STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 6/11/24 through 6/13/24. Good Samaritan Society Sioux Falls Center was found not in compliance with the following requirements: F761, F800, F812, and F880 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/11/24 through 6/13/24. The areas surveyed were resident rights, quality of care, and abuse. Good Samaritan Society Sioux Falls Center 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 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of	F 761	All expired medication bottles were removed immediately from the medication carts when identified on 6/13/24 and discarded. All residents have the potential to be affected by the deficient practice. To ensure that deficient practice does not recur, on 6-14-24, a full sweep of the med carts and med storage room was completed by DNS. All medications were found to be in compliance. Weekly medication checks assigned to night shift nursing to ensure medications are removed if expired. All nurses and CMAs were educated by DNS on 7-3-24 on medication removal process and compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 7/5/2024

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 761	Continued From page 1 the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure seven bottles of one bulk medication that was expired were appropriately discarded. Findings include. 1. Observation and interview on 6/13/24 at 8:00 a.m. of the medication cart for the city view residents and the second-floor medication storeroom with certified medication aide's (CMA) I revealed: *CMA I confirmed the hand written dates on the medication bottles indicated the dates the bottles were opened to administer to the residents. *There were three bottles of aspirin 325 milligrams (mg) in the medication cart, two of the three bottles were expired. One on 2/2024 (February) and one on 1/2024 (January). *CMA J stated all medications should be checked for the date they were opened and the date they would expire before administering the medications to the residents. *The storeroom cupboard on the second floor had eleven bottles of chewable aspirin 81 mg. *Four of the eleven chewable aspirins expired on 5/2024 (May). *CMA J stated, expired medications should be removed from the carts and everyone who administered medications was responsible for that. Interview on 6/13/24 at 9:00 with director of	F 761	To monitor compliance, DNS or designee will complete routine audits to ensure no medication is expired for weekly x 4, monthly x2 and quarterly x1. Monitoring results will be reported by administrator, DON, and/or designee to the QAPI committee and continued until the facility demonstrates substantial compliance as determined by committee. Substantial compliance will be achieved on 7-8-24.	7/8/2024

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F 761	Continued From page 2 nursing B revealed: *She stated she was frustrated she missed these medications because she went through the stock medications monthly in the carts and storeroom cupboard and removed those that were close to their expired dates. *She stated everyone who administered medications is responsible for checking expiration dates before administering them to the residents. Review of the provider's 3/29/24 medication receiving, dispensing, and storage policy revealed: *"6. The location will routinely check for expired medications and necessary disposal will be done in accordance with state/pharmacy regulations." *"11. All the medications (including medication samples or other medications dispensed by the physician) are packaged in accordance with the location dispensing system and state pharmacy rules. These medications must be labeled according to state pharmacy regulations. Cautionary and accessory instructions, as well as the expiration date, will be included. New labels will be applied by the pharmacist or the pharmacist's agent as needed."	F 761		
F 800 SS=D	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider	F 800	Resident 33: On 6/11, resident did not receive chicken strips as requested on meal order form. Dining Director spoke with resident immediately when brought to their attention, corrected, and in-serviced dining staff member after meal service on meal substitution policy & procedure. All dietary staff and CNAs educated on providing food items timely to the residents upon request by DNS and dietary manager on 6/29/2024. Brown sugar and	

