STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/22/25 through 7/23/25. The area surveyed was quality of care related to not providing a physician-ordered treatment for a resident. Good Samaritan Society Luther Manor was found not in compliance with the following requirement: F684.	F0000		
F0684 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), record review, interview, and policy review, the provider failed to administer a physician-ordered BiPAP (a device that delivers pressurized air through a specialized mask to assist with breathing) for one of one sampled resident who was lethargic and unresponsive the following morning and was transferred to the hospital. Findings include: 1.Review of the providers 7/7/25 SD DOH FRI revealed: *Resident 1 was a full code and found not responsive to verbal commands and sent to the hospital on 7/3/25. * Resident 1's diagnoses upon admission to long term care on 7/2/25 were: *Included acute respiratory failure (problems with breathing) with hypercapnia (too much carbon dioxide in the bloodstream) and hypoxia (low levels of oxygen),	F0684	1.Resident 1 is no longer a resident at the facility. A report in Point Clinck Care will be ran weekly acknowledging CPAP and BiPAP orders to identify all other residents that may potentially be affected by this plan of correction. 2.All nursing staff will be educated by the Director of Nursing(DON) or designee on CPAP BiPAP orders and the need for them to be specific in the resident chart. MAR/TAR documentation will reflect that the resident has worn the equipment as ordered or refusal will be documented along with a progress note to support. The Non-Invasive Respiratory-R/S, LTC Policy, and Quality of Care Power Point education will occur by 8/15/2015. Those not in attendance due to illness, vacation, or casual work status will be educated upon return to work during their next scheduled shift. 3. The DON or designee will monitor all new admission orders to verify if any new residents have orders for CPAP or BiPAP to ensure orders have been entered apporpriately and are on the MAR/TAR appropriately. The DON or designee will audit 5 random residents that have CPAP or BiPAP orders to ensure that they are consistently wearing their CPAP or BiPAP per provider orders.	8/15/2025

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	8/13/2025

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F0684 SS = D	Continued from page 1 chronic fatigue (low energy), and hypertension (high blood pressure). *She had a full code status (wishes to receive life-sustaining measures) with CPR (cardiopulmonary resuscitation) to be administered. *She had gone to the hospital on 6/9/25 and again on 7/3/25 for similar symptoms. *Resident 1's 7/3/35 hospitalization admitting diagnoses were, CIPD (chronic inflammatory demyelinating polyneuropathy) (disorder affecting the peripheral nerves that may cause loss of strength and sensation), hypertension, Acute respiratory failure with hypoxia and hypercapnia and paroxysmal atrial fibrillation (irregular heart rate). *The BiPAP machine was not put on resident 1 the night 7/2/25 prior to that incident. *She had a Brief Interview for Mental Status) (BIMS) of 15 (which indicated her cognition was intact and she had the ability to ask for her BiPAP. *Resident 1's baseline oxygen was delivered at 2 lpm (oxygen flow rate two liters per minute) via NC (nasal canula, tubing with nasal prongs). *Resident 1's oxygen saturation (oxygen level in the blood) was 98 percent. *Resident 1 had a doctor's order for oxygen (O2) to be delivered at a rate of 2L (liters) to titrate (measure and adjust) to keep her O2 saturation (sat) greater or equal to 90 percent. *Resident 1's family was present at the hospital with her and she had been alert and oriented with some lethargy. They family had decided to stop all treatments and changed her code status to do not resuscitate and do not intubate with palliative and comfort cares started. *Resident 1 passed away in the hospital. 2.Review of resident 1's electronic medical record (EMR) revealed: *A 6/21/25 physicians order for BiPAP by mask at bedtime related to acute respiratory failure with hypercapnia.	F0684	The audits will be done weekly for 4 weeks, Bi-weekly for 1 month, and monthly for 4 months. Results of the audits will be discussed by the DON or designee at the monthly QAPI meeting with the IDT and medical director for analysis and recommendation for continuation, discontinuation or revision of audits based on findings.	

