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 06/18/2025

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

(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 complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/17/25 through 6/18/25. Areas surveyed included resident safety related to falls and potential resident abuse/neglect. Good Samaritan Society Luther Manor was found not in compliance with the following requirements: F684 and F689.	F 000		
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 observation, interview, record review, and policy review, the provider failed to ensure staff followed the care plan regarding the hydration needs for one of two sampled residents (2). Findings include: 1. Observation and interview on 6/18/25 at 8:50 a.m. in resident 2's room with certified medication aide (CMA) G revealed: *Resident 2 was sitting in his wheelchair. *CMA G brought resident 2 his morning pills in a medicine cup with chocolate pudding in it. *He agreed to take his pills. *CMA G administered him the pills with a spoon.	F 684	1. Resident 2's care plan was updated on 6/19/25 to reflect no straws for any liquids or medication pass. Task was initiated on the Kardex so it is visible to all staff. Special instructions section in Point Click Care (PCC) was updated to note: DO NOT USE STRAWS FOR ANY LIQUIDS OR MED PASS. Special instructions appears on the Plan of Care (POC) and Electronic Medication Administration Record (EMAR) for easy to view information for the CNA's (certified nursing assistant), certified medication aide (CMA) and Nurses. Signage was placed in resident room to alert staff and family of No Straw use. All residents are at risk for staff not following their care plan regarding hydration needs of No Straw use. All residents care plans have been reviewed and updated to reflect hydration needs of No Straw use and	7/18/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7/16/25

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 *She gave him a drink of water from his water mug through a straw. *She stated this was the first time she had passed medications in that hallway. 2. Review of resident 2's electronic medical record (EMR) revealed: *He was admitted on 10/9/24. *He had diagnosis of: -Essential (primary) hypertension (high blood pressure). -Cerebral infarction, unspecified. -Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. -Dysphagia following cerebral infarction. *The care plan dated 4/9/25 stated: -"Resident has order for mildly thickened liquids with meals." -"OK for thin liquids in room, NO straws per speech therapy." 3. Interview on 6/18/25 at 1:00 p.m. with dietitian H and dietary manager I regarding resident 2's dietary needs revealed: *He was admitted with an ordered minced and moist therapeutic diet. *The speech therapist upgraded his diet to soft and small bites of food in January 2025. *He was also on the Frazier Free Water Protocol (he needed thickened liquids with food at meals, and thin liquids in his room after oral care was provided). *He was not to use straws to drink liquids. *His care plan stated no straws. *The no straw information had not transferred over to the Kardex (electronic report of residents' care needs) for the front-line caregiver staff to see. *They expected that information to have been on	F 684	needs were triggered to reflect in the Kardex and put under the special instructions. 2. All CMA's, CNA's and nurses will be educated regarding where to find specific information regarding hydration needs such as no straw use in the EMR by the director of nursing (DON) or designee. The education will be completed by 7/18/2025 and those not in attendance at the education session due to vacation, illness or casual work status will be educated upon their return prior to their next scheduled shift. Dietary manager will educate dietary staff no later than 7/18/25 to ensure they are aware of the list of residents that have specific hydration needs of no straw use. 3. The DON or designee will review 5 care plans to ensure resident care plans capture hydration needs of no straw use and those needs are displayed in the Kardex and special instructions. Audits will be weekly for 4 weeks, biweekly for 1 month, and monthly for 4 months. The DON will audit residents with hydration needs monthly to ensure that hydration needs have been reflected in Kardex and special instructions and will	

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F 684	Continued From page 2 the Kardex. 4. Observation on 6/18/25 at 1:20 p.m. in resident 2's room revealed his water mug still had a straw in it. 5. Interview on 6/18/25 at 1:35 p.m. with certified nursing assistant (CNA) J regarding resident water mugs revealed: *The CNAs were responsible for replacing water mugs. *The mugs usually got straws put in them. *She would rely on the Kardex or the dietary staff to know which residents were not allowed to have straws. 6. Interview and record review on 6/18/25 at 2:00 p.m. with registered nurse (RN) K regarding resident 2's hydration status needs revealed: *Resident 2 had a history of a stroke. *He could have thin liquids in his room with no food. *He confirmed resident 2 should not have had a straw in his water mug. *That hydration information was documented in resident 2's care plan. *The information had not been selected in the care plan to be transferred to the Kardex for the front-line caregiver staff to know. 7. Interview on 6/18/25 at 3:05 p.m. with director of nursing (DON) B regarding resident 2's care plan and hydration needs revealed: *She was not aware that he should not have used a straw. *She expected that the information the front-line caregiver staff needed to know to provide the resident's care needs should have been on the Kardex.	F 684	monitor Speech Therapy recommendations via email to ensure that any resident that has special hydration recommendations are communicated with front line staff and that necessary signage is posted in resident room if appropriate. Audits will be conducted monthly for 6 months. The Dietary Manager will create a list for the dietary personnel to reflect who has hydration needs. The DON and Dietary Manager will review lists monthly to ensure lists are correct. Lists will be reviewed monthly for 6 months. 4. 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/revision of audits based on audit findings.	

