

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

ORIGINAL

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 Surveyor: 26180 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/16/13 through 9/18/13. Good Samaritan Society Luther Manor was found not in compliance with the following requirement(s): F166, F241, F279, F280, F309, F371, F385, F425, F431, and F441.	F 000		
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on interview, record review, and policy review, the provider failed to resolve grievances in a timely manner according to sixteen confidential residents. Findings include: 1. During an interview on 9/17/13 ar 10:30 a.m. with sixteen confidential residents regarding call lights revealed residents had stated their call lights had not been answered in a timely manner especially during busy times. Surveyor: 32355 Review of the provider's computer generated call light staff response time log from 8/18/13 through 9/18/13 for the following residents' rooms revealed: *Room 107, bed B's call light log revealed nine	F 166	F166 1. For Residents in rooms 107, 410, 510, 513, and 525: The times identified for the call lights were during busy times of the shift which were primarily after meals at lunch and supper. All residents are at potential risk for being affected. Nurses were instructed to be in the dining room and/or hallways during meal times so they can assist with answering the lights or assisting residents with their meals so the CNA's can answer the lights. The nurses were instructed to tape report for the oncoming shift so the nurses are available during the supper meal. The Administrator or designee will audit the call lights on each end of the building 1 time a week times 4 weeks then 1 time a month times 4 months who will then report any identified concerns to the QA committee at the next QA meeting and will continue until the committee advises to discontinue. All staff in-service was provided on 9-18-13, 10-3-13 and Nurses again on 10-10-13 at the Nurse meeting.	

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

Lawrence D. Cichoff

TITLE

Administratrix

(X6) DATE

11/22/13

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.

DEC 02 2013
If continuation sheet Page of 47
SD DOH L&C

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 166	<p>Continued From page 1</p> <p>times the call light had been turned on, and the staff had taken longer than 10 minutes to respond. The response times had varied from 11 minutes and 38 seconds to 22 minutes and 30 seconds.</p> <p>*Room 410, bed A's call light log revealed eight times the call light had been turned on, and the staff had taken longer than 10 minutes to respond. The response times had varied from 10 minutes and 57 seconds to 23 minutes and 44 seconds.</p> <p>*Room 510's call light log revealed twenty-five times the call light had been turned on, and the staff had taken longer than 10 minutes to respond. The response times had varied from 10 minutes and 43 seconds to 23 minutes and 26 seconds.</p> <p>*Room 513's call light log revealed fourteen times the call light had been turned on, and the staff had taken longer than 10 minutes to respond. The response times had varied from 10 minutes and 53 seconds to 22 minutes.</p> <p>*Room 525's call light log revealed eleven times the call light had been turned on, and the staff had taken longer than 10 minutes to respond. The response times had varied from 11 minutes and 30 seconds to 20 minutes and 2 seconds.</p> <p>Interview on 9/18/13 at 9:05 with the director of nursing (DON) revealed:</p> <p>*The call light response time by the staff had been an on-going area of concern for some time.</p> <p>*The call light response time had been implemented as part of their Quality Assurance (QA) program (group in the facility that monitors areas of concern).</p> <p>*She and the administrator had been doing random audits to verify the call light response time by the staff.</p>	F 166		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 166	<p>Continued From page 2</p> <p>*She would have expected the staff to answer a call light within 3 to 5 minutes.</p> <p>Review of the provider's March 2012 Resident Handbook revealed "If the call light is not answered in five minutes this call light system will also prompt the administrator if the light is not answered in ten minutes."</p> <p>2. During an interview on 9/17/13 ar 10:30 a.m. with sixteen confidential residents about privacy and dignity revealed: *During their bathing staff had knocked on the door and then entered without permission. *Staff had also knocked on resident room doors and entered without waiting for acknowledgement to enter.</p> <p>Surveyor: 32355 Interview on 9/18/13 at 9:10 a.m. with the DON revealed: *There should not have been any interruptions during a resident's bathing time. *She would have expected the staff to wait for a response from the resident prior to entering their room.</p> <p>Review of the provider's January 2007 Resident's Bill of Rights For Skilled Nursing Facilities pamphlet revealed "Dignity: The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality."</p> <p>Review of the provider's April 2005 Resident Dignity procedure revealed "Respecting resident's private space and property by knocking on the doors and requesting permission to enter."</p>	F 166	<p>2. We were unable to identify the residents who voiced the concern. All residents are at potential risk for being affected . All staff were in-serviced on dignity and resident rights as well as knocking on doors before entering on 10-3-13. We identified that the total lift slings were in the 2 bathing rooms and this is why staff were going in and out of the bathing rooms, to get a sling for a resident. These slings were removed and located elsewhere so staff did not have to enter the bathing rooms when residents were bathing. A sign was also made and hung on each of the bathing room doors on 10-14-13 to indicate when bathing was in progress and when the bathing room was available. All residents are at potential risk for being affected. The Administrator or designee will audit the staff knocking on resident room and bathing room doors and awaiting resident's response to enter 1 time a week times 4 weeks then 1 time a month times 3 months who will then report any identified concerns to the QA committee at the next QA meeting and will continue until the committee advises to discontinue.</p>		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 166	Continued From page 3 3. During an interview on 9/17/13 ar 10:30 a.m. with sixteen confidential residents about activities revealed: they had request more or different evening and weekend morning activities which had not been implemented. The residents felt as if there had been nothing to do during those times. *Review of the March 2013 through September 2013 activity calendars revealed there had been an evening activity one time per week and the residents felt that was not enough. *Review of the March 2013 through September 2013 activity calendars revealed there had been an activity in the am on Saturday and Sunday. The residents at the confidential meeting felt the activities had not been well attended and wanted something else. *Request for the daily television schedule posting had not been completed. Surveyor: 32355 Interview on 9/18/13 at 9:05 a.m. with the DON confirmed that old business from the prior resident council meetings should have been reviewed. Interview on 9/18/13 at 1:20 p.m. with the activities coordinator revealed: *She had asked at every resident council meeting if the residents had requests or changes for activities. She stated the residents had offered no recommendations for changes in her department. *In the future they would try to review old and new business at each resident council meeting. *She had realized the provider needed to offer more activities in the evenings. 4. During an interview on 9/17/13 ar 10:30 a.m.	F 166	3. Regarding evening and weekend activities: We were unable to identify which residents voiced the concern. All residents are potentially affected. Program and Activities Coordinator met 1-1 with 21 interviewable residents regarding activities. Twenty of the 21 residents voiced no concerns with weekend activities. After the interviews, activity staff decided to offer two to three evening activities per week instead of the one to two activities per week offered at time of survey. Activity staff will work with the resident who expressed a desire for an additional activity on Sunday morning. Administrator or designee will interview 10% of interviewable residents 1 time a week times 4 weeks then 1 time a month times 3 months who will then report any identified concerns to the QA committee at the next QA meeting and will continue until the committee advises to discontinue. 4. Regarding clothing, we are unable to identify who voiced the concern. All residents are at potential risk for being affected. Social Worker and Laundry supervisor educated nurses on 10/10/13 on procedures for marking clothes. Laundry supervisor will review each admission for proper marking of clothes and audit 10% of all residents for marking of clothes Admission procedures reviewed with nursing and laundry staff 1 time a week times 4 weeks then 1 time a month times 3 months who will then report any identified concerns to the QA committee at the next QA meeting and will continue until the committee advises to discontinue.	

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 166	<p>Continued From page 4</p> <p>with sixteen confidential residents regarding laundry services revealed: *Request for labeling of clothing to be completed on the unit before the clothing ended up in the laundry and then became missing. *Missing clothing had not been followed up.</p> <p>Surveyor: 32355 Interview on 9/18/13 at 9:05 a.m. with the DON revealed: *She had been aware of the concerns for missing clothing items. *She would have to check into the process for labeling clothes upon admission. *If they cannot locate the lost item the administrator would have determined if the lost items should have been replaced by the provider or not.</p> <p>5. During an interview on 9/17/13 ar 10:30 a.m. with sixteen confidential residents regarding the resident room environment revealed: *Resident room soap dispenser had been difficult to reach for residents with shoulder problems in lower wheelchairs. *High rise toilets or toilet seats had not been available right away for resident with orthopedic problems (hip or knee surgeries). Residents had to ask for these accommodations.</p> <p>Surveyor: 32355 Interview on 9/18/13 at 9:05 a.m. with the DON revealed: *She had not been aware the soap dispensers or high rise toilet seats had been an issue. *She would have expected therapies to have checked on the appropriate level of the soap dispensers and the need for a high rise toilet seat.</p>	F 166	<p>5. Regarding high rise toilet seats, we were unable to identify the resident that voiced the concern. All residents with joint surgeries were asked if they wanted a stool riser and if they did one was provided. All residents with orthopedic surgical procedures, such as hip or knee are at potential risk for being affected. Nursing staff were instructed at the in-service provided on 10-3-13 to ensure that a toilet rise is in the rooms of those residents who need them. Upon admission the admission nurse and or therapy will assess if the resident wants/needs to use the toilet riser and at what height and kind for safety. The CNA pre-admission check list will also be updated to include getting a stool riser for the residents who may need one. The DON or designee will audit residents who have had joint surgeries for toilet risers 1 time a week times 4 weeks then 1 time a month times 3 months who will then report any identified concerns to the QA committee at the next QA meeting and will continue until the committee advises to discontinue.</p> <p>Regarding soap dispensers, we were unable to identify confidential resident who had difficulty with the soap dispensers. All staff inservices on process for resident resident grievences on 10/03/13. For those residents identified through request, observation, or interview to have difficulty reaching the soap dispenser, a portable automatic soap dispenser will be provided for the resident to place where it is most comfortable. All residents are at a potential risk for being affected. Director of Nursing Services or designee will audit the need and use of portable soap dispensers 1 time a week time 4 weeks and</p>	