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F 800	Continued From page 3 failed to have available, prepare, and serve, resident preferred and selected menu items requested by four of four sampled residents (33, 46, 71, and 335) for two of two observed meals (breakfast and noon). Findings include: 1. Interview on 6/11/24 at 11:45 a.m. with resident 335 revealed: *She state she was supposed to be on a heart-healthy diet. She was not sure if what she received for meals were "heart healthy." *She had received macaroni and cheese, pork and beans, a bun, and dessert for the evening meal on 6/10/24. She did not think this was a heart-healthy meal. *She felt staff did not want to go upstairs to the main kitchen to get things that were forgotten and stated they often did not have ketchup available. 2. Observation and interview on 6/11/24 from 12:10 p.m. to 1:00 p.m. with certified nursing assistant (CNA) O and dietary server H in the Sunrise Suites dining room revealed: *All residents received the same meal. *The meal included: Asian braised beef, fried rice, braised cabbage, and lemon poppyseed bread. *When asked how they ensured each resident received the correct diet CNA O removed dietary cards from an open area to the left side of the serving counter. *There were cards for each resident that included the residents name, diet ordered, food likes, and food dislikes. *They both stated the dietary cards were not used and the residents received the same meal or an alternative if they had requested one. 3. Observation and Interview on 6/11/24 at 12:24	F 800	supplemental menu items such as additional snacks and condiments are provided in the sunrise suites rehab dining room for timely use upon request. Staff was identified not utilizing meal cards during meal service on 6/11 & 6/12. In-services were conducted with dining staff on 6/13, 6/22, and 6/29 to review policy and meal serving procedures. All residents have the potential to be affected by the deficient practice. Corrective action/training will be addressed with all dining staff members. Dining Management will train staff using our training materials as well as on the job visual training. New staff will have the same training upon onboarding/first day training. All staff will revisit the protocol quarterly within the year minimum. Staff will be monitored by management to ensure that meal cards are utilized in both dining rooms during every service and substitutions are accommodated accordingly & correctly. All initial in-services (meal card policy and substitution/short order policy) will be completed with 100% of dining staff by 7/5/24. Should an employee be out on LOA or miss training, they will not be allowed on shift until completed. Inservice 100% of the dining staff & cna staff on meal card policy by 7/5/24. Begin a management or "dining room quarterback" rotation of meal service oversight in the Sunrise Suites starting 7/8/24 to ensure meal card compliance.	

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F 800	Continued From page 4 p.m. with resident 33 revealed: *He had ordered chicken strips, fries, and coleslaw. He was served the braised beef, fried rice, and braised cabbage. He told dietary server H he was not going to eat that. Dietary server told him they did not have what he had ordered, and they were out of chicken strips. *Resident 33 stated no staff had informed him prior to the meal of not having chicken strips. He was not offered any substitute. *Neither dietary server H and CNA O offered to go to the kitchen to get an acceptable substitute for him. *Resident 33 stated "Forget it, I'll go and talk with [name of dietary director K]. *He then aggressively left the dining room in his electric wheelchair. 4. Interview on 6/11/24 at 12:26 p.m. with dietary server H and CNA O revealed: *They usually did not know before a meal if a resident had requested a substitute. *They did not know what was not available. *They were not sure if anybody visited with the residents if the substitute ordered was not available. 5. Observation and interview on 6/12/24 from 8:00 a.m. through 9:00 a.m. with dietary server H in the Sunrise Suites dining room revealed: *The food from the kitchen was brought to the dining room at 8:04 a.m. *There was no staff in the dining room at that time. The first resident served breakfast at 8:21 a.m. *Dietary server H did not refer to the dietary cards. *The menu had the following food items listed: orange juice, fresh fruit cup, oatmeal, cheese	F 800	Inservice 100% of the dining staff & cna staff on substitution & short order policy by 7/5/24 to ensure company & regulatory compliance. Monitor process for the system change including frequency and person responsible: Director of Dietary or designee will complete audits on ensure that meal cards are utilized in both dining rooms during every service and substitutions are accommodated accordingly & correctly for 2 x week for 4 weeks, 1 x for 4 weeks, and 1 x monthly for 3 months with all audits taken to QAPI monthly until the facility demonstrates sustained compliance as determined by the committee. Substantial compliance will be achieved on 7/8/2024.	7/8/2024

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F 800	Continued From page 5	F 800		