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F0684 SS = D	Continued from page 2 *A 6/29/25 physician's order or O2 at 2L to titrate for O2 sat greater or equal 90 percent every shift related to acute respiratory failure with hypoxia. * She had a BIMS assessment score of 15. *Her treatment administration record (TAR) for the BiPAP treatment did not have a nurse's initials to have indicated the treatment was completed as ordered in the boxes dated 6/24/25, 6/25/25, or 7/2/25. 3.Interview on 7/22/25 at 1:40 p.m. registered nurse (RN) G regarding resident 1 revealed: *She was familiar with that resident 1 and stated that resident 1 had moved from a different wing 7/2/25 and had an order for O2, and an autoimmune disorder that was making her muscles weaker. *RN G had worked the day shift on 7/3/25 when resident 1's episode occurred. *On 7/3/25 at approximately 7:00 a.m. certified nursing assistant (CNA) H had asked her to look in on resident 1 because she was not responding to her like she normally would have. *She stated resident 1 was in bed with the head of the bed elevated at about 30 degrees, she did not answer to her name, she opened her eyes, but did not visually track (follow an object one's eyes as it moves) anything. *RN G asked resident 1 to squeeze her hands and move her toes, but she did not follow that command. *She stated east clinical care leader (ECCL) C had come to the facility and agreed that resident 1 should go to the emergency room. *RN G obtained her vital signs (measurement of the body's basic functions, such as temperature, blood pressure, pulse and respirations). Resident 1's heart rate was elevated, but her other vitals signs were normal at that time. *She stated she had received a physicians order for resident 1 to transfer to the the emergency room. *She had not received verbal report from the night shift nurse regarding resident 1 not using her BIPAP the night before 7/2/25.	F0684		

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F0684 SS = D	Continued from page 3 *She was not aware if resident 1 had refused her BiPAP at any time. *She stated that resident 1 like the nurse to put the BiPAP on her. *She stated resident 1's BiPAP order in the TAR would have turned red, indicating that treatment had not been completed during that shift when it was due, but did not indicate she had checked that at that time. *Resident 1's family were notified. 4. Interview on 7/22/25 at 3:25 p.m. with RN D regarding resident 1 revealed: *Resident 1's BiPAP order was a new from her last hospitalization on 6/9/25 for confused, altered mental status and respiratory distress. *Resident 1 had been very compliant with the BiPAP, and it was important to her. *She stated that when she worked, resident 1 had not refused to wear the BiPAP, had always worn the BiPAP and had needed physical help to put it on. *She stated she would have documented on the TAR either "yes" or "no" in the TAR to have indicated if the BIPAP had been put on resident 1 or not. *She stated that when she documented "yes" in the TAR resident 1's name would have turned green on the computer screen, if she had documented "no" it would have turned red, to indicate the BiPAP was late or not done. *She stated she used those colors to ensure she had not missed any of her assigned residents' treatments when she worked, and that was how she double checked that she had completed and documented the residents' ordered treatments. 5. Interview on 7/23/25 at 9:36 a.m. with licensed practical nurse (LPN) E regarding resident 1's BiPAP the night of 7/2/25 revealed: *She did not put resident 1's BiPAP on her the night of 7/2/25.	F0684		

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F0684 SS = D	Continued from page 4 *She had a very busy shift that night and had been in another hall with a resident with a low blood sugar. *The CNA I had told her that resident 1 would call for her when she wanted the BiPAP put on. *She had not been called in to resident 1's room by the CNA the night of 7/2/25. *LPN E agreed she was responsible for 1's treatments and should have made she had her BiPAP on that night but she didn't. *She stated she could not remember exactly what resident 1's BIPAP order said; she just put it on her at night. *She stated she thought the CNAs could put a BiPAP on the residents but had not put it on resident 1 that night. *She stated she had not received training regarding how to use a BIPAP but had her own personal experience with her own. *She had not gone in resident 1's room that night but she had walked by her room and had visually seen her from the doorway. *She stated the blank on the TAR for resident 1's BIPAP treatment for the night of 7/2/25 indicated she had not put resident 1' BiPAP on her. *She stated she had not reported to the nurse working the next day shift 7/3/25 that she had not put resident 1's BIPAP on her. 6. Interview on 7/23/25 at 10:03 a.m. with ECCL C revealed: *CNAs could apply BiPAP devices and turn them on, but the nurse check that the resident had it on. The facility staff did not change any BiPAP settings which were done by the company who had originally set up that machine. *She was not sure if it was in their policy that a CNA could apply a BiPAP to a resident. *She thought BiPAP training had been part of the CNA onboarding training. *The day of resident 1's episode 7/3/25 episode, she	F0684		

