

ORIGINAL

CENTERS FOR MEDICARE & MEDICAID SERVICES

(FAA) 0007 / 00007

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  11/08/2014
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY LUTHER MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1800 W 38TH ST SIOUX FALLS, SD 57105
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F 000

INITIAL COMMENTS *Addendums noted with an asterisk per 11/11/14 telephone to facility interim administrator DK/SDDH/INF*

Surveyor: 16385  
A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 11/4/14 through 11/6/14. Good Samaritan Society Luther Manor was found not in compliance with the following requirements: F280, F281, F309, F323, F371, F431, and F441.

F 000

Initial Comments  
Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.

F 280  
SS=D

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

The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State law. For the purpose of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with Section 7305 of the State Operations Manual.

This REQUIREMENT is not met as evidenced by:  
Surveyor: 28180  
Based on record review, observation, interview,

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>DAS</i>	TITLE Administrator Interim	(X6) DATE 11-25-2014
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 280	<p>Continued From page 1</p> <p>and policy review, the provider failed to ensure 1 of 17 sampled resident's (8) care plan was revised as changes in his care needs occurred. Findings include:</p> <p>1. Review of resident 8's physician's orders revealed he was admitted 7/17/14 and had the following:            *Diagnoses of alcohol-induced persisting dementia (confusion), depressive disorder, and insomnia (inability to sleep).            *Received the following medications for mood, behaviors, and sleep:            -Citalopram (for depression).            -Clonazepam (for insomnia).            -Melatonin (for insomnia).            -Seroquel (for dementia with behaviors).            -Trazodone (for insomnia).            *An order to receive psychological services effective 9/9/14.</p> <p>Review of resident 8's 10/14/14 physician progress notes revealed:            *8/13/14-Was pleasant but physician stated "Behaviors. Very problematic on admission. Primarily verbal abuse. Had delusions [thoughts not based on reality]. Wanted to get out [of the nursing home] and return to work. Last recorded behavior: bending silverware."            *10/14/14-"Confused and angry about another male resident. Staff shared concerns regarding increased agitation, wandering into other rooms and vulgar language toward others. He was evaluated by [name of psychological services] who noted patient was able to throw punches well. They all need control of environment."</p> <p>Random observations of resident 8 from 11/4/14 through 11/5/14 revealed he:</p>	F 280	<p>Resident 8's care plan was updated to address the appropriate items by the MDS Coordinator. All care plans will be reviewed to ensure all items are addressed by the care plan team.</p> <p>An inservice will be conducted by the Interim DNS to the care plan team about using a checklist to ensure all aspects of the care plan are addressed.</p> <p><i>x by Director of Nursing Services or designee monthly. DK/SDDH/ME</i></p> <p>During the care plan meeting, at least quarterly for each resident, we will review the care plan to ensure all items are addressed. When incidents occur, it will be reviewed at the daily stand up meeting and any changes will be updated to the care plan.</p> <p>An audit will be completed on at least six care plans to ensure accuracy each month for six months by the Director of Nursing Services or designee. Results will be forwarded to the QAPI committee for review to ensure compliance*</p>	<p><i>DK/SDDH/ME</i></p> <p><i>DK/SDDH/ME</i></p> <p><i>11/20/14</i></p> <p><i>DK/SDDH/ME</i></p>	