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 166	<p>Continued From page 5</p> <p>*They had plenty of high rise toilet seats in the facility for residents to utilize.</p> <p>6. During an interview on 9/17/13 ar 10:30 a.m. with sixteen confidential residents regarding dietary services revealed: *Temperatures of the food were not acceptable as hot foods were not hot and cold foods had not been cold. *Pureed foods ran together on the plate. *Bedtime snacks had not been available for all residents. *Hot dishes had not been visually appealing. *Large amounts of food had been served when small amounts had been requested. *Length of meal time service had been extremely long.</p> <p>Surveyor: 32355 Interview on 9/18/13 at 9:05 a.m. with the DON revealed: *She had not been aware of the above issues in dietary. *She would have expected the dietary service manager (DSM) to have been aware of the above concerns in dietary. *She would have expected every resident to have been offered a bedtime snack. *Refer to F371, findings 1, 2, 3, and 8.</p> <p>7. During an interview on 9/17/13 ar 10:30 a.m. with sixteen confidential residents regarding designated smoking areas revealed smoking areas did not provide shade during extremely hot summer days.</p> <p>Surveyor: 32355 Interview on 9/18/13 at 9:05 a.m. with the DON revealed she would have to check the area for</p>	F 166	<p>then 1 time a month time 4 months, and report any identified concerns to the QA Committeeat the next QA meeting and will continue until the committee advises to discontinue.</p> <p>6. Regarding resident concerns about dietary services: *Temperatures of the food not acceptable as hot foods were not hot and cold foods had not been cold. All residents have the potential to be affected. DM and RD will educate all dietary staff on proper food handling and temperature policy and procedures. Dietary will be in-serviced on the policy and procedures of Proper Food handling, Food Preparation and Food Temperatures during the Oct 14, 2013 dietary in-service</p> <p>*Pureed foods ran together on the plate. All residents on a NDD diet have the potential to be affected. Dietary will serve puree foods in small dishes to prevent them from running together.</p> <p>*Bedtime snacks had not been available for all residents. All residents have the potential to be affected. Dietary will send out more snacks on the HS cart.</p> <p>*Hot dishes had not been visually appealing. On 10/10/13 Dietary manager ordered oval shaped dishes to serve the hot dishes in at meal times.</p> <p>*Large amounts of food had been served when small amounts had been requested.</p>	

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 166	<p>Continued From page 6</p> <p>shade. She would refer the concern to the administrator and the environmental services manager.</p> <p>8. During an interview on 9/17/13 ar 10:30 a.m. with sixteen confidential residents regarding resident council revealed the attending residents requested the formation of officers for resident council.</p> <p>Surveyor: 32355 Interview on 9/18/13 at 1:30 p.m. with the social worker (SW) revealed she had stated: **"They don't want officers." **"It is a mute (void) point as far as I am concerned." **"Resident council is a waste of time." **"Resident council is only a small group and does not represent all of the residents in the facility."</p> <p>Review of resident council meeting minutes from February 2013 through August 2013 revealed: *Residents had requested more bingo. *Meals at night had been getting late. *Residents' clothing had sometimes been misplaced by the laundry staff. *Many clothing items had been missing. *Resident room with windows had not been able to be opened. *Residents' toilet had not been flushing correctly. *Request a more central location for the aviary (birds). *More towels had been needed in the resident bathrooms. *Too much chicken was served. *Ice cream bars were messy, and they had preferred ice cream cups.</p> <p>Interview on 9/17/13 at 10:30 a.m. with a</p>	F 166	<p>All residents with small portions requested on their diet card have the potential to be affected. Dietary Manager will audit diet cards with small portions three times per week for four weeks, then one time per week for 3 months.</p> <p>*Length of meal time service had been extremely long. Dietary Manager will audit meal times for three times per week for four weeks and make improvements as needed and report to resident council</p> <p>7. Regarding shaded smoking area, we were unable to identify the resident who voiced the concern. Social worker talked with the residents who smoked and revised smoking policy to include a shaded. Interviewed residents voiced approval of the new area. Social Worker educated nursing staff of new area on 10/10/13. Social or designee will ask residents who smoke if smoking areas are satisfactory 1 time a week times 4 weeks then 1 time a month times 3 months who will then report any identified concerns to the QA committee at the next QA meeting and will continue until the committee advises to discontinue.</p> <p>8. Regarding response to Resident Council issues, we were unable to identify the residents who voiced the concerns. All residents are at potential risk for being affected. At Resident Council of 9/23/13, Social Worker asked if the residents would like officers for Resident Council. Residents who were present were not sure whether or not this was wanted, so they decided to think</p>		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 166	Continued From page 7 confidential group of resident's revealed they had discussed all the above issues with staff members. They stated no one had responded to those issues. Interview on 9/18/13 at 11:30 a.m. with licensed social worker Q revealed: *Social services oversaw the Resident Council meetings. *At those meetings they reviewed the minutes from the previous meeting and that included previous concerns. *They had not documented follow-up discussions of previously addressed concerns in their minutes. Surveyor: 32355 Review of the provider's February 2013 Resident Council policy revealed: "The purpose: To ensure that residents are provided a means of voicing grievances and participating in decision making." *"A resident has the right to organize and participate in resident council in the center." Surveyor: 26180	F 166	about it and bring back a decision at the next Resident Council meeting. To address response to resident concern brought up at Resident Council, Social Worker or designee will use meeting minutes template with old and new business. Social Worker or designee will give copy of minutes to each department managers to that they are able to respond to concerns. Social Worker or deignee will review old business at Resident Council Meeting to make sure concerns have been addressed. Social Worker or designee will review the resolution of Resident Council concerns with department managers 1 time a month times 3 months who will then report any identified concerns to the QA committee at the next QA meeting and will continue until the committee advises to discontinue.		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced	F 241	Regarding towels in the resident bathrooms, we were unable to identify the resident who voiced the concern. We were able to identify that staff were passing linens only at the morning shift. The practice of passing linens each shift was re-established. Nursing staff were in-serviced on this information on 10-3-13. All residents are at potential risk for being affected. The DON or designee will audit that linens are being placed in resident rooms every shift 1 time a week times 4 weeks then 1 time a month times 3 months who will then report any identified concerns to the QA committee at the next QA meeting and will continue until the committee advises to discontinue.	10/18/13	

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 241	Continued From page 8 by: Surveyor: 32355 Based on observation, interview, record review, and policy review, the provider failed to maintain dignity during three of three meal services: *For two of two sampled residents (8 and 12). *All residents that had required assistance to eat. Findings include: 1a. Review of resident 12's medical record revealed: *She had been admitted on 9/26/97. *She had diagnoses of a stroke (part of the brain stops receiving blood), seizure disorder (uncontrollable body movements), depression, and anxiety. *She had been totally dependent on staff for all activities of daily living. Observation on 9/16/13 from 5:30 p.m. through 6:30 p.m. of resident 12 revealed: *She had been sitting in a wheelchair in the dining room. *She had been served her supper meal at 5:50 p.m. Her supper meal had consisted on blended cucumber salad, chicken dumpling soup, tuna salad sandwich, and pineapple. *She had been sitting with her head down starring at her food. *She had required total staff assistance with her meal. *Certified nursing assistant (CNA) C had been sitting between her and resident 19. *CNA C had been assisting resident 19 with her meal. He had not attempted to assist resident 12 with her meal until 6:12 p.m. *At 6:15 p.m. CNA C had left the table to answer a call light. *Three unidentified nurses had been sitting in the	F 241	F241 1. For Residents 8 and 12 the following measures have been put into place to ensure these residents are assisted with interruption. Nurse and CNA staff were educated 9/18/13 during report, 10-3-13 and 10-10-13 at in-services that Nurses were to be in the dining room and/or hallways during meal times so they can assist with answering the lights or assisting residents with their meals so the CNA's can answer the lights. The nurses were instructed to tape report for the oncoming shift so the nurses are available during the supper meal. Nurse and CNA staff also reviewed the correct way to assist a resident with their meals. All residents requiring assistance with their meal are at potential risk for being affected The DNS or designee will audit staff in the dining room during meals, residents are spoken to appropriately and referred to as "residents needing assistance" rather than "feeders" and that there is staff available to answer call lights without leaving the dining table 1 time a week times 4 weeks then 1 time a month times 4 months who will then report any identified concerns to the QA committee at the next QA meeting and will continue until the committee advises to discontinue.	