strata, bacon, and whole wheat toast.
*The meal that was served included: oatmeal, cheese strata, sausage patty, and french toast sticks.
*There was no fruit cup or whole wheat toast.
*Each resident was offered coffee and apple, orange, or cranberry juice.
*No condiments such as syrup, brown sugar, or milk were offered.
*At 8:30 a.m. CNA G went upstairs to the main kitchen to get the brown sugar residents 46 and 335 had asked for.
*At 8:35 a.m. dietary server H had dished residents 33 and 71's food onto plates and covered them the plates.
*At 8:39 a.m. residents 33 and 71 had not received their breakfasts as there were no staff to serve them. They were complaining the were hungry.
*Interview at 8:45 a.m. with dietary server H regarding the observed meal service revealed he:
-Dished the residents' meals when there were no staff present to serve them because he was not allowed to serve the meals to the residents.
*Was not able to answer why the condiments were not available in the dining room at the time the meal was served.
*Stated he "supposed he could" have called the main kitchen for additional requested or needed food items. he stated he*Between 8:35 a.m. and 8:55 a.m. he had dished other residents' breakfasts who had entered the dining room
*At 8:55 a.m. CNA R entered into the dining room. The dished meals had remained on the tray line counter until that time. CNA R had to reheat the meals for each resident.
*At 9:05 a.m. CNA G returned to the dining room. She stated she had not been able to go to the main kitchen to bring any brown sugar for

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F 800	Continued From page 6 residents 46 and 335. She stated she had helped another resident get ready for the day.	F 800		
F 812 SS=F	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 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, and policy review, the provider failed to ensure: *Food items were appropriately labeled and stored in one of one observed walk-in cooler in one of one kitchen. *The minimum water temperature of the dishwashing machine was used for the cleaning and disinfecting of dishes. *Food was prepared and served in a safe and sanitary manner by two of two dietary staff (dietary director K and cook M) who did not perform appropriate hand hygiene during one of	F 812	No specific residents affected but all residents have the potential to be affected by the deficient practice. Items in walk-in cooler were identified as being out-of-date/expired and missing daymarking label. Items discarded immediately and staff were in-serviced on 6/11, 6/12, and 6/22. Dishmachine temperature policy/procedure was identified as being missing on 6/11. Procedure posted on 6/11 and dining staff were in-serviced on 6/11, 6/12, and 6/22. Improper hand hygiene was observed 6/11 and 6/12. Both dining employees were in-serviced immediately and all dining staff were in-serviced 6/11, 6/12, and 6/22. Corrective action/training will be addressed with all dining staff members. Dining Management will train staff using our training materials as well as on the job visual training. New staff will have the same training upon onboarding/first day training. All staff will revisit the protocol quarterly within the year minimum. Staff will be monitored by management to ensure that labeling/dating/expired food policy, dishwasher policy & procedure, and proper hand hygiene policy & procedure are followed daily. Management team will be responsible for audits of staff	

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F 812	Continued From page 7 one observed meal service. Findings include: 1. Observation on 6/11/24 at 8:01 a.m. of the kitchen revealed: *Metal storage shelves in the walk-in cooler which contained the following food items: -One opened bottle of Mayonnaise with no open, or discard date, or printed use by date. -An opened bottle of BBQ sauce with an open date of 2/1/24 and a discard date of 4/1/24. -An opened bottle of Dijon mustard with an open date of 4/3/24 and a discard date of 6/2/24. -An opened bottle of coleslaw dressing bottle with "6/4" written on the top of it with no discard date on it. -There was an opened bottle of balsamic vinegar with no open or discard dates. -A container marked "tuna salad" with "open 6/9 and discard 6/11" written on it. -An opened whipped topping piping bag with an exposed tip and no open or discard date on it. -An opened bag of crumbled blue cheese with no open or discard date on it. 2. Observation on 6/12/24 at 8:06 a.m. and 2:59 p.m. of the kitchen walk-in cooler revealed: *There was an opened half-full milk with no open or discard date on it. *An open cardboard container of heavy whipping cream with no open or discard dates on it. 3. Observation on 6/11/24 at 8:20 a.m. and 11:10 a.m. of the kitchen's dishwashing machine and temperature documentation revealed: *The dishwasher utilized a low temperature wash and a chemical sanitizing process. *The manufacturer's information plate on the front of the dishwasher indicated the minimum wash	F 812	members to ensure that federal & state regulatory compliance is met. 1.) Inservice 100% of the dining staff on labeling/dating/expired food policy by 7/5/24 to ensure company & regulatory compliance 2.) Inservice 100% of the dining staff on dishwasher policy & procedure (including minimum water temperature for cleaning and disinfecting dishes in the dish machine and appropriate manner on obtaining temperature as the dish machine cycles). By 7/5/24 to ensure company & regulatory compliance 3.) Inservice 100% of the dining staff on proper hand hygiene and glove use when preparing and serving meals policy & procedure by 7/5/24 to ensure company & regulatory compliance. All initial in-services (labeling/dating/ expired foods policy, dishmachine policy, and hand hygiene policy) will be completed with 100% of dining staff by 7/5/24. Should an employee be out on LOA or miss in-services, they will not be allowed on shift until completed. Audit labeling/dating/expired food policy compliance 5 times per week for two weeks with the CCL Food Safety & Sanitation Quick Pulse audit. After two weeks, audit labeling/dating/expired food policy compliance 3 times a week for one month and then twice-a-week as a standing audit	