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F 280	<p>Continued From page 2</p> <ul style="list-style-type: none"> <li>*Was alert to person and situation.</li> <li>*Could carry a conversation when spoken to.</li> <li>*Was in a room by himself. The room was not homelike.</li> <li>*Relled on a wheelchair for mobility.</li> <li>*Was able to walk with a wheeled walker and stand-by assistance of staff.</li> </ul> <p>Interview on 11/4/14 at 4:45 p.m. with the social services coordinator regarding resident 8 revealed he:</p> <ul style="list-style-type: none"> <li>*Exhibited significant physical and verbal behaviors toward others.</li> <li>*Used very foul language at times.</li> <li>*Had gestured he would threaten that he would hit people when he was agitated.</li> <li>*Had shared a room with another male resident but became very upset about that, so the roommate was moved out.</li> <li>-Seemed to be more intolerant of men.</li> <li>*Needed a placement in a facility that dealt with difficult behaviors, and would be transferred as soon as a facility could be found.</li> <li>-That was proving to be a challenge as most facilities would not take someone who threatened others and swore the way he did.</li> </ul> <p>Review of resident 8's 7/30/14 care plan revealed:</p> <ul style="list-style-type: none"> <li>*Focus: "The resident has a behavior symptom r/t [related to] dementia, new environment and new staff E/B [evidenced by] threatening staff verbally, wandering and leaving the building."</li> <li>*Interventions: "Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed."</li> <li>*The care plan had not addressed:</li> </ul>	F 280		

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F 280	<p>Continued From page 3</p> <ul style="list-style-type: none"> <li>-How staff assisted with him with becoming familiar with his environment.</li> <li>-The medications he received to manage the moods and behaviors.</li> <li>-The potential difficulties he had with having a male roommate or male caregivers.</li> <li>-Any resident specific interventions to prevent the behaviors.</li> <li>-Non-medicinal interventions to help with sleep.</li> <li>-How the psychological services supported the staff in managing his behaviors.</li> <li>-Discharge planning.</li> </ul> <p>Interview on 11/5/14 at 2:00 p.m. with Minimum Data Set (MDS) coordinator/registered nurse G revealed resident 8's care plan had not been updated in regards to the behaviors he exhibited.</p> <p>Interview on 11/5/14 at 5:00 p.m. with the Interim director of nursing/nurse consultant revealed the care plans should have been updated as care needs changed. She confirmed that had not been done for resident 8.</p> <p>Review of the provider's September 2012 care plan policy revealed "A qualified team of persons will review care plans at last quarterly. Care plans also will be reviewed, evaluated and updated when there is a significant change in the resident's condition and/or in accordance with state guidelines. The plan of care will be modified to reflect the care currently required/provided for the resident."</p>	F 280			
F 281 SS=E	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p>	F 281			

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F 281	Continued From page 4  This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, record review, and policy review, of one sampled resident's (20) gastrostomy tube (used to provide nutrition or medication directly into the stomach) (G-tube) was not checked for appropriate placement prior to administering medications by two licensed nurses (A and B). Findings Include:  1a. Observation and interview on 11/4/14 at 11:50 a.m. with licensed practical nurse (LPN) A while she administered medications through a G-tube for resident 20 revealed: *She gathered her supplies and medications to be administered. *After she had washed her hands and put on gloves she proceeded to connect a syringe to the G-tube. *She poured 30 milliliters (ml) of sterile water into the syringe. *She stated "I check the G-tube with 30 ml of water to make sure it's not plugged." *She proceeded to administer the resident's ordered medication.  b. Observation and interview on 11/5/14 at 7:30 a.m. with registered nurse (RN) B while she administered medications through a G-tube for resident 20 revealed: *She gathered her supplies and medications to be administered. *After she had washed her hands and put on gloves she proceeded to connect a syringe to the G-tube. *She flushed the tube without checking	F 281	Licensed Nurses on staff were immediately informed to check the G-tube placement prior to administering medications by the Administrator at the all staff meeting on 11/6/14.  Licensed Nurses will be inserviced on the policy and procedure medication administration via tube by the Staff Development Coordinator.  The Director of Nursing Services or designee will be responsible to audit the medication administration for residents with a G-tube per our policy on all shifts monthly for three months. Results will be forwarded to the QAPI committee for review *by Director of Nursing Services or designee monthly. DK/SDH/MT	X DK/SDH/MT 11/20/14 X DK/SDH/MT	