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 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 241	<p>Continued From page 9</p> <p>nurses' room located by the dining room. They had made no attempt to assist resident 12 or answer the call light so CNA C could have continued to assist resident 12 with her meal.</p> <p>*At 6:18 p.m. CNA C had returned to assist resident 12 with her meal. He had given her a bite of her meal without asking her if she would have liked her food warmed up.</p> <p>*At 6:20 p.m. this surveyor had asked CNA C to have the certified dietary manager (CDM) check the temperature of food. The temperatures of her food were:</p> <ul style="list-style-type: none"> -Cucumber salad 66 degrees Fahrenheit (F). -Chicken dumpling soup 89 degrees F. -Tuna salad sandwich 81 degrees F. -Pineapple 64 degrees F. <p>Interview on 9/16/13 regarding the above observations with the CDM revealed:</p> <p>*The temperatures of the above foods had been the wrong temperatures.</p> <p>*He had stated the cold foods should not have been more than 40 degrees F. and the hot foods should have not been less than 140 degrees.</p> <p>*Confirmed resident 12 had been dependent upon staff to assist her with her meal.</p> <p>*Confirmed she should not have been served her meal until staff had been ready to assist her with eating.</p> <p>b. Observation on 9/17/13 from 12:15 p.m. through 12:30 p.m. of resident 12 revealed:</p> <p>*She had been sitting in her wheelchair at the dining room table.</p> <p>*CNA M had been assisting her with her meal.</p> <p>*She had required staff assistance to keep food particles off of her mouth.</p> <p>*CNA M who had been assisting her with her meal had:</p>	F 241		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 241	<p>Continued From page 10</p> <p>-Not wiped her mouth of food particles on her lower lip during the above time frame.</p> <p>-Made no attempt to verbalize with the resident during the above time frame and while assisting her with her meal.</p> <p>Observation on 9/17/13 from 5:50 p.m. through 6:05 p.m. of resident 12 revealed: *She had been sitting in her wheelchair at the dining room table. *CNA C had been assisting her with her meal. *CNA C had: -Not wiped her mouth of food particles running out of her mouth during the above time frame. -Made no attempt to verbalize with the resident during the above time frame and while assisting her with her meal.</p> <p>c. Interview on 9/18/13 at 10:20 a.m. with the director of nursing services (DON) revealed: *She had confirmed resident 12 should not have been served her meal until staff had been able to assist her with eating. *The CNAs should have been able to assist two residents at the same time. *CNA C should not have answered the call light while assisting the resident with her meal. *She would have expected the staff to visit with her during her meal and to keep her mouth clean from food.</p> <p>Review of the provider's January 2007 Resident's Bill of Rights for Skilled Nursing Facilities pamphlet revealed: **"QUALITY OF LIFE: A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life." **"Dignity: The facility must promote care for</p>	F 241			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 241	<p>Continued From page 11</p> <p>residents in a manner and in an environment that maintains or enhances each residents' dignity and respect in full recognition of her or her individuality."</p> <p>Review of the provider's April 2005 Resident Dignity procedure revealed: ***To promote, encourage, support, and enhance the residents' self-esteem." ***To promote a sense of self-worth." ***Focusing on residents as individuals when staff talk to them and addressing them as individuals when providing care and services."</p> <p>Surveyor: 32333 2. Observation on 9/18/13 between 8:55 a.m. and 9:35 a.m. of resident 8 revealed: *She had been sitting in her wheelchair in her room. *She had her head down and was in front of her television. *CNA U entered the resident's room. *The resident told CNA U she did not think she had breakfast yet. *CNA U told the resident , "No one is available to feed you right now." *At 9:30 a.m. the resident was taken to the dining room, and she was served eggs at that time. *The temperature of the eggs had been 107.6 degrees F. *The resident had refused to eat the eggs. *At 9:35 a.m. the resident was then served oatmeal.</p> <p>Interview on 9/18/13 at 9:00 a.m. with CNA U revealed: *Resident 8 woke up at 7:00 a.m. and was placed in her wheelchair. *There had been no staff available to help feed</p>	F 241	<p>2. Resident 8 was taken to the dining room and assisted with her meal. All staff in-service was completed on 10-10-13 regarding the word "feeder" in referring to our residents who need assistance with their meal. The staff is not to refer to our residents as "feeders". They were also instructed to ensure residents are out to meal time on time. All residents requiring assistance with their meal are at potential risk for being affected The DNS or designee will audit all staff particularly in the dining room getting residents to the dining room on time, assisting residents at mealtime and meals, and that they are referring to residents as "residents needing assistance" rather than "feeders" 1 time a week times 4 weeks then 1 time a month times 4 months who will then report any identified concerns to the QA committee at the next QA meeting and will continue until the committee advises to discontinue.</p>	10/18/13

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 241	<p>Continued From page 12 her.</p> <p>Interview on 9/18/13 at 1:40 p.m. with the director of nursing revealed: *She agreed it was unacceptable for resident 8 to have to wait over two and a half hours to be taken to breakfast. *She would have expected the resident's food to have been served at the appropriate temperatures.</p> <p>Surveyor: 26180 4. Observation on 9/18/13 at 9:30 a.m. in the dining room revealed there were six covered breakfast trays on the counter.</p> <p>Interview with an unidentified CNA at that time revealed: *There were usually five or six residents who had not eaten yet. *Those residents were the 'feeders' and they would be fed after the staff had gotten everyone else up. They then came out to the dining room to feed them.</p> <p>Confidential interview on 9/18/13 at 9:40 a.m. with a resident's family member revealed: *She often visited in the morning. *She usually arrived after 9:00 a.m. *There were usually residents who had not eaten yet when she had arrived at that time.</p> <p>Interview on 9/18/13 at 12:40 p.m. with the dietary service manager revealed: *There were five or six residents who ate later than 9:00 a.m. every day. *They had covered their meals and set them out until the staff were available to feed those residents.</p>	F 241			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 241	Continued From page 13	F 241		
F 279 SS=D	<p>*That happened daily.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on observation, record review, policy review, and interview, the provider failed to develop a comprehensive care plan for 3 of 15 sampled residents (2, 3, and 15). Findings include:</p> <p>1. Review of resident 15's electronic medical record (EMR) revealed: *A tobacco assessment had been performed on</p>	F 279	<p>F279</p> <p>1. The Care Plan for Resident #15 was updated on 9-18-13 to include the ability to use tobacco products. Ensured that the care plans of all other residents who smoke had it on their care plan. Nursing staff and Social Services were in-serviced on 10-3-13 and nurses were again in-serviced on 10-10-13</p>	

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 279	<p>Continued From page 14 9/9/13. *The activity interest data collection tool had been filled out on admission on 8/21/13. *The 9/4/13 care plan had not addressed smoking or activities.</p> <p>Interview with the facility social worker on 9/18/13 at 10:10 a.m. revealed the resident's smoking instructions and allowances should have been included on the care plan. It had just been missed. She stated the new EMR system was set-up in a way that if a resident was not marked as at risk for activities then that area would not be addressed on the care plan.</p> <p>Interview with the activities director on 9/18/13 at 11:45 a.m. revealed resident 15 had been admitted on 8/21/13 and had been interviewed about activity preferences at that time. Resident 15 was a younger resident, was in rehabilitation and preferred one to one activities more than group activities. There were not many group activities that were planned for younger residents. Resident 15's activities were not documented in his care plan. The activities director would not have an updated progress note about activities in the EMR until the resident had been there three months.</p> <p>Surveyor: 32572 2. Observation on 9/16/13 at 3:30 p.m. of resident 2 resting in bed with a nebulizer mask in place. The nebulizer was administering medication.</p> <p>*Resident 2 had a physician's order for self-administration of nebulizer after set-up by the nurse or unlicensed assisted personnel (UAP).</p> <p>Interview on 9/18/13 at 9:40 a.m. with the director</p>	F 279	<p>regarding updating the care plan. All residents who smoke are at potential risk for being affected The DNS or designee will audit 10% of the care plans for updates 1 time a week times 4 weeks then 1 time a month times 4 months who will then report any identified concerns to the QA committee at the next QA meeting and will continue until the committee advises to discontinue.</p> <p>2. Resident #2: Order that had been received on 9-10-13 for self-administration of Nebulizer after set up was updated in the resident care plan and Medical administration record on 9-18-13. Nursing staff were in-serviced on 10-3-13 and 10-10-13 regarding updating the care plan and self administration of medication. All residents who self administer medications are at potential risk for being affected The DNS or designee will audit 10% of the care plans for self-administration of medications 1 time a week times 4 weeks then 1 time a month times 4 months who will then report any identified concerns to the QA committee at the next QA meeting and will continue until the committee advises to discontinue.</p> <p>3. Medication items were removed from resident #2's room on 9/17/13. Staff were reminded at the in-service on 10-3-13 and 10-10-13 to make sure and check the resident rooms for any medications that may have been</p>	