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F 812	Continued From page 8 and rinse temperatures were to have been 120 degrees F. *The posted June dishwashing machine log on the dishwasher revealed: -"Wash Temp: 120 degrees [F]." -Temperatures on the log ranged from 120 to 150 degrees F. -No dishwasher temperatures were documented on that log for 6/9/24, 6/10/24 or 6/11/24 for any meal services. *At 11:10 a.m. temperatures were noted to have been added to the log for 6/9/24, 6/10/24 and 6/11/24. 4. Observation, testing, and interview on 6/11/24 from 11:37 a.m. through 11:55 a.m. with dietary assistants (DA) N and dietary server (DS) H revealed: *DS H put the breakfast dishes in the dishwasher to complete a dishwashing cycle. *DA N placed the digital thermometer in the protruding drain on the outside of the machine giving a temperature of 113 degrees F. *DS H plunged the digital thermometer into the liquid that was still in the dishwasher after a washing cycle was completed. *Neither was sure if there was a policy on how to obtain the temperature of the dishwasher. *Temperatures of the dishwasher via a digital holding thermometer was placed inside the dishwasher on a dish rack that indicated: -At 11:45 a.m. the wash cycle was 113 degrees F. -At 11:50 a.m. the wash cycle was 116 degrees F. -At 11:55 a.m. the wash cycle was 120 degrees F. 5. Observation and interview on 6/11/24 at 8:21 a.m. with dietary director K revealed: *She wore gloves while cracking and handling eggs and used egg shells.	F 812	Audit compliance of dishwasher policy & procedure 5 times per week for two weeks using the CCL Focus Checklist – Dish and Ware Washing Area audit. After two weeks, audit dishwasher policy & procedure once-a-week in perpetuity to ensure compliance. Audit compliance of proper hand hygiene policy & procedure 5 times per week for two weeks using the CCL Food Safety & Sanitation Quick Pulse and CCL Focus Checklist – Dish and Ware Washing Area audits. After two weeks, audit proper hand hygiene policy & procedure 3 times a week for a month, and the once-weekly in perpetuity to ensure compliance. Substantial compliance will be achieved on 7/8/2024.	7/8/2024

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F 812	Continued From page 9 *While wearing those same gloves she handled resident plates and placed toast on those plates. *She discarded those gloves and did not wash her hands before she put on a new pair of gloves. *She again cracked and handled eggs and egg shells, placed toast on another plate and then served that plated toast to a resident. *She then stated, she should have performed hand hygiene when she changed her glove changes and should not have used the same pair of gloves when she cracked eggs and then touched residents' food items. *She was not sure if there was a policy on when to change gloves. 6. Observation and interview on 6/11/24 at 8:21 a.m. with cook M revealed: *He wore gloves and cracked and handled eggs and egg shells. *With those same gloved hands he picked up a piece of bacon and placed it on a resident's plate. *With those same gloved hands he touched a fried egg and repositioned it on a resident's plate. *He stated that he had only been working at this facility for three days and had never cooked in a nursing home before. *Stated the dietary director said she would train with him. 7. Interview on 6/11/24 at 4:20 p.m. with dietary director K and kitchen general manager L regarding food storage and dishwasher temperature revealed: *They would have expected staff to document the temperatures of the dishwasher on the log. *They were not aware of the expired foods in the cooler. *The walk-in cooler was to have been checked	F 812		