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F 281	<p>Continued From page 5</p> <p>placement with 30 ml of sterile water.</p> <p>*She administered the ordered medications and flushed the tube.</p> <p>*When asked what her normal practice was for checking G-tube placement she replied "I listen for sounds in the abdomen after I put air in the syringe. I did that earlier this morning."</p> <p>*She was unaware of what the provider's policy was regarding G-tube placement.</p> <p>Review of the medical record for resident 20 revealed:</p> <p>*She had been admitted in March 2013.</p> <p>*She had medications to be given via G-tube per physician's order from that admission until the present time.</p> <p>Interview on 11/5/14 at 4:00 p.m. with the director of nursing regarding the above G-tube medication administrations revealed it was her expectation that nursing staff should have followed the provider's policy. That policy was checking placement prior to administering medications through a G-tube.</p> <p>Review of the provider's November 2013 Medication Administration Via Tube policy revealed placement should be checked:</p> <p>*Prior to administering medication.</p> <p>*Inject 5 to 10 ml of air into the G-tube to clear the tube.</p> <p>*Pull back on syringe and remove a small amount of stomach contents</p> <p>*Check the contents for gastric ph (test using special paper that measures the amount of acid in the stomach).</p> <p>Review of Donna D. Ignatavicius and M. Linda Workman, Medical-Surgical Nursing, 7th Ed., St.</p>	F 281		
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F 281	Continued From page 6 Louis, MO, 2013, page 1346, revealed for G-tube placement, "Check placement before each drug administration."	F 281	Resident 12's care plan was updated to include hospice services by the MDS Coordinator.	X [REDACTED] DK/SDD/HMF	
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 and plan of care.  This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, record review, and interview, the provider failed to ensure one of one sampled resident (12) had an integrated comprehensive care plan that included hospice services. Findings include:  1. Interview on 11/4/14 at 7:35 a.m. during initial tour of the facility with licensed practical nurse (LPN) A revealed: *Resident 12 was currently receiving hospice care. *She had a current pressure ulcer on her coccyx (tailbone area). *LPN A was unsure whether hospice or the provider would be responsible for assessing resident 12's ulcer and providing the dressing changes.  Interview on 11/5/14 at 4:45 p.m. with registered nurse (RN) B regarding resident 12's pressure	F 309	All residents on hospice services will have their care plan reviewed to ensure hospice services on the care plans. The hospice care plan will be integrated with the facility's care plan as well. An inservice will be conducted by the Interim DNS to the care plan team about using a checklist to ensure all aspects of the care plan are addressed. The MDS Coordinator will be responsible to ensure the care plan is updated with hospice services and delineation of responsibilities upon admission to hospice. The Social Services Director or designee will be responsible to audit the care plan within three days of admission to hospice services. Results will be forwarded to the QAPI Committee for review by Social Services Director monthly.	X [REDACTED] DK/SDD/HMF 11/26/14 [REDACTED] DK/SDD/HMF	

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F 309	<p>Continued From page 7</p> <p>ulcer care revealed she had thought the provider had been responsible for wound assessment and dressing changes.</p> <p>Observation and interview on 11/6/14 at 7:50 a.m. with hospice certified nursing assistant (CNA) C while performing personal care for resident 12 revealed:</p> <ul style="list-style-type: none"> <li>*She provided personal care for the resident, five days per week, Monday through Friday.</li> <li>*She gave the resident a bed bath daily and then feed her breakfast.</li> <li>*After she had fed her breakfast she left the facility.</li> <li>*She stated the hospice nurse visited once to twice per week, but the days would vary.</li> </ul> <p>Interview on 11/6/14 at 8:00 a.m. with LPN D regarding the care plan for resident 12 revealed:</p> <ul style="list-style-type: none"> <li>**The treatment administration record (TAR) tells the nursing staff how to care for her pressure ulcer. We [nurses] don't look at the care plan."</li> <li>*When asked how a new nurse or a new CNA would know how to take care of her she replied, "We use word of mouth to communicate here. Staff should just know how to take care of her."</li> <li>*She agreed there were no duties on the care plan that delegated who was responsible to care for the resident and what care they would provide.</li> </ul> <p>Interview and record review on 11/6/14 with the director of nursing regarding resident 12's care plan revealed:</p> <ul style="list-style-type: none"> <li>*There had been only one delegation of care to hospice by the provider on the care plan.</li> <li>*That care was for the hospice CNA to give the resident a bed bath and the provider's CNA to document that it had occurred.</li> <li>*No other tasks were delegated between the</li> </ul>	F 309			