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 279	<p>Continued From page 15 of nursing (DON) revealed she would have expected the self-administration of the nebulizer to have been on the MAR not the care plan.</p> <p>Record review revealed the 3/26/13 care plan had not stated the resident had been able to self-administer the nebulizer. Review of the September 2013 medication administration record (MAR) revealed DuoNeb (nebulizer medication) to be administered twice a day without mention of self-administration.</p> <p>3. Observation on 9/17/13 at 2:30 p.m. with resident 2 in her room revealed she had Mentholatum and Carmex (medicated lip balm) at bedside.</p> <p>Review of the medical record had not revealed an interdisciplinary team's determination the resident could safely self-administer those medications.</p> <p>Review of the 9/6/13 signed physician orders had not indicated orders for self-administration for those above medications.</p> <p>Review of the 3/26/13 care plan had not indicated she could self-administer those medications.</p> <p>Interview on 9/17/13 at 5:00 p.m. with registered nurse (RN) A revealed she had not been aware of those medications at resident 2's bedside. She confirmed there would need to have been a physician's order for those medications. There should have been be an interdisciplinary teams determination for safety of medication for self-administration completed prior to the resident's self-administration of those medications.</p>	F 279	<p>left in rooms or for any medications that the family may have brought in and take it to the nurses station and check if resident has a self administration of medication order for it. Upon further investigation, the carmex that the nursing home provides is not medicated. All residents are at potential risk for being affected</p> <p>The DNS or designee will audit 10% of self administration orders and medications in resident rooms 1 time a week times 4 weeks then 1 time a month times 4 months who will then report any identified concerns to the QA committee at the next QA meeting and will continue until the committee advises to discontinue.</p>		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 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 279	<p>Continued From page 16</p> <p>Review of the provider's January 2011 Resident Self-Administration of Medication policy stated "The care plan must indicated which medication the resident is self-administering, where they are kept, who will document the medication and the location of the administration."</p> <p>Review of the provider's January 2009 Care Plan policy indicated "The care plan should have been modified to reflect the care currently required/provided for the resident."</p> <p>Surveyor: 32355</p> <p>4. Review of resident 3's medical record revealed: *She had been admitted on 10/17/11. *She had diagnoses of atrial fibrillation (irregular heartbeat), diabetes mellitus (uncontrollable sugar levels in the blood), macular degeneration (poor eyesight), history of left hip fracture, and a current State II (first layer of skin was missing), pressure ulcer to her left gluteal fold (wound at buttock area). *The Stage II pressure ulcer had developed while being a resident at the facility. *She had required extensive assistance of one to two staff members for being repositioned in the bed.</p> <p>Random observations from 9/16/13 through 9/18/13 of resident 3 revealed when she had been lying in her bed, the air flow mattress (a pressure relieving pad that lays directly over the mattress) had been turned off.</p> <p>Review of resident 3's undated comprehensive care plan revealed: *A focus area stated the resident had the potential for pressure ulcer development related</p>	F 279	<p>4. For resident #3 the air mattress was turned back on. All other residents with air mattress and overlays were check to ensure they were all turned on and functioning.</p> <p>CNA's and Nurses were in-serviced on checking the air mattresses for those residents who have them on each shift to ensure they are inflated. It was also placed on the Care Plan and CNA Kardex for documentation for all residents with air mattress or air overlays. All residents with air mattress or air overlays are at potential risk for being affected The DNS or designee will audit the air mattresses and air overlays 1 time a week times 4 weeks then 1 time a month times 4 months who will then report any identified concerns to the QA committee at the next QA meeting and will continue until the committee advises to discontinue.</p>	10/18/13

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 279	Continued From page 17 to a history of ulcers. *The goal was the resident would have intact skin by 11/14/13. *An intervention included to have provided a pressure relieving device (an air flow mattress) on her bed. Interview on 9/18/13 at 10:20 a.m. with the DON confirmed the staff should have recognized the air flow mattress had not been on. Review of the provider's January 2009 Care Plan policy revealed "Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment."	F 279			
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 280	Continued From page 18 This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure 5 of 15 fifteen sampled residents (6, 7, 8, 12, and 14) had their care plans revised when changes in their care had occurred. Findings include: 1. Review of resident 7's 9/9/13 Minimum Data Set (MDS) revealed he had been re-admitted from the hospital. He had been admitted with a catheter (urine drainage tube). His diagnoses included diabetes, dementia, neurogenic bladder (prone to bladder spasms). Review of resident 7's 9/2/13 hospital discharge summary revealed a miscellaneous discharge order "Foley [catheter] placed 8/31/13, routine cares BID [twice a day] and PRN [as needed]." Review of resident 7's 9/17/13 physician's orders revealed orders for: *"Foley cath routine cares BID and PRN and every day and evening shift for Foley cath placed." *"_____(Name of counseling agency) may provide psychological services." *"Celexa (antidepressant medication) 10 milligrams (mg) one time a day related to depressive disorder not elsewhere classified." Review of resident 7's 9/2/13 interdisciplinary care plan revealed: *It had not been updated to address the catheter	F 280	F280 Resident #7 : Order for the Foley Catheter was obtained on 9/18/13 as well as counseling services due to being on Celexa and depression. Care Plan updated for Foley Catheter placement and Deer Oaks Counseling on 9/18/13 Nursing staff were in-serviced on 10-3-13 and 10-10-13 regarding updating the care plan. All residents are at potential risk for being affected The DNS or designee will audit 10% of the care plans for updates 1 time a week times 4 weeks then 1 time a month times 4 months who will then report any identified concerns to the QA committee at the next QA meeting and will continue until the committee advises to discontinue.		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 280	<p>Continued From page 19 placement.</p> <p>*The problem related to depression and inappropriate behaviors had not addressed the referral to psychological counseling.</p> <p>Interview on 9/18/13 at 10:20 a.m. with registered nurse (RN) Minimum Data Set (MDS) coordinator F regarding resident 7's care plan revealed:</p> <p>*His care plan had been reviewed 9/2/13 since his hospitalization.</p> <p>*The care plan had not addressed the catheter and care of it but should have.</p> <p>*Psychological counseling should have been addressed on it.</p> <p>*Their computerized care plans were new, and they were still learning how to individualize them.</p> <p>2. Review of resident 14's 9/3/13 quarterly MDS revealed he:</p> <p>*Had short and long term memory impairment and was severely confused.</p> <p>*Enjoyed music and religious activity.</p> <p>Review of resident 14's 9/2/13 care plan revealed:</p> <p>*He had little or no activity involvement related to anxiety, depression, disinterest, and refusing to attend activities.</p> <p>*He preferred activities that were entertaining such as happy hour and devotions.</p> <p>Interview on 9/18/13 at 10:00 a.m. with activity assistant R regarding resident 14 revealed:</p> <p>*Up until recently it was difficult for him in activities, because he would have verbal outbursts.</p> <p>-Those outbursts had recently changed as they were adjusting some of his medications.</p> <p>*He enjoyed music.</p>	F 280	<p>Resident #14 has expired.</p> <p>Nursing staff were in-serviced on 10-3-13 and 10-10-13 regarding updating the care plan.</p> <p>All residents are at potential risk for being affected The DNS or designee will audit 10% of the care plans for updates 1 time a week times 4 weeks then 1 time a month times 4 months who will then report any identified concerns to the QA committee at the next QA meeting and will continue until the committee advises to discontinue.</p>		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 280	<p>Continued From page 20</p> <p>*For approximately the past six months, he had enjoyed an activity called Opening doors. -That was a small group activity for residents who had dementia and were lower functioning cognitively (memory impairment). -Open door was a sensory group which used their senses such as touch or relied on remembering type activity. *She thought he was not as focused in the past three weeks. *She agreed his care plan had not been updated to reflect his current status and level of participation.</p> <p>Review of the provider's January 2009 care plan policy revealed: **"An initial/temporary care plan will be developed by nursing upon admission as soon as a problem is identified." **"Care plans will also be reviewed, evaluated and updated when there is a significant change of the resident's condition and/or in accordance with state guidelines. This plan of care will be modified to reflect the care currently required/provided for the resident."</p> <p>Surveyor: 32333 3. Review of resident 6's entire medical record revealed on 9/11/13 documentation of a ten percent weight increase in the last 6 months. The revised 6/28/13 care plan revealed a focus area of a nutritional problem related to multiple sclerosis as evidenced by history of weight loss. There was no mention of the resident's weight increase.</p>	F 280	<p>3. Resident #6: Care Plan has been updated on 10/16/13 regarding weight gain. New focus of weight gain added. New goal of weight maintenance to maintain weight less than 190# was added to the care plan. Nursing staff were inserviced on 10-3-13 and 10-10-13 regarding updating care plans. All</p>		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 280	<p>Continued From page 21</p> <p>4. Review of resident 8's 8/3/13 nurses progress note revealed "Resident stated that she was scared to have men come in her room and take care of her at night. Resident expressed fear verbally with tears noted. When asked resident what reason for this was she doesn't want men cleaning her up and touching her at night. " Review of resident 8's undated care plan printed on 9/17/13 revealed no mention of her preference of not having men take care of her.</p> <p>Surveyor: 32355</p> <p>5. Review of resident 12's undated comprehensive care plan revealed: *A focus area indicating she had been dependent on staff for activities, cognitive (mental) stimulation, and social interaction. *A goal of "Resident will attend activities to the best of her ability such as entertainment, worship with family on community outings." *Interventions had included: -"Assist with arranging community activities. Arrange transportation." -"Encourage ongoing family involvement. Invite resident's family to attend special events, activities, and meals." *It had not addressed any activity program that had been set-up for one-to-one visits. *It had not been care planned that she could become resistive with one-to-one visits or activities.</p> <p>Interview on 9/18/13 at 11:30 a.m. with the activities director regarding resident 12 revealed: *She had been on a one-to-one program. *She had occasionally become resistive with activities or would refuse them. *Her goal for the resident had been to attempt a one-to-one program with her once a week.</p>	F 280	<p>residents are at a potential risk for being affected. The Director of Nursing Services or designee will audit 10% of the care plans for updates 1 time a week times 4 weeks then 1 time a month times 4 months who will then report any identified concerns to the QA Committee at the next QA meeting and will continue until the committee advises to discontinue.</p> <p>4 Resident #8: Staff were aware of this request but it was not in the care plan. Care plan was updated on 9-18-13. Nursing staff were in-serviced on 10-3-13 and 10-10-13 regarding updating the care plan. All residents are at potential risk for being affected The DNS or designee will audit 10% of the care plans for updates 1 time a week times 4 weeks then 1 time a month times 4 months who will then report any identified concerns to the QA committee at the next QA meeting and will continue until the committee advises to discontinue.</p> <p>5 & 6: Resident #12's care plan was updated to include intervention to attempt a 1:1 activity 1 time a week. All residents are at potential risk for being affected. Inservice provided on 10/03/13 and 10/10/13 to update care plans for nursing and interdisciplinary team. Program and Activities Coordinator or designee will audit 10% of the care plans for updates 1 time a week times 4 weeks then 1 time a month times 4 months who will then report any identified concerns to the QA committee at the next QA meeting and will continue until the committee advises to discontinue.</p>	10/18/13