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(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 812	Continued From page 10 daily and weekly for expired items. *They stated that each item in the walk-in cooler should have an open and discard date on it. *They stated each item in the walk-in cooler should have had a sticker with the opened date and the discard date for three days later. *They had asked management for the dishwasher water temperature to be turned up. *They stated the dishwasher would have to have been run five to six times for the temperature to have reached 120 degrees F. *Kitchen general manager L stated he had never seen the temperature for the dishwasher reach 150 degrees F. *They would have expected items in the walk-in cooler to have been labeled with the open and discard dates and the dishes would have been washed in the dishwasher at the proper temperature of 120 degrees F. 8. Review of the provider's January 2024 Food and Supply Storage policy revealed: *"Procedures: -Foods past the "use-by ", "sell-by," best-by," or enjoy-by" date should be discarded. -Cover, label, and date the unused portions and open packages. Complete all sections on a Morrison orange label or use the Medvantage/Freshdate labeling system. Products are good through the close of business on the date noted on the label." *"Refrigerated Storage Life of Foods: -Use manufacturer's expiration date for products before they are opened. If there is no expiration date on the package, add the time listed here to the date the food is received. Add the time in the "opened" column to the date when the food is prepared or opened. Label when product is	F 812		

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	435046	A. BUILDING _____ B. WING _____	C 06/13/2024

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GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

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F 812	Continued From page 11 "opened." 9. Review of the provider's March 2022 Hand Hygiene policy revealed: *"1. Gloves are never to be reused or sanitized. 2. Hand hygiene should be performed after glove removal." 10. Review of the provider's January 2024 Dishmachine Temperatures policy revealed: *"Low Temperature Machine: -Wash Temperature 120 degrees F. *Director: -Confirms the wash and rinse temperatures listed on the manufacturer's data plate on the dishmachine. Modify the dishmachine temperature record as necessary. *Low Temperature dishmachine-record on Dishmachine temperature record form: -Wash temperature during each period of use."	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880	On 6-13-24, proper signage and precautions were put in place for the resident who was diagnosed with active C Diff for Resident #333. All staff responsible for care and cleaning services were educated by DNS on 6-13-24 to ensure proper policy/procedure were being followed once resident diagnosis was identified. All care givers were educated by DNS on 6-13-24 on proper hand hygiene when caring for a resident with an active C Diff diagnosis. LPN F educated on policy and procedure related to glove changes and hand hygiene when checking placement with G tube on 7/1/2024.	

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F 880	Continued From page 12 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the	F 880	All residents have the potential to be affected by the deficient practice. All staff education provided by Clinical Lead Development Specialist on 7-3-24 to ensure appropriate procedure technique is provided when administration of nutritional formula through a gastric tube is completed. All staff education on 7-3-24 also included the reeducation of all staff responsible for care and cleaning services to ensure compliance when providing care for a resident identified with C. Diff. All staff who were not present for the reeducation will be reeducated prior to starting their next scheduled shift. Education completed with resident and family about care and cleaning for C.Diff. Will provide education to any new cases of C.Diff for resident and families. To monitor compliance, DNS or designee will complete routine hand hygiene audits of all residents with gastric tube orders to ensure proper hand hygiene policy/procedure is being followed. DNS or designee will complete random audits over all shifts for 5 residents who are currently on precautions to ensure compliance in policy/procedure. Audits will occur weekly X4, monthly x 2, and quarterly x1. Monitoring results will be reported by administrator, DON, and/or designee to the QAPI committee and continued until the facility demonstrates	

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F 880	Continued From page 13 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure infection control practices had been followed for: *One of two observed administrations of nutritional formula and fluids through a gastric tube (G-tube) feedings for one of one sampled resident (67) by one of two licensed practical nurse (LPN) (F) . *One of one sampled resident (333) tested for signs and symptoms of clostridium difficile (C-Diff) (bacteria that can infect the bowel and cause diarrhea). Findings include: 1. Observation on 6/11/24 at 9:30 a.m. of LPN F during administration of resident 67's nutritional formula and fluids revealed LPN F: *Entered the room and had gloves and a gown on. *Had two unopened 500 cubic centimeter (cc) bottles of sterile water, a 60 cc tube feeding syringe, and an enteral (intestinal) nutrition feeding bag. *Opened the doors to the room and bathroom and filled two eight-ounce glasses with water from the bathroom sink with those same gloved hands. *Placed the syringe on the overbed table without	F 880	substantial compliance as determined by committee. Substantial compliance will be achieved on 7-8-24.	7/8/2024