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F 309	Continued From page 8 provider's staff and hospice staff. *She agreed the care plan had not been integrated with hospice care. *She further agreed staff would not know what care was to have been provided by facility staff and what care was to have been provided by hospice staff.	F 309	Facility had locks for the soiled utility rooms on order and the locks were installed by maintenance. An inservice will be conducted by the Director of Nursing Services/designee and the Environmental Services Director/designee for the licensed nurses, housekeeping, laundry and maintenance employees on the safe storage and hazardous material and chemicals policy. The Environmental Services Director will audit the storage of hazardous materials and chemicals for the soiled utility rooms monthly for three months. Results will be forwarded to the QAPI committee for review by Environmental Services Director monthly.	11/10/14 11/10/14	
F 323 SS-E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, and policy review, the provider failed to store hazardous materials and chemicals in a safe manner to protect all residents in two of two infectious waste soiled utility rooms. Findings include:  1. Observation on 11/5/14 from 3:55 p.m. through 4:00 p.m. in the 300 wing hallway revealed: *An unlocked door with a sign that read "Infectious Waste." On the wall to the right of the door was a sign that read "Soiled Utility Room." *Inside the room were two red garbage cans with red liners inside them. *Inside one of the garbage cans were several containers with used syringes and other materials.	F 323			

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F 323	<p>Continued From page 9</p> <p>*The room was across the hall from the beauty shop.</p> <p>*There were residents who walked past the room during the above time frame.</p> <p>Interview on 11/5/14 at 4:05 p.m. with the interim administrator revealed:                  *She confirmed there had not been a lock on the door.                  *Her expectations were for the door to have a lock on it.</p> <p>2. Observation on 11/6/14 at 7:45 a.m. in the focused rehabilitation unit revealed:                  *An unlocked door with a sign that read "Infectious Waste." On the wall to the right of the door was a sign that read "Soiled Utility Room."                  *Inside the room were three red barrels with red liners inside them. One of the barrels was filled to the top with containers of used syringes. Inside another barrel were red lined garbage bags that contained some type of used material.</p> <p>Interview on 11/6/14 at 8:00 a.m. with licensed practical nurse F revealed:                  *The above door was not locked.                  *She had placed used syringe containers and drainage bags that contained drainage from a wound vac in one of those barrels.                  *The garbage cans had been used for drainage from residents who had clostridium difficile (c-diff) (infectious diarrhea) or methicillin resistant staphylococcus aureus (MRSA) (staph resistant bacteria infection) drainage.                  *She had discarded used Duragesic patches (pain patches applied to the skin) in the sharps containers that were in the red garbage cans.</p> <p>3. Interview on 11/6/14 at 8:35 a.m. with the</p>	F 323			

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F 323	Continued From page 10 interim administrator revealed: *She confirmed there had not been a lock on the doors. *Her expectations were for the doors to have a locks on them.  Review of the provider's revised September 2012 Biohazard Waste or Infectious Waste policy revealed "All biohazard or infectious waste must be stored in a locked area not accessible to residents."	F 323	Dietary and maintenance staff cleaned the kitchen to ensure sanitary conditions. Some food items and pots and pans were moved to more appropriate areas to ensure sanitary conditions and safe food storage. The Director of Dietary Services implemented a system to cover food while transporting to the Rehab dining room.	* [REDACTED] DK/SDDH/INF	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  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  This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, and policy review, the provider failed to ensure sanitary conditions were maintained: *For the kitchen: -Walls. -Nine out of eleven vents. -Conduit (a pipe for protecting electrical wires) located between a food storage area and the stove. -Four of four hood panels above the stove.	F 371	The resident care items under the sink were removed immediately. A zip tie will be placed to ensure no items are placed under the sink by maintenance. A contract service will be utilized for detailed cleaning in hard to reach areas. The cleaning responsibilities for staff will be adjusted. An inservice will be conducted by the Director of Dietary Services for dietary staff to review the policy and procedures for safe and sanitary conditions, specifically related to the new procedure for transporting food, food storage and the cleaning schedule.	* [REDACTED] DK/SDDH/INF * [REDACTED] DK/SDDH/INF * [REDACTED] DK/SDDH/INF * [REDACTED] DK/SDDH/INF * [REDACTED] DK/SDDH/INF	