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 280	Continued From page 22 *The care plans had been hard to personalize as the staff had been allowed to only edit certain parts of the the computer program. 6. Interview on 9/18/13 at 10:30 a.m. with the director of nursing (DON) revealed she would have expected one-to-one visits as a program offered to resident 12. Surveyor: 32333 Interview on 9/18/13 at 1:40 p.m. with the director of nursing revealed she agreed the care plans should have been updated to reflect the residents' current status and needs. Review of the provider's January 2009 Care Plan Policy revealed: **"Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment." **"Each resident will have an individualized comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs." **"The care plan will emphasize the care and development of the whole person assuring that the resident will receive appropriate care and services."	F 280			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 309	Continued From page 23 and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, interview, record review, and policy review, the provider failed to ensure care and services for: *One of thirteen residents (2) with pain had been assessed or reassessed per their policy. Findings include: 1. Observation on 9/17/13 at 2:30 p.m. of resident 2 during repositioning revealed: *The resident was hollering during repositioning. *The resident had facial grimacing and muscle twitching during repositioning. *The resident had a stage 3 (deep tissue injury that forms crater) pressure ulcer (bed sore). Review of resident 2's medical record progress notes indicated the resident had been in pain by the following documentation: 8On 9/9/13 "Resident calling out in bed at this time. Resident yelling OW!" *9/10/13 "Resident calling out in pain in room at this time." *9/16/13 "Will cry out when cares done and repositioning." *9/18/13 "Resident has been repositioned every time she has yelled out, with no avail. Writer will give resident PRN (as needed) tylenol #3 (pain medication) at this time." Review of the September 2013 medication administration record (MAR) indicated she had received the following scheduled and PRN pain	F 309	F309 1. Resident #2 : At this time unable to go back and correct this resident due to resident passing away on 9/27/13. Hospice was involved with her care and she was receiving both scheduled and PRN medications for comfort. The only pain assessment completed was on 9/04/13; no others were completed prior to survey or upon survey. For all other potential residents the facility plans to follow the Policy for Pain Assessment completion. Nursing was in-serviced on 10-3-13 and 10-10-13 regarding the policy on when Pain Assessments needed to be completed. All residents are at potential risk for being affected. The DNS or designee will audit for completion of pain assessments 1 time a week times 4 weeks then 1 time a month times 4 months who will then report any identified concerns to the QA committee at the next QA meeting and will continue until the committee advises to discontinue.	10/18/13

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 309	<p>Continued From page 24</p> <p>medications on:</p> <p>*The scheduled Tylenol #3 one tablet every night at bedtime had been started on 9/6/13.</p> <p>*Tylenol #3 one tablet PRN for pain had been written on 8/30/13 and had been given on the following dates:</p> <p>-Once on 9/10/13 and on 9/11/13.</p> <p>-Three times on 9/14/13.</p> <p>-One time on 9/15/13 and on 9/16/13.</p> <p>*The scheduled Tylenol extra strength (pain medication) two tablets three times a day had been started on 9/7/13.</p> <p>*Tylenol 325 mg two tablets every four hours as needed for pain or temperature over 100.4 degrees Fahrenheit (F) had been written on 11/15/12 and had been given on the following dates:</p> <p>-Once on 9/1/13.</p> <p>-Three times on 9/2/13.</p> <p>-Twice on 9/3/13 and on 9/4/13.</p> <p>-Three times on 9/5/13.</p> <p>-Once on 9/6/13 through 9/9/13.</p> <p>Review of resident 2's clinical assessments revealed the last pain assessment had been completed on 9/4/13 and revealed:</p> <p>*The resident had been hurting within the last five days.</p> <p>*The resident had been experiencing pain or hurting frequently over the last five days.</p> <p>*The pain had been described as mild pain.</p> <p>*The resident had not been able to provide characteristics (cramping, splitting, shooting, and etcetera) for the pain.</p> <p>*The resident had described the pain as making her "irritable."</p> <p>*Non-medicated pain management techniques or scheduled pain medications were ordered.</p> <p>*Registered nurse F concluded the resident's</p>	F 309			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 309	<p>Continued From page 25</p> <p>pain was controlled.</p> <p>*There had not been a pain assessment completed after a change in the medication regime.</p> <p>Review of the 9/6/13 care plan indicated a problem with acute (short term) pain. One of the intervention strengths indicated the "resident is able to call for assistance when in pain, ask for medication, tell you how much pain is experienced, tell you what increases or alleviates pain."</p> <p>Review of the 9/3/13 Minimum Data Assessment (MDS) indicated resident 2's Brief Interview for Mental Status (BIMS) scored an eight, which indicated moderate cognitive (thinking) impairment.</p> <p>Review of the provider's November 2009 Pain Data Collection and Management policy revealed: **"Residents identified at high risk for pain will be reviewed weekly." **"If the current pain management is not effective or pain is of new onset, reassess." **"After a single episode of pain is resolved with the pain management plan, any new occurrence of pain will initiate the process again."</p> <p>Interview on 9/17/13 at 5:00 p.m. with registered nurse A regarding resident 2 revealed: *The resident had recently been started on scheduled Tylenol and Tylenol #3 PRN. *The resident's condition had recently declined. *The resident had recently started hollering due to her declining health.</p> <p>Interview on 9/18/13 at 9:40 a.m. with the director of nursing confirmed a pain assessment should</p>	F 309			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 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 309 F 371 SS=E	<p>Continued From page 26 have been completed after a change in the resident's pain medication. That would have been done to monitor the effectiveness of the medication change.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 16385 Based on observation, testing, interview, document review, and policy review, the provider failed to maintain safe food practices for four of four meal services: *Cold foods were not maintained at or below 41 degrees Fahrenheit (F). *Hot foods were not maintained at or above 140 degrees F. *Proper hand washing and glove use technique was not used during meal service. *Plate covers were reused. Findings include: 1. Observation and temperature testing on 9/16/13 at 6:15 p.m. immediately following the evening meal service revealed: *Ham salad sandwich temperature was 50.5</p>	F 309 F 371		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 371	<p>Continued From page 27</p> <p>degrees F.</p> <p>*Tuna salad sandwich temperature was 46.5 degrees F.</p> <p>*Pureed tuna salad sandwich temperature was 60.4 degrees F.</p> <p>*Pea salad was 61.1 degrees F.</p> <p>*Cucumber salad was 55.2 degrees F.</p> <p>Temperature testing of the walk-in refrigerator on 9/16/13 at 6:25 p.m. revealed a temperature of 40 degrees F.</p> <p>2. Observation and temperature testing on 9/18/13 at 11:35 a.m. revealed the egg salad sandwich temperature was 53.4 degrees F.</p> <p>Interview with the dietary service manager (DSM) at that time confirmed the above temperature. At 11:45 a.m. the DSM had put the egg salad sandwiches in the walk-in freezer. Further interview revealed food had been transported from another provider in a passenger truck. The passenger truck had not been equipped with cooling containers. The food transport truck with cooling containers had been in the shop for repairs.</p> <p>Further interview and documentation review with the DSM at 12:05 p.m. revealed:</p> <p>*The refrigerator temperature at the other provider had been 38 degrees F.</p> <p>*The sandwiches had been put in that refrigerator on 9/18/13 at 7:00 a.m.</p> <p>*The truck left the supplying provider at 10:40 a.m.</p> <p>Temperature testing of the egg salad sandwiches at 12:10 p.m. revealed a temperature of 37.2 degrees F.</p>	F 371	<p>F371</p> <p>1. Food Temperatures of hot and cold foods during meal service: All residents have the potential to be affected by this. Dietary Manager and Registered Dietitian will educate all dietary staff on proper food handling and temperature policy and procedures. Dietary in-service was held on Oct. 14, 2013 to retrain staff on food temperatures. Food temperatures as recorded on the temperature logs will be audited by Dietary Manager three times per week for four weeks, then one time per week for 3 months.</p> <p>2. Food temperatures of cold foods during transportation from the Village: All residents in the facility have the potential to be affected by this. The delivery van was back in service on 09/24/13 and all the proper temperature maintaining lowerators are being used. Food temperatures as recorded on the temperature logs will be audited by Dietary Manager three times per week for four weeks, then one time per week for 3 months.</p>		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER -GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 371	<p>Continued From page 28</p> <p>Review of the Administrative Rules of South Dakota, Article 44:02 Food Service Code, Section 44:02:07:35 revealed: "Potentially hazardous food must be kept at an internal temperature of 41 degrees F or below...during display and service."</p> <p>Surveyor: 32333 3. Observation on 9/18/13 at 9:30 a.m. of resident 8 in the dining room revealed: *She had been served eggs. *The resident immediately refused to eat the eggs. *The temperature of the eggs had been 107.6 degrees F.</p> <p>Interview on 9/18/13 at 1:40 p.m. with the director of nursing revealed she would have expected resident 8's food to have been served at the appropriate temperature.</p> <p>Review of the South Dakota Department of Health's Food Service Code revealed "All potentially hazardous food must be maintained at 140 degrees F or above." Surveyor: 32572</p> <p>Surveyor 32572: 4. Observation on 9/16/13 at 6:00 p.m. in the 500 and 600 hallway dining room revealed: *Certified nursing assistants (CNA) J and K had not washed their hands before glove application and removal of gloves. *Dietary Aide (DA) O had applied gloves without hand washing or hand sanitizing. -He went on to touch numerous areas such as the eating surfaces on plates, the inside of salad cups, and touching the ready-to-eat foods.</p>	F 371	<p>3. Nurse and CNA staff were educated 9/18/13 during report, 10-3-13 and 10-10-13 at in-services that Nurses were to be in the dining room and/or hallways during meal times so they can assist with answering the lights or assisting residents with their meals so the CNA's can answer the lights. The nurses were instructed to tape report for the oncoming shift so the nurses are available during the supper meal. Nurse and CNA staff also reviewed the correct way to assist a resident with their meals. All residents requiring assistance with their meal are at potential risk for being affected The DNS or designee will audit the dining room and call lights on each end of the building 1 time a week times 4 weeks then 1 time a month times 3 months who will then report any identified concerns to the QA committee at the next QA meeting and will continue until the committee advises to discontinue</p>	