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F 880	Continued From page 14	F 880		

sanitizing the surface of the table or placing a barrier on it.
*Entered the bathroom a second time and retrieved several paper towels.
*Lifted resident 67's shirt, unwrapped his abdominal binder, and took his G-tube out from under the binder.
*Placed the paper towels under the end of his G-tube.
*Moved a folding chair closer to sit on.
*Wiped the end of the G-tube with alcohol.
*Opened the door, took keys out of her pocket, and retrieved a different feeding syringe from the medication cart, all with those same gloved hands.
*Removed the glove from her right hand, and without washing her hand, retrieved a new glove from the same pocket her keys were in and put that new glove on her unclean right hand.
*Filled the syringe with water and administered 300 cc of water through the G-tube in 60 cc increments.
*Opened the two bottles of the nutritional formula and poured then into the G-tube feeding bag.
*Placed the bag on the pole and primed the tubing, connected the tubing to the G-tube, and started the gravity flow of nutritional formula.
*Collected the garbage.
*Went into the bathroom, removed her gloves, and washed her hands for approximately 10 seconds.
*Came out of the bathroom and removed her gown, and left the room.

Interview on 6/12/24 at 10:00 a.m. with LPN F confirmed she:
*Should have checked for placement of the G-tube prior to starting the water administration.
*Had not changed her gloves between tasks,

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F 880	Continued From page 15 such as going out to the medication cart and moving the folding chair. *Should have put down a barrier on the overbed table before placing the tube feeding supplies on it. *Should not keep extra gloves in her uniform pocket with the keys and pen she used frequently. 2. Observation on 6/11/24 at 9:00 a.m. of resident 333's door revealed no signage had been placed after a physician's order had been received for precautions for C-Diff. Random observations on 6/11/24 from 1:00 p.m. through 5:00 p.m. revealed no contact precaution signage had been placed on resident 333's door. There were no specific trash or laundry bins in his room. 3. Interview on 6/12/24 at 9:00 a.m. with registered nurse T regarding resident 333 revealed she was not aware he had been tested for C-Diff on 6/11/24. She was not aware of what type of hand hygiene or cleaning products were to have been used when a resident had tested positive for C-Diff. 4. Interview on 6/12/24 at 10:29 a.m. with resident 333 revealed: *He had a colostomy that he cared for himself, which included emptying the bag and changing the appliance that holds the bag. *He had not been feeling well with abdominal cramps and his bowel movements had been very foul-smelling. *He was not aware the physician had ordered a test for C-Diff. *He had not been educated on what C-Diff was or	F 880		

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F 880	Continued From page 16 what type of precautions should have been started. 5. Random observations on 6/12/24 from 8:00 a.m. through 5:00 p.m. revealed no contact precaution signage had been placed on resident 333's door. There were no specific trash or laundry bins in his room. 6. Interview on 6/13/24 at 9:42 a.m. with laundry technician P regarding what would be done if a resident had C-diff revealed she explained all the proper steps to avoid cross-contamination. She had not been informed resident 333 had been tested for C-Diff. 7. Interview on 6/13/24 at 10:17 a.m. with LPN Q regarding resident 333 revealed she was not aware he had been tested for C-Diff. It had not been passed on in shift report. She was not sure what type of precautions should have been put in place. 8. Interview on 6/13/24 at 1:30 p.m. with LPN Q revealed she had read the policy regarding C-Diff precautions. She agreed contact precaution signage should have been put up when he had been tested and he was symptomatic. 9. Interview on 6/13/24 at 2:30 p.m. with environmental services technician S revealed she had not been informed of resident 333's C-Diff. status. She showed the chemicals she would have used to clean the room. It was not a bleach product. She did not know she would have had to clean with a different product. 10. Observation and interview on 6/13/24 at 4:40 p.m. with maintenance supervisor U regarding	F 880		