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  11/06/2014
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 11</p> <ul style="list-style-type: none"> <li>-Three of three fans in the walk-in refrigeration units.</li> <li>-All of the ceiling lights.</li> <li>-A food storage rack (cart) behind the stove.</li> <li>-A clean dishes storage cart in the dishroom.</li> <li>-A stainless steel shelf behind the stove.</li> </ul> <p>*To adequately cover food while being transported from the Terrace Lane dining room to the Focused dining room for two of two observed meals for all residents served there.</p> <p>*For storage of food service supplies (straws, Styrofoam cups, and water pitchers) for resident use underneath the pipes of two of two hand sinks located in the Terrace Lane dining room area.</p> <p>Findings include:</p> <p>1. Observation on 11/4/14 in the kitchen from 7:40 a.m. through 8:15 a.m. revealed:</p> <ul style="list-style-type: none"> <li>*An accumulation of dust on randomly located areas on all the walls including the dishroom area.</li> <li>*Nine out of eleven vents had a large build-up of dust and lint.</li> <li>*The conduit located between a food storage area and the stove contained a moderate build-up of dust and lint.</li> <li>*Four hood filters above the stove had a moderate accumulation of grease with multiple brown and black spots.</li> <li>*Three fans in the walk-in refrigeration units (freezer and refrigerator) contained a moderate build-up of brown and black spots.</li> <li>-In the walk-in refrigerator one of those fans was blowing directly over a rack containing:                     <ul style="list-style-type: none"> <li>-A tray of uncovered cake.</li> <li>-A tray of fruit.</li> </ul> </li> <li>*All of the ceiling lights had an accumulation of dust and lint along the sides of the light fixtures.</li> </ul>	F 371	<p>Maintenance will add the fan and vent cleaning to the monthly preventative maintenance schedule.</p> <p>The Director of Dietary Services or designee will audit the cleanliness of the kitchen, including fan and vent cleaning, and monitor to ensure the zip ties are in place on cabinets under the sink monthly for six months.</p> <p>The Director of Dietary Services or designee will audit to ensure compliance with covering food from the Terrace Cafe to the Rehab dining room weekly for four weeks for all meals, then monthly for three months. Results of the audits will be forwarded to the QAPI committee for review <i>by the Director of Dietary Services or designee monthly.</i></p> <p style="text-align: right;"><i>DJSD/BOHMF</i></p>	