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 371	<p>Continued From page 29</p> <p>-He had wiped his brow and touched the baseball cap that had been covering his hair during that time.</p> <p>*He then proceeded to remove the gloves and did not perform hand sanitizing or hand washing.</p> <p>*Also during the meal service he had removed the tongs from inside the pans and placed them on the top of the pan lid thus contaminating them.</p> <p>Interview on 9/16/13 at 6:20 p.m. with DA O confirmed he sometimes used tongs for ready-to-eat foods and sometimes not. He had usually used gloves when serving meals.</p> <p>5. Observation on 9/17/13 from 7:40 a.m. through 8:00 a.m. for the 500 and 600 hallway dining room revealed:</p> <p>*DA T had applied gloves without hand washing or hand sanitizing.</p> <p>*Tongs had been placed on top of the aluminum foil between uses.</p> <p>*During the meal service multiple surfaces had been touched with her gloved hands such as, eating surfaces of the plates, the dietary cards, ready-to-eat foods, the saran wrap box, along with drawer and cupboard handles.</p> <p>Interview on 9/17/13 at 12:30 p.m. with DA T confirmed that tongs should have been used with the ready-to-eat foods. She had been unaware she had placed the tongs on top of the aluminum foil between uses. She also was unaware of all the surfaces she had touched with her gloved hands.</p> <p>Surveyor 32573:</p> <p>6. Observation on 9/17/13 at 12 noon in the 500 and 600 hallway dining room revealed:</p> <p>*Dietary aid (DA) T had put on gloves without hand washing or hand sanitizing.</p> <p>-She had then touched eating surfaces of plates,</p>	F 371	<p>4, 5 6, and 7. Glove use: All residents have the potential to be affected by this. Dietary Manager and Registered Dietitian educated the dietary staff on proper glove use and food handling at an inservice held on Oct 14, 2013. Dietary Manager will audit once a week x 1 month and then monthly x 4 months.</p> <p>4, 5, 6, 7, and 9. Improper handling of dishes and utensils: All residents have the potential to be affected by this. Dietary Manager and Registered Dietitian educated the dietary staff on proper handling of dishes and utensils at an inservice held on Oct 14, 2013. Dietary Manager will audit once a week x 1 month and then monthly x 4 months.</p>		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 371	<p>Continued From page 30</p> <p>ready to eat foods, cupboard doors, a hot water dispenser handle, and the dietary cards without changing gloves.</p> <p>-She had used one gloved hand to scratch her wrist under the glove on the other hand and then had not changed gloves before she continued to serve food.</p> <p>-She had rinsed out a cup in the sink with gloves on and had wiped her gloved hands on a paper towel. She then opened the cupboard door, reached under the sink, and threw the paper towels away. She had kept the same gloves on and had begun serving food again.</p> <p>*Plate domes had been used to cover and serve one resident's meal then that same dome had been used to serve different resident's meals.</p> <p>Surveyor 32572: 7. Observation on 9/17/13 at 5:35 p.m. of DA G and certified nursing assistants (CNA) I, J, K, and L during the evening meal service in the dining room revealed: *Hand washing or hand sanitizing had not been completed prior to glove application. *While serving the evening meal CNA I touched the eating surfaces of the soup spoons without prior hand sanitization. *CNA J had started serving food to residents without hand washing or hand sanitation, and then had applied gloves. *When hand washing had occurred CNA I, J, K, and L had touched the door handle of the cupboard that was an unclean surface to dispose of the paper towels.</p> <p>Surveyor 32573: Observation on 9/17/13 from 5:35 p.m. to 6:05 p.m. revealed: *Dietary aide (DA) H had not washed her hands or put on gloves before serving the first resident's</p>	F 371			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 371	<p>Continued From page 31</p> <p>meal.</p> <p>-She then put on gloves without hand washing or hand sanitizing.</p> <p>-She went on to touch eating surfaces of plates, a hot water dispenser handle, drinking glasses and swept crumbs off of a counter top without changing gloves.</p> <p>Surveyor 32572:</p> <p>Interview on 9/18/13 at 9:40 a.m. with the director of nursing (DON) confirmed she had been aware of the placement of the garbage can but had not been aware of the unclean surfaces touched when disposing of the paper towels. She also confirmed hand washing or hand sanitizing should have been completed prior to and after glove use.</p> <p>Surveyor: 32355</p> <p>8. Observation on 9/16/13 from 5:30 p.m. through 6:30 p.m. of resident 12 revealed:</p> <p>*She had been sitting in her wheelchair at the dining room table.</p> <p>*She had been served her meal at 5:50 p.m.</p> <p>*CNA C had not attempted to assist her with her meal until 6:12 p.m.</p> <p>*At 6:15 p.m. CNA C left the table to answer a call light.</p> <p>*At 6:18 p.m. CNA C returned to the table to assist her with the meal. He had given her a bite without asking her if she would have liked her food warmed up.</p> <p>*Her meal had consisted of the following blended foods:</p> <ul style="list-style-type: none"> -Cucumber salad. -Chicken dumpling soup. -Tuna salad sandwich. -Pineapple. <p>*At 6:20 p.m. this surveyor requested the DSM to check the temperature of her food.</p>	F 371	<p>8. Nurse and CNA staff were educated 9/18/13 during report, 10-3-13 and 10-10-13 at in-services that Nurses were to be in the dining room and/or hallways during meal times so they can assist with answering the lights or assisting residents with their meals so the CNA's can answer the lights. The nurses were instructed to tape report for the</p>		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 371	<p>Continued From page 32</p> <p>*The following temperatures of the above food revealed:</p> <ul style="list-style-type: none"> -Cucumber salad temperature was 66 degrees F. -Chicken dumpling soup temperature was 89 degrees F. -Tuna salad sandwich temperature was 81 degrees F. -Pineapple temperature was 64 degrees F. <p>Interview on 9/16/13 with the DSM at the above time confirmed the above temperatures were incorrect. He had stated the cold foods should have been 40 degrees F. or lower and the warm foods should not have been below 140 degrees F.</p> <p>9. Observation on 9/16/13 from 5:30 p.m. to 6:00 p.m. during the supper meal revealed:</p> <ul style="list-style-type: none"> *Dietary aide (DA) D had been serving drinks to the residents in the dining room. *At 5:40 p.m. she had moved an unidentified resident's walker by touching the handles. *She had not washed her hands after touching the resident's walker and continued to serve drinks. *She had touched the tops of the residents' glasses with the tips of her fingers multiple times during the serving process. <p>Observation on 9/17/13 from 5:05 p.m. to 5:30 p.m. during the supper meal revealed:</p> <ul style="list-style-type: none"> *Dietary aide D had been serving drinks. *She had touched the tops of the residents' glasses with the tips of her fingers multiple times during the serving process. *She had grabbed the ice water pitchers that had been sitting at residents' tables on the rims multiple times. 	F 371	<p>oncoming shift so the nurses are available during the supper meal. Nurse and CNA staff also reviewed the correct way to assist a resident with their meals. All residents requiring assistance with their meal are at potential risk for being affected</p> <p>The DNS or designee will audit the dining room and call lights on each end of the building 1 time a week times 4 weeks then 1 time a month times 3 months who will then report any identified concerns to the QA committee at the next QA meeting and will continue until the committee advises to discontinue.</p>	10/18/13	