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F 880	Continued From page 17 what product was used for sanitizing for C-Diff revealed: *The product to have been used was Rapid Multi Surface Disinfectant Cleaner. *This list of organisms it would have been effective against did not include C. Diff. *He stated the supplier had told him it was effective against C.Diff. 11. Interview on 6/13/24 at 5:00 p.m. with DON B confirmed contact precautions should have been initiated when an order for testing C. Diff had been received for resident 333. 12. Review of the provider's 5/3/23 Clostridium Difficle policy revealed: *When C. Diff infection was identified all department directors were to have been informed. *Contact precautions for residents with known or suspected C.Diff. *Gown and gloves would be worn prior to entering the room and removed before exiting the room. *Hand hygiene with soap and water would have been performed after removing gloves. *Cleaning of any shared medical equipment with appropriate sporicidal disinfectant or bleach solution would have been performed. *The resident's hand would been washed frequently with soap and water. 13. Review of the provider's 4/2/24 Standard and Transmission Based Precautions policy for contact precautions revealed: *Clear signage on the door or wall outside the resident room indicated the type of precautions and personal protection equipment (PPE) to have been used. *Soap and water for hand hygiene when in the	F 880		

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F 880	Continued From page 18 room and when leaving the room. *Linen was to have been placed in a bag linen prior before it was removed from the room. *Disposable resident care equipment was to have been used.	F 880		

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	435046	A. BUILDING 02 - BUILDING 02 - 1965, 1972, AND 2000 ADDITION B. WING _____	06/12/2024

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted 6/11/24 through 6/12/24. Good Samaritan Society Sioux Falls Center Building 2 was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K222, K241, and K325 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 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.	
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the	K 222	It is the policy of the facility to assure all egress doors and delayed egress are fully functional per NFPA requirements and accept this facility credible allocation of compliance and correct citation of K222. The Environmental Services manager adjusted first floor east exit door was fixed 6/13/2024. The upper dining room exit door was fixed 6/14/2024 to ensure the audible signal and release after 15 seconds and meg lock operate within NFPA standards by 6/13/2024. The Environmental Services manager or designee will adjust the egress operations of the exterior exit door for the upper-level dining room to ensure the audible signal operates within NFPA standards by 7/5/2024.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 7/5/2024

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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	435046	A. BUILDING **02 - BUILDING 02 - 1965, 1972, AND 2000 ADDITION** B. WING _____	**06/12/2024**

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K 222	Continued From page 1 Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by:	K 222	All residents have the potential to be affected by the deficient practice. Educate maintenance on ensuring all egress doors release after 15 seconds, and have audible signal, was completed on 7/5/2024. Administrator will be monitoring the completion of education with new hires and annually or as needed for maintenance staff. Maintenance or designee will complete random audits on ensuring all egress doors release after 15 seconds, have audible signal, and operate by opening. Audits will be completed for 2 x week for 4 weeks, 1 x for 4 weeks, and 1 x monthly for 3 months with all audits taken to QAPI monthly. Substantial compliance will be achieved on 7/5/2024.	7/8/2024

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K 222	Continued From page 2 Based on observation, testing, and interview, the provider failed to provide egress doors as required at two of five locations (Building 2, first floor east exit and upper dining room exit). Findings include: 1. Observation on 6/11/24 at 8:45 a.m. revealed the east exterior exit door for the rehabilitation wing was equipped with magnetic lock hardware that prevented egress. The door was labeled as a delayed egress locked door. Testing of the door by applying force in the direction of the path of egress revealed the audible signal would not sound. The door did not release after fifteen seconds. 2. Observation on 6/11/24 at 10:45 a.m. revealed the exterior exit door for upper level dining room was equipped with magnetic lock hardware that prevented egress. The door was labeled as a delayed egress locked door. Testing of the door by applying force in the direction of the path of egress revealed the audible signal would not sound. The door released after fifteen seconds, but because the alarm did not sound a user would not know it was functional. Interview at the time of the observation with the maintenance supervisor confirmed that condition. He stated the quote for system repair was $185,000 and it had not been approved. Failure to provide egress doors as required increases the risk of death or injury due to fire. The deficiency affected one of five exit doors. Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6.2(3)(a)	K 222		