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  11/06/2014
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 W 36TH 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)	(X6) COMPLETION DATE	
F 371	<p>Continued From page 12</p> <p>*A food storage cart behind the stove and a clean dish storage cart in the dishroom contained a moderate build-up of dust.</p> <p>-That cart behind the stove had four shelves of crackers, canned goods, bananas, cookies, and clean pots and pans.</p> <p>-That cart in the dishroom had four shelves of clean dishes on them.</p> <p>*A stainless steel counter behind the stove contained an accumulation of dust and lint.</p> <p>Interview on 11/4/14 at 10:50 a.m. with the certified dietary manager (CDM) and the maintenance supervisor regarding the above listed areas in the kitchen revealed:</p> <p>*The maintenance supervisor stated his department was responsible for cleaning the refrigeration unit fans and the vents on an as needed basis.</p> <p>*He did not have the fan and vent cleaning on a cleaning schedule.</p> <p>*The CDM stated his department was responsible for cleaning the rest of the kitchen.</p> <p>*He stated he had a cleaning schedule for some of the items that had needed cleaning.</p> <p>Review of the kitchen cleaning schedules for October 2014 through July 2014 revealed:</p> <p>*Hood filters were to have been cleaned weekly by the a.m. production leader.</p> <p>*Fans were to have been cleaned every Monday by the p.m. production leader.</p> <p>*Dishroom walls were to have been cleaned every Friday by the west p.m. aide.</p> <p>*None of the other areas were on the cleaning schedule including the:</p> <p>-Rest of the kitchen area walls.</p> <p>-Ceiling.</p> <p>-Conduit.</p>	F 371			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  438044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  11/06/2014
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 13</p> <ul style="list-style-type: none"> <li>-Food storage cart behind the stove.</li> <li>-The clean dishes storage rack in the dishroom.</li> <li>-The stainless steel shelf behind the stove.</li> </ul> <p>Review of the provider's revised March 2009 Cleaning-Sanitation of Non-Food Contact Surfaces policy revealed:</p> <ul style="list-style-type: none"> <li>*The provider would have store, prepare, distribute, and serve food under sanitary conditions at all times.</li> <li>*Walls were to have been spot cleaned on an "as needed" basis and washed at a minimum of annually.</li> <li>*Ceilings were to have been spot cleaned on an "as needed" basis and thoroughly washed at a minimum of once per year.</li> <li>*Light fixtures and fans were to have been on a cleaning schedule.</li> <li>*Scheduled weekly cleaning of the hood filters in the dishwasher or other method.</li> <li>*Scheduled cleaning of the fans weekly or as needed.</li> <li>*Walls and vents were to have been scheduled for cleaning about every six months or at a minimum annually.</li> <li>*Carts were to have been cleaned and sanitized at the beginning of the a.m. shift and at least every four hours throughout the day.</li> <li>*Counter tops were to have been cleaned and sanitized between use and at the end of the day.</li> </ul> <p>Review of the provider's revised September 2012 Dietary Department Safety Rules policy revealed:</p> <ul style="list-style-type: none"> <li>*A cleaning checklist was to have been developed so all equipment was cleaned on a regular basis.</li> <li>*Remove accumulations of dirt and grease from the range hoods regularly (weekly at a minimum).</li> <li>*Hood filters should have been cleaned weekly.</li> </ul>	F 371			

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  11/06/2014
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)	(X4) COMPLETION DATE
F 371	<p>Continued From page 14</p> <p>Review of the provider's revised December 2013 Food Storage policy revealed food was to have been stored under sanitary conditions.</p> <p>2. Observation on 11/4/14 at 11:58 a.m. and on 11/4/14 at 5:40 p.m. in the Terrace Lane dining room from the steam table area revealed:                      *Unidentified dietary and nursing staff were transporting food and beverages to the Focused dining room for all the residents eating there.                      *Those staff were transporting all food and beverages uncovered to that area.                      *During the transport of those residents' food and beverages the staff had needed to go down a resident hallway that included:                      -An infection control supply room.                      -One occupied resident room.</p> <p>Interview on 11/5/14 at 4:15 p.m. with the administrator, director of nursing, registered dietitian (RD), and CDM in the Focused dining room regarding the above revealed:                      *They all agreed there was a potential for contamination of the uncovered foods and beverages from the Terrace Lane dining room to the Focused dining room.                      *They all agreed the food needed to have been covered.</p> <p>Review of the provider's February 2013 Food Transport policy revealed:                      *Safe practices were to have been ensured when transporting food and fluids.                      *All food items were to have been covered.</p> <p>3a. Observation on 11/4/14 at 8:20 a.m. in the Terrace Lane dining room underneath the hand sink located next to the steam table revealed:                      *A box of opened flexible straws.</p>	F 371		