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 371	Continued From page 33 Interview on 9/18/13 at 8:20 a.m. with the DSM confirmed DA D should not have been grabbing the residents' drinking glasses or ice water pitchers on the rims with her fingers. He had agreed that had not been a sanitary practice. Review of the provider's 2008 Kitchen General policy and procedure revealed the glasses should have been handled by the base.	F 371		
F 385 SS=D	Surveyor: 32573 483.40(a) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure physician's orders were obtained for one of six sampled residents (7) with a catheter. Findings include: 1. Review of resident 7's 9/9/13 Minimum Data Set (MDS) revealed he had been re-admitted	F 385		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 385	<p>Continued From page 34</p> <p>from the hospital with a catheter (urine drainage bag). His diagnoses included diabetes, dementia (memory loss), neurogenic bladder (prone to spasms).</p> <p>Review of resident 7's 9/2/13 hospital discharge summary revealed a miscellaneous discharge order for "Foley [catheter] placed 8/31/13, routine cares BID [twice a day] and PRN [as needed]."</p> <p>Review of resident 7's 9/17/13 attending physician's orders revealed orders for: **"Foley cath routine cares BID and PRN and every day and evening shift for Foley cath placed." *There was not an order for the placement of the catheter. *There was not an order for changing the catheter or the size of the catheter.</p> <p>Interview on 9/18/13 at 10:20 a.m. with registered nurse (RN) MDS coordinator F regarding resident 7 revealed: *He had not had the catheter prior to hospitalization. *When a resident was readmitted from the hospital they immediately contacted the resident's attending physician for order clarification. *They had waited over two weeks for that physician to clarify his orders. *She recalled that physician had been on vacation but the physician should have had someone on-call for him. *She confirmed there was not an order for the catheter placement. *The physician should have clarified: -When to change the catheter. -Irrigating the catheter. -The size of the catheter.</p>	F 385	<p>F385</p> <p>Order for Resident 7's Foley catheter placement along with changing orders, and size of catheter was obtained on 9/18/13. Nurses were in-serviced on 10-3-13 that all non-emergent orders that have been sent to physicians will continue to be placed on the clip board for each neighborhood. The clip board will be checked daily and PRN for orders needing to be returned. Once the order is returned the copy of the order will be placed in the shred box. If the order has not come in, the nurse is to contact the physician's office to clarify if they had received the fax. If they did receive it the nurse will ask for the physician to send orders back. If the office had not received the fax, the nurse will instruct the office he or she will re-fax it again immediately and ask if the physician could please address the fax that day. Nurses were also reminded not to wait until the end of their shift to check the clip board.</p> <p>All residents are at potential risk for being affected.</p> <p>The DNS or designee will audit the clip boards and orders 1 time a week times 4 weeks then 1 time a month times 4 months who will then report any identified concerns to the QA committee at the next QA meeting and will continue until the committee advises to discontinue.</p>	10/18/13

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 385	Continued From page 35 -The diagnosis (reason) for the catheter. *A later interview with MDS coordinator F revealed they had sent several other communications to that physician regarding resident 7. They had not received clarification on the catheter placement until 9/18/13. *She confirmed they should not have waited two weeks for clarifying orders. Review of the provider's January 2009 physician orders - content policy revealed: **Clarification orders are needed when reviewing any type of physician's orders that are incomplete or raise questions. -If any questions arises, nursing services is responsible for obtaining clarification." **Common components of catheter physician's order include the following: -Specific type and size of catheter/balloon. -Frequency of catheter changes. -Type of equipment being used and the frequency of changes."	F 385			
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 425	<p>Continued From page 36</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, record review, and interview, the provider failed to ensure insulin medications had not been given past the expiration dates in one of three medication carts in the east medication room. Findings include: 1. Observation on 9/18/13 at 11:40 a.m. of licensed practical nurse (LPN) S's medication cart revealed: *Lantus insulin for resident 1 marked with an opened date of 8/16/13. *Novolog insulin for resident 1 marked with an opened date of 8/17/13. *Lantus insulin and Novolog insulin expire twenty-eight days after they had been opened. Review of resident 1's September 2013 medication administration record revealed: *Lantus insulin had been documented as given five days after the expiration date. *Novolog insulin had been documented as given four days after the expiration date.</p> <p>Interview on 9/18/13 at 11:40 a.m. with LPN S revealed she: *Used the same medication cart each shift she worked. *Had not checked the dates on the insulin and did not realize they had been expired.</p>	F 425	<p>F425</p> <p>The expired Lantus and Novolog were replaced on 9/18/13. Nurses were in-serviced on 10-3-13 to remember to watch for expiration dates each time they administer the insulin. All diabetic residents are at potential risk for being affected.</p> <p>The DNS or designee will audit insulin for expiration dates 1 time a week times 4 weeks then 1 time a month times 4 months who will then report any identified concerns to the QA committee at the next QA meeting and will continue until the committee advises to discontinue.</p>	10/18/13	