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(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
K 241 SS=F	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced by: Based on observation and testing the provider failed to maintain conforming exits from each floor level of Building 2. The first floor had only one functioning exit. Findings include: 1. Observation on 6/11/24 at 8:45 a.m. revealed the east exit at the north end of Building 2 (the rehabilitation wing) did not open. The metal door was firmly wedged shut. A second maintenance staff person was called, and with those two pushing on the door it was able to be operated. Further attempts to operate the door demonstrated a return to the original nonfunctional condition. A fire watch was put in place by the maintenance supervisor in conjunction with the administrator until mechanical grinding could occur. This deficiency would affect any of the residents and staff within first floor Building 2. Further observation on 6/12/24 at 10:15 a.m. verified the correct operation of the exit door.	K 241	It is the policy of the facility to assure all egress doors and delayed egress are fully functional per NFPA requirements and accept this facility credible allocation of compliance and correct citation of K241. East exit at the north end of building 2 door was adjusted to properly open was fixed on 6/12/2024. All residents have the potential to be affected by the deficient practice. Measures put into place or systemic changes made to ensure that will not recur include education provided to maintenance employees on 7/3/2024 on ensuring all exit doors will properly open. Administrator will be monitoring the completion of education with new hires and annually or as needed for maintenance staff. Maintenance director or designee will complete random audits on ensuring that exit doors will open properly. Audits will be completed for 2 x week for 4 weeks, 1 x for 4 weeks, and 1 x monthly for 3 months with all audits taken to QAPI monthly. Substantial compliance will be achieved by 7/5/2024.	7/8/2024
K 325 SS=D	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101	K 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING 02 - BUILDING 02 - 1965, 1972, AND 2000 ADDITION B. WING	06/12/2024

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GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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
K 325	Continued From page 4 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to properly limit the quantity of alcohol based hand rub (ABHR) in storage in the first floor supply room in Building 2. Findings include: 1. Observation on 6/11/24 at 9:10 a.m. revealed the first floor supply room in Building 2 had 131 twelve-ounce hand pump containers of ABHR stored. Requirements for quantities are found in the Life Safety Code, as well as the Flammable Liquids Code. Five gallons is the maximum quantity allowed in storage per smoke	K 325	Alcohol based hand rub was removed from first floor supply room on 6/12/2024. All supply rooms in the facility were checked to ensure proper amount of ABHR were stored. All residents have the potential to be affected by the deficient practice. Education proved to maintenance, laundry and housekeeping departments on ensuring the proper amount of ABHR are stored in supply rooms was completed on 6/14/2024. The administrator will be monitoring the completion of education with new hires and annually or as needed for maintenance, housekeeping and laundry staff. Maintenance or designee will complete random audits on ensuring supply rooms have adequate storage levels for ABHR. Audits will be completed for 2 x week for 4 weeks, 1 x for 4 weeks, and 1 x monthly for 3 months with all audits taken to QAPI monthly. Substantial compliance will be achieved by 7/5/2024.	7/8/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING 02 - BUILDING 02 - 1965, 1972, AND 2000 ADDITION B. WING _____	06/12/2024

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K 325	Continued From page 5 compartment and the amount stored in this room was approximately twelve gallons. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He said a recent shipment of back-ordered quantities was the reason for the overage. The deficiency affected one of numerous requirements for ABHR use and could affect 100 percent of the occupants of the smoke zone.	K 325		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

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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 from 6/11/24 through 6/12/24. Good Samaritan Society Sioux Falls Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 7/5/2024

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	**401 WEST SECOND STREET SIOUX FALLS, SD 57104**

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 6/11/24. Good Samaritan Society Sioux Falls Center Building 1 was found in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 7/5/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10679	A. BUILDING: _____ B. WING _____	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 W 2ND ST SIOUX FALLS, SD 57104

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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 6/11/24 through 6/13/24. Good Samaritan Society Sioux Falls Center 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 6/11/24 through 6/13/24. Good Samaritan Society Sioux Falls Center was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 7/5/2024