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F 684	Continued From page 3 *She agreed staff should have marked it in the care plan so it would pull over to the Kardex. 8. Review of the provider's 12/2/24 revised Care Plan policy revealed: *"Residents will receive and be provided with the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment." *"The plan of care will be modified to reflect the care currently required/provided for the resident." *"The care plan will emphasize the care and development of the whole person ensuring that the resident will receive appropriate care and services."	F 684		
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: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), observation, interview, record review, and policy review, the provider failed to implement fall prevention interventions as described in the care plan for one of one (1) resident who fell and sustained injuries that required treatment at an emergency department. Findings include:	F 689	1. Resident 1's silent TABs alarm and Stop wait for assistance signs have been removed from resident room on 7/7/25. Care plan has been reviewed and updated to reflect changes. All residents with a care plan Focus of "The resident has had an actual fall" were reviewed to ensure fall prevention interventions are implemented and communicated to frontline staff. 2. The facility will be TABs alarm free by August 1, 2025. New radios were ordered and received on 7/10/25 and put at the nurse's stations on 7/11/25 for staff use. Purposeful more frequent rounding will be implemented. Purposeful rounding is educated as enter resident rooms	7/18/25

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F 689	Continued From page 4 1. Review of the SD DOH FRI submitted on 2/2/25 at 10:34 a.m. revealed: *On 2/1/25 at 10:20 p.m., resident 1 was found lying face down on the floor next to his bed. -There was noticeable blood on the floor. -Resident 1 had a laceration near his right eye. -He was transported to the emergency department for further evaluation. -He received six sutures and was transported back to the facility. *The provider's investigation of the fall determined that resident 1's silent TABs alarm (a device that flashes at the nurses station to alert staff when resident stands up) was in his recliner at the time of the fall and the resident was in his bed. *The certified nursing assistant (CNA) that assisted resident 1 to bed had forgotten to move the TABs alarm when she assisted the resident to bed. *As a result of the fall, the provider updated resident 1's care plan and Kardex to have a TABs alarm in both his recliner and his bed at all times. *Director of nursing services (DNS) O placed a "STOP, Wait for assistance" sign in the resident's room as a reminder for resident to not get up without staff assistance. 2. Review of resident 1's electronic medical record revealed: *He was admitted to the facility on 4/11/23. *His diagnoses included: repeated falls, generalized muscle weakness, Dementia (a group of symptoms affecting memory, thinking, and social abilities), use of anticoagulants (blood thinning medications). *His 6/3/25 Brief Interview for Mental status (BIMS) assessment score was 12, which indicated he was moderately cognitively impaired.	F 689	quietly, make sure they are in bed sleeping. If they are awake: Do they need a drink? Do they need to go to the bathroom? Do they need changed? Are they hungry? Ask questions, provide comfort, maybe they need their TV off? Find out the why and provide what cares are needed. Rounding will occur at least every hour. Nurses, CNA, and Med Aides will be participating in purposeful rounding. The goal of purposeful rounding is to help decrease falls. High risk fall residents will be highlighted on the white boards at each nurse's station. Fall prevention interventions will be communicated daily in the morning huddle report. Morning huddle reports will be posted on the white boards at each nurse's station Monday through Friday. Morning huddle will be discussed at each nurse's station following safety event review. Frontline staff on each wing are to attend the huddle given by a nurse manager or the administrator.	

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F 689	Continued From page 5 *A progress note on 3/16/25 at 11:54 p.m. regarding his TABs alarm stated "Alarm not placed under resident at bedtime, alarm pad found in recliner chair and resident is sleeping in bed. Resident [was] not woke [woken] up at this time to place under him d/t [due to] [the resident] sleeping soundly. Will monitor closely, night CNAs aware of this." *A progress note on 3/19/25 at 11:35 p.m. regarding his TABs alarm stated "Not under resident in bed, alarm found in recliner chair and not connected." *Resident 1's 6/18/25 Kardex stated in the "Monitoring" section "Personal Alarm: Silent TABs alarm used to alert staff of resident's movement and to assist staff in monitoring movement. Place TABs alarm in both bed and recliner at all times. Ensure this is used, plugged in, and functioning when [the resident is] in bed or [the] recliner. *Resident 1's 6/4/25 Care Plan Report indicated: *A Focus are of "The resident has had an actual fall R/T [related to] epilepsy, dementia, muscle weakness, decreased balance as E/B [evidenced by] history of falls." *Goals for that area included "Resident will be free of falls through the review date." "Resident will be free of minor injury through the review date." "Resident will not sustain serious injury through the review date." *Interventions included "PERSONAL ALARM: Silent TABs alarm used to alert staff to resident's movement and to assist staff in monitoring movement. Place TABs alarm in both [his] bed and recliner at all times. Ensure this is used, plugged in, and functioning when [resident is] in bed or [the] recliner." 3. Observation and interview on 6/17/25 at 10:45	F 689	Safety events are discussed every morning after morning meeting and interventions are updated in the care plan at time of discussion. Fall prevention interventions will be placed in the care plan and triggered to the Kardex for easy access to front line staff. Nurse managers have designated halls and are responsible for their hall to update the care plan and Kardex. Staff follow up will be done during morning huddle. 3. The DON or designee will educate all nursing staff on the importance of fall prevention interventions to be current and updated timely, what is expected during purposeful frequent rounding, where to find new fall prevention interventions and information. Nurse Managers will be educated on importance of updating care plan fall prevention interventions at time of safety event review. Each nurse manager is responsible for their designated hall for updating of care plans. The education will occur no later than July 18, 2025, and those not in attendance due to vacation, illness or casual work status will be educated upon their return prior to their next scheduled shift.	