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 425	Continued From page 37	F 425			
F 431 SS=D	<p>Interview on 9/18/13 at 1:40 p.m. with the director of nursing revealed she agreed medication should not have been given after the expiration date.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>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.</p> <p>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.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of 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</p>	F 431			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 431	<p>Continued From page 38 be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, interview, and record review, the provider failed to ensure: *Unauthorized personnel had access to the schedule II narcotic medication that was awaiting destruction. *Proper medication labeling for one of one observed resident (22) receiving an eye drop during medication pass.</p> <p>1. Observation on 9/17/13 at 10:30 a.m. in the director of nursing (DON) office revealed: *A locked filing cabinet with several locked boxes inside the top drawer. *The filing cabinet had been bolted to the wall.</p> <p>Interview on 9/17/13 at 10:30 a.m. with the DON revealed: *She had the key to the filing cabinet and the locked boxes in the filing cabinet on a key ring. *She kept those keys in her office in an unlocked desk drawer at all times. *Her office had been unlocked and unattended during the day. *The administrator and the maintenance man had a key to her office. *She had no outside log of what schedule II narcotics had been inside of the filing cabinet. *She would have no way of knowing if something was missing.</p> <p>Review of the provider's December 2012 Disposal of Medications policy revealed controlled</p>	F 431	<p>F431</p> <p>1. On 10/17/13 the Director of Nursing will receive a key for her desk. When the Director of Nursing is not in her office for extended periods of time such as meetings or rounds, she will lock her office door. No one will have access to any keys to get into her office. Upon receiving the Scheduled II medications, the DNS and the nurse will count the medications to be destroyed, document the number on the destruction form and both nurses will initial this amount. Director of Nursing will then copy those drug sheets and keep the copy in the locked desk with the keys. The original destruction forms will be kept with the medications in the lock box in the locked filing cabinet in the Director of Nursing office. All resident's scheduled II drugs are at potential risk for being affected.</p>		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 431	Continued From page 39 substances listed in schedule II, III, IV, V remain in the nursing care center after the order had been discontinued. They were to be retained in a securely double-locked area with restricted access until destruction. 2. Observation on 9/17/13 at 8:45 a.m. of licensed practical nurse (LPN) P during medication pass while giving an eye drop to resident 22 revealed a bottle of artificial tears eye drops with no label on it. Interview on 9/17/13 at 8:45 a.m. with LPN P revealed: *She would not know whose eye drop she had given, because they were not labeled. *At the present time resident 22 had been the only one on her hall receiving artificial tears eye drops. Review of the provider's revised October 2009 Administration of Medication policy revealed medication designed for multiple administrations (such as inhalers, eye drops, and insulin) a label should have been affixed in a manner to promote administration. The multi-dose bottle should have had the opened date on the label.	F 431	One of the Unit Managers or designee will audit the destruction forms in the file cabinet against what is in the locked desk 1 time a week times 4 weeks then 1 time a month times 4 months who will then report any identified concerns to the QA committee at the next QA meeting and will continue until the committee advises to discontinue. Resident #22: bottle of eye drops were labeled. All residents are at potential risk for being affected. On 10-3-13 and 10-10-13 Nurses were instructed to ensure all medication designed for multiple administrations should have an affixed label on them designating what resident they belong to. The DNS or designee will audit proper labeling of medication 1 time a week times 4 weeks then 1 time a month times 4 months who will then report any identified concerns to the QA committee at the next QA meeting and will continue until the committee advises to discontinue.	10/18/13	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 40</p> <p>Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) 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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on observation, interview, and policy review, the provider failed to maintain proper infection control practices for: *Two of two observed resident dressing changes (1 and 3) by two of two nurses (S and B). *One of one observed resident's personal care (3).</p>	F 441			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 41</p> <p>*One of one randomly observed resident's (21) insulin injections.</p> <p>*The maintenance of four of four hoppers in four of four soiled utility rooms.</p> <p>*The cleaning and storage of resident care items found in two of four soiled utility rooms in the 500 hallway.</p> <p>Findings include:</p> <p>1. Observation on 9/17/13 at 9:50 a.m. revealed LPN S:</p> <p>*Entered resident 1's room with supplies to do a dressing change.</p> <p>*Cleared the resident's bedside table of personal belongings.</p> <p>*Placed the clean supplies directly on the bedside table without first cleaning it or applying a barrier.</p> <p>*Washed and put gloves on her hands.</p> <p>*Removed the resident's soiled dressings.</p> <p>*Removed her soiled gloves.</p> <p>*Opened the supplies onto the bedside table.</p> <p>*Added iodine to four by four gauze pads.</p> <p>*Put clean gloves on her hands without first washing them.</p> <p>*Cleansed the resident's wounds.</p> <p>*Removed her gloves.</p> <p>*Commented, "I should have brought some sanitizer."</p> <p>*Washed her hands for ten seconds or less.</p> <p>*Opened the clean dressings onto the bedside table.</p> <p>*Put clean gloves on and applied the clean dressings to the resident's wounds.</p> <p>*Washed her hands when she had finished.</p> <p>Interview on 9/18/13 at 10:20 a.m. with the director of nursing (DON) confirmed she had expected:</p> <p>*Hands to have been washed for fifteen seconds</p>	F 441	<p>F441</p> <p>Resident personal items such as ointment tubes, were placed in resident specific baggies in the medication cart to keep from being commingled with other resident items. All residents are at potential risk for being affected. Nurses and CNA's were in-serviced on 10-3-13 and 10-10-13 on Infection Control including dressing change procedure, resident care items, proper gloving and hand washing. The DNS or designee will audit proper infection control techniques during dressing changes, resident personal cares and injections 1 time a week times 4 weeks then 1 time a month times 4 months who will then report any identified concerns to the QA committee at the next QA meeting and will continue until the committee advises to discontinue.</p> <p>The utility rooms were all cleaned on 9/17/12. Nursing and housekeeping staff were in-serviced on 10-3-13 regarding the cleaning of the items in the soiled utility rooms. CNA's were instructed to ensure that the items in the soiled utility rooms be cleaned each shift. A CNA will also be assigned each shift to be responsible for this task. Housekeeping cleans the utility room each afternoon. All utility rooms are at potential risk for being affected.</p> <p>The DNS or designee will audit soiled utility rooms 1 time a week times 4 weeks then 1</p>		

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 42 or longer.</p> <p>*Hands to have been washed or sanitized when gloves had been changed.</p> <p>*Supplies should have been placed on a cleaned surface or a barrier used to protect those supplies during a dressing change.</p> <p>Review of the provider's revised March 2008 Wound Dressing Change procedure revealed:</p> <p>*Hands were to have been washed after changing gloves or removing the soiled dressings.</p> <p>*A field (clean area) was to have been created for the dressings and supplies.</p> <p>Surveyor: 32333</p> <p>5. Observation on 9/17/13 at 9:00 a.m. of registered nurse B while administering an insulin injection to resident 21 revealed:</p> <p>*She had not washed her hands before putting on her gloves.</p> <p>*She administered the resident's insulin.</p> <p>Interview on 9/18/13 at 1:40 a.m. with the director of nursing revealed she would expect staff to have had washed their hands for at least 15 seconds before and after glove removal.</p> <p>Surveyor: 32355</p> <p>2. Observation on 9/17/13 at 8:25 a.m. revealed registered nurse (RN) B:</p> <p>*Entered resident 3's room with supplies to do a dressing change.</p> <p>*She had placed a tube of Calmoseptine ointment directly on the resident's bed pad.</p> <p>*She had placed a bottle of Mineral Oil directly on the bedside table without first cleaning it or applying a barrier.</p>	F 441	<p>time a month times 4 months who will then report any identified concerns to the QA committee at the next QA meeting and will continue until the committee advises to discontinue</p>	10/18/13	

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 43</p> <ul style="list-style-type: none"> *Washed and put gloves on her hands. *She opened the tube of Calmoseptine ointment and applied a small amount to the resident's wound. *Washed her hands and put on clean gloves. *She opened the Mineral Oil and applied it to several areas on the resident's body. *She removed her gloves, retrieved the treatment supplies, and went to the resident's bathroom to wash her hands. *She had placed the tube of Calmoseptine ointment and mineral oil directly on the edge of the bathroom sink. *After she had washed her hands she had retrieved the treatment supplies and returned to her medication cart. *She had placed the treatment supplies directly in a compartment in the bottom of the medication cart. *The treatment supplies had been placed in the compartment with several other residents' treatment supplies. *No separate containers had been noted in the medication cart to separate all the residents' treatment supplies. <p>Interview on 9/18/13 at 7:40 a.m. with RN E revealed she had confirmed:</p> <ul style="list-style-type: none"> *They had been storing the treatment supplies inappropriately. *All of the residents' individual treatment supplies should have been stored separately in a plastic bag. *The above practice had been a form of cross-contamination. <p>Interview on 9/18/13 at 10:30 a.m. with the DON confirmed RN B should have either provided a barrier for the treatment supplies or placed the</p>	F 441			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 44</p> <p>ointments in a separate cup. She stated all treatment supplies should have been placed in their own plastic bag.</p> <p>3. Observation on 9/17/13 from 7:50 a.m. through 8:20 a.m. revealed certified nursing assistant (CNA) M:</p> <ul style="list-style-type: none"> *Entered resident 3's room with supplies to do personal care. *Washed and put gloves on her hands. *Wiped resident 3's perineal (bottom) area with wet wipes. *Opened a plastic bag laying on the resident's bed and retrieved a wash cloth. *After she had retrieved the wash cloth she grabbed a tube of Tena perineal wash and placed some on the wash cloth. *Placed the plastic bag directly on the resident's night stand. The plastic bag had been touching the resident's telephone and the top cover and straw of her water glass. *After she had further cleansed the resident's perineal area she disconnected her Tabs monitor device (alarming system to alert staff when residents move) from her gown. *She had done all of the above procedures with the same gloves on. <p>Interview on 9/18/13 at 10:35 a.m. with the DON confirmed the above observation had not been a sanitary process. The CNA should have removed her gloves after each perineal care procedure and washed her hands.</p> <p>Review of the provider's January 2009 Standard Precautions procedure revealed "Wash hands immediately after gloves are removed, between resident contact and when otherwise indicated to avoid transfer of microorganisms to other</p>	F 441			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 45 residents or environments."</p> <p>Surveyor: 32573 4. Observation on 9/16/13 from 3:45 p.m. to 5:15 p.m. revealed: *A bedpan soaking in the hopper in the soiled utility room across from the oxygen storage room in the 500 hallway (photo 5). The hose for the hopper had been hanging down with the nozzle touching the floor (photo 4). *The surface of the hopper in the soiled utility room towards the east end of the 500 hallway had been covered in brown flecks that appeared to be stool (photo 3). Toilet risers wrapped in plastic bags had been placed in the sink, on the floor, and under the sink (photos 1 and 2). *The hose for the hopper in the soiled utility room in the 100 hallway had been wrapped around the faucet, and the nozzle of the hose had been hanging down into the water in the hopper (photo 6). *The hose for the hopper in the soiled utility room in the 400 wing had been hanging over the sink with the nozzle of the hose on the floor. Observation on 9/17/13 at 2:10 p.m. revealed that all of the above soiled utility rooms were in the same condition as observed on 9/16/13. It had been almost twenty-four hours since that initial observation.</p> <p>Interview with the director of nursing on 9/17/13 at 4:40 p.m. revealed the certified nursing assistants or housekeeping staff were responsible for cleaning the soiled utility rooms. The hoses for the hoppers should not have been touching the floor or hanging down in the water of the hopper. Hoppers that were visibly dirty should have been cleaned right away and at least every twenty-four</p>	F 441			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	Continued From page 46 hours. Staff would have been expected to clean soiled residents' items at the end of each shift which was about every eight hours. Toilet risers should have been cleaned and then stored in equipment storage rooms not under sinks or on the floor.	F 441			