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F0684 SS = D	Continued from page 5 had been asked to go int to her room because she was lethargic but responding. *She stated the doctor and ambulance had been called and resident 1 had been sent out to the emergency room within 20 minutes of her assessment. *She had gone into resident 1's room after she had left for the emergency room to clean it up. *She stated when she was cleaning resident 1's room, the BIPAP mask was on top of he BiPAP machine and the cannister was dry, which indicated it had not been used the night before. *She stated if resident 1 had refused her BiPAP the nurse would have documented "no" in the RAR documentation system, and a progress note would have automatically opened for that nurse to document a reason why the resident refused their BiPAP treatment. *She stated that she was not sure if resident 1 not wearing her BiPAP caused that episode,as she had gone to the hospital before with the same symptoms. *She stated resident 1 had a new diagnosis of autoimmune disorder of CIPD that weakened her muscles, and she had declined quickly. *She stated resident 1 had been started on an immunoglobulin (antibodies that boost the immune system), but resident 1 had stated she felt the medicine was not working. *She stated the facility did not have a process in place for the next shifts nurse to check if things were not done but the nurse should have verbally reported to the oncoming nurse that resident 1 had not had on her BIPAP. 7. Interview on 7/23/25 at 10:34 a.m. with director of nursing B revealed: *She expected the nurse to go into each resident room during their shift and check on each resident. *She expected each nurse to have completed and documented the care and treatments ordered for each resident and to have documented before leaving at the end of their shift. *The CNA had been in resident 1's room the night 7/2/25 to turn and reposition her that night. She felt a CNA could put on a residents BiPAP but no they were not	F0684		

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F0684 SS = D	Continued from page 6 trained to and it was not part of their policy. *She did not think that resident 1 going without her BiPAP the night of 7/2/25 had caused her episode on 7/3/25 because she had gone without out it on 6/24/25 and 6/25/24 and did not have a episode. 8. Interview on 6/22/25 at 3:05 p.m. with certified nursing assistant (CNA) F regarding resident 1 revealed: *She stated she had worked on the focus rehab unit when resident 1 had resided on that unit. *She stated resident 1 would be in her recliner during her shift with her oxygen, on not her BiPAP because she did not go to bed until after 10:00 p.m. *She stated the nurse would have put the BiPAP on resident 1 because she did do that. 9. Review of the provider's "LPN Long Term Care (LTC) Job Description" dated 5/12/25 revealed: *"Essential Functions" *"...Observe patients, document and report changes in patient condition, such as adverse reactions to medication or treatment, and take any necessary action." *"...Promote a safe and therapeutic environment by providing appropriate monitoring and surveillance of the care environment." 10. Review of the provider's policy for "Non-Invasive Respiratory Support-R/S, LTC" dated 10/30/24 revealed: *"...Provide the most effective treatment option for reducing CO2 in hypercapnic COPD patients and those suffering with respiratory insufficiency." *"Policy" *"[BiPAP] - -A term used to refer to a bi-level positive airway pressure. A BiPAP machine is a breathing apparatus that helps its user get more air into the lungs. BiPAP uses variable levels of air pressure instead of continuous pressure."	F0684		

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F0684 SS = D	Continued from page 7 11. Review of the provider's "Legal Documentation Standards-Rehab/Skilled and Assisted Living" policy dated 2/10/25 revealed: *"Completeness" *"Document all facts and pertinent information related to occurrences, course of treatment, resident condition, response to care and deviation from standard treatment (including reason for it). Each entry will be complete and contain all significant information."	F0684		