with director of nursing service (DNS) B revealed: *She sent the report into the SD DOH concerning the patch incident that involved resident 1. *They had not been concerned because he had a history of UTI'S and he had the symptoms his daughter had explained that he would have when he had a UTI. *She stated she talked to the nurse at the hospital about the 2 patches and that the doctor had suspected they had cause his altered mental status. *She stated his labs were pending but the urine drug analysis screen came back negative, and she was to call back the next day.	F 684		

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F 684	Continued From page 7 *She called back the next day but he was being discharged back to the facility. *She stated she had wanted to explain to the hospitalist to have the doctor further investigate because the first patch went on 1/3/25 and the dose on 1/10/25 was a missed dose. -The second patch was applied on 1/11/25 and the duration of the medication was five days. *The resident was sent back with a Keflex antibiotic order for UTI. *She stated the symptoms that resident 1 had during this survey were the same symptoms that he would have with UTIs. *She had spoken with LPN E about the patches. *She stated there was now an apply and a remove area to sign off on for the nurses in the MAR. *She reiterated that the drug screen was negative, but they did not run the specific drug screen for that particular synthetic Buprenorphine at the hospital. *She stated that they were considering revising the forms and the new patch process for removal and applying patches with signatures by the nurses. *She expected the forms the nurse signed out for placement of the TD patches would not be removeed from the book until new ones had been placed in the book for new orders. *She stated that she had educated the LPN who placed the 2nd patch but not for all staff regarding the new process of the forms for removal and applying TD patches. -She had contacted their education specialist to get the education set up for all staff but did not have the date when this would occur. 13. Interview on 1/32/25 at 9:30 a.m. with LPN G regarding transdermal medication patches for	F 684		

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F 684	Continued From page 8 resident revealed: *She knew she had to take a patch off before putting another patch on and to check if they had a patch on. *She did not remember any new education or of a new process for the signing removal or application of transdermal medication patches. 14. Interview on 1/23/25 at 9:58 a.m. with administrator A regarding the transdermal patch policy and education revealed: *She did not have a more updated transdermal patch policy since 11/25/24. *She did not think a change in policy was needed because it was the ordering process that was updated. -Her nurses knew of the new process and should have known the process because the orders had the removal and apply information on them. *She stated more education was not needed because it was just adding the signature for the removal but again reiterated that the removal was part of the doctor's orders for the transdermal patches. 15. Review of the provider6's medication transdermal patch application and disposal policy dated 11/25/24 revealed: *"Purpose, to administer medication as ordered." *"Procedure 13. b. Fentanyl and other controlled medication patches - Disposal should be documented on the Individual Resident's Narcotic Record ..."	F 684		