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F 689	Continued From page 6 a.m. with resident 1 in his room revealed: *Resident stated he had lived there for the past couple years. *He had no obvious observed signs of bruising or injury. *His room was free of clutter. *He was sitting on his TABs alarm and his call light was within his reach. *There was no TABs alarm on his mattress. *There was no "STOP, Wait for assistance" sign on his wall. 4. Observation and interview on 6/17/25 at 1:20 p.m. with resident 1 revealed he was still sitting up in his chair, with the TABs alarm under him. 5. Interview on 6/17/25 at 2:20 p.m. with certified medication aide (CMA) M revealed: *Resident 1 should have had a TABs alarm in both his chair and on his bed. *That was to be documented in the resident's TAR (treatment administration record) by a nurse. 6. Interview on 6/17/25 at 2:30 p.m. with CMA L revealed: *There should be an alarm in the resident's chair and in his bed. *She was not aware why there was not two alarms because she was not usually assigned to that unit. 7. Interview on 6/17/25 at 3:45 with registered nurse (RN) N revealed she was the nurse assigned to work in resident 1's unit but was not aware if resident 1 should have one or two TABs alarms. 8. Interview on 6/17/25 at 3:50 p.m. with CNA E revealed:	F 689	The DON or designee will audit Daily Huddle postings to ensure communication is getting to the frontline staff and the white boards at each nurse's station reflect high fall risk residents. 4. The DON will audit 5 residents with a care plan Focus of "The resident has had an actual fall" to ensure fall prevention interventions are current and up to date. Audits will be weekly for 4 weeks, biweekly for 1 month, and monthly for 4 months. 5. 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/revision of audits based on audit findings.	

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F 689	Continued From page 7 *There should have been two TABs alarms in resident 1's room. *She was aware there was only one alarm that was being transferred back and forth from his chair to his bed. *She reported that there had not been two alarms in resident 1's room recently due to a malfunction when using two alarms. *She explained that when there were two alarms, one would malfunction and alarm when the resident was not using it. *She stated that maintenance personnel had tried to repair the system but were unable to. -The solution to that was to remove the second TABs alarm from resident 1's room. *She was not aware of any other fall prevention interventions that had been put into place for resident 1. 9. Interview on 6/17/25 at 4:00 p.m. with resident 1's spouse revealed: *She felt resident 1 received good care at the facility. *She stated, "I wish sometimes there were more staff, but they work very hard." *She reported that resident 1 had fallen and that required him to go to the hospital and receive sutures. 10. Interview on 6/17/25 at 4:15 p.m. with RN/clinical care leader (CCL) F revealed: *Resident 1's cognition varied (sometimes he was confused, sometimes he was not), which could make it difficult to provide his care at times. *She was aware he was care planned to have two TABs alarms in his room. *She was aware there was only one TABs alarm in his room. *She reported that the staff were performing more	F 689		

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F 689	Continued From page 8 frequent rounding (visually checking on resident's status) to ensure their safety. 11. Observation on 6/18/25 at 9:05 a.m. revealed: *Resident 1 was not in his room. *There was one TABs alarm in his chair, and none on his bed. *There was no "STOP, Wait for Assistance" sign visible in his room. 12. Interview on 6/18/25 at 1:50 p.m. with DON B revealed: *She was familiar with resident 1's fall but was not employed by the facility when the fall occurred in February 2025. *She was not aware of the fall prevention interventions that were to have been put in place as a result of the February 2025 fall (additional TABs alarm and "STOP, Wait for assistance" sign) for resident 1. *She was not aware that only one alarm was being used for resident 1. *She agreed resident 1 could fall again. 13. Interview on 6/18/25 at 2:30 p.m. with administrator A revealed: *His goal was to eliminate the use of TABs alarms for residents in the facility. *He preferred to focus on completing more frequent rounding on the residents instead of relying on alarms. *He stated "Frequent checks should have been added" to resident 1's care plan after his fall. *He agreed resident 1 could fall again. 14. Review of the provider's 4/8/25 Fall Prevention and Management policy revealed: *"Purpose, To promote resident well-being by developing and implementing a fall prevention	F 689		

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F 689	Continued From page 9 and management program. To identify risk factors and implement interventions before a fall occurs." *"Proactive Approach before a Fall Occurs (e.g., New Admit) 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 the 24-Hour Report, care plan and Kardex, daily stand-up meeting, and/or Fall Committee meetings."	F 689		