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  11/06/2014
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1600 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 15 *Two plastic pitchers.  b. Observation on 11/4/14 at 8:22 a.m. in the Terrace Lane dining room underneath the hand sink located in the kitchenette area next to the dining room revealed: *A box of opened flexible straws. *Five opened Styrofoam cups and one package of closed Styrofoam cups.  c. interview on 11/5/14 at 10:30 a.m. with the CDM and the RD regarding the above being stored under hand sinks in the Terrace Lane dining room area revealed: *The CDM stated the straws and Styrofoam cups were resident care items. *The plastic pitchers had been used to fill the steam table wells in the Terrace Lane dining room. *They both agreed those were resident care items. *They confirmed the resident care items should not have been stored under the sinks. *The pipes could leak and there could be a possible contamination of those resident care items stored there.  Interview on 11/05/14 at 10:30 a.m. with the CDM and the RD regarding food supplies used for resident care being stored under the hand sinks revealed the provider did not have a specific policy regarding that.	F 371			
F 431 SS-E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431			

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  11/06/2014
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY LUTHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 W 38TH ST SIOUX FALLS, SD 57108	
(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)	(X6) COMPLETION DATE
F 431	<p>Continued From page 16</p> <p>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 be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:                  Surveyor: 33488                  Based on observation, interview, and policy review, the provider failed to:                  *Ensure limited access by unauthorized staff to discarded Fentanyl patches (narcotic pain medication) that had been stored in two of two</p>	F 431	<p>The Interim DNS had already ordered the Drug buster for fentanyl patches and other controlled substances so that those items would not be placed in the sharps containers for disposal. The container with drug buster will be stored in the med room.</p> <p>The Licensed Nurses on staff were informed by the Administrators to have both the incoming nurse and the departing nurse sign the controlled substance count sheet. The Director of Nursing Services will be inserviced on the policy for biohazard/infectious waste and the procedure for safe disposal of patches and controlled substances and procedure for incoming and departing nurses to sign the controlled substance count sheet.</p>	<p>X [REDACTED] DK/SDDH/MF</p> <p>X [REDACTED] DK/SDDH/MF</p> <p>X [REDACTED] DK/SDDH/MF</p>

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  11/06/2014
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 17</p> <p>soiled utility rooms.</p> <p>*Ensure nursing staff were signing the change of shift controlled substances count sheet in one of two medication rooms as required from the nurse arriving on and the nurse departing from duty.</p> <p>Findings Include:</p> <p>1. Review of the medication carts and the medication rooms, located on the west wing and the rehab wing, on 11/5/14 from 1:50 p.m. through 2:30 p.m. revealed Fentanyl patches had been discarded into the sharps containers (used needles containers) that were affixed to the medication carts. Once the sharps containers were full, they were stored in two of two soiled utility rooms.</p> <p>Interview with registered nurse (RN) B during the above medication carts and rooms review regarding used Fentanyl patches revealed:</p> <p>*When an old patch [Fentanyl] had been removed it was placed in the sharps container on the medication cart by the nurse.</p> <p>*The carts commonly sat outside the medication room when not in-use or in direct sight by nursing staff.</p> <p>*When the containers were full they were removed from the cart and stored in one of the soiled utility rooms awaiting destruction.</p> <p>*There were no locks on either soiled utility room door.</p> <p>*All staff and residents had access to the provider's two soiled utility rooms.</p> <p>Interview on 11/5/14 at 4:00 p.m. with the director of nursing regarding the above storage of used Fentanyl patches revealed:</p> <p>*She was unaware the Fentanyl patches were stored unsecured in the two soiled utility rooms</p>	F 431	<p>The Director of Nursing Services or designee will audit weekly for four weeks then monthly for three months to ensure controlled substances are disposed of properly and that both incoming and departing nurses sign the controlled count med sheet. Results of the audits will be forwarded to the QAPI Committee for review* by the Director of Nursing Services or designee monthly. D/SDDH/MF</p>		

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  11/06/2014
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>Continuad From page 18 after use.</p> <p>*She agreed unauthorized personnel had access to the used patches.</p> <p>*She agreed there was a potential for drug diversion by not having the Fentanyl patches secured away from residents and unauthorized personnel.</p> <p>Review of the provider's June 2014 Controlled Substances policy revealed it had not addressed the proper disposal of narcotic medication patches.</p> <p>2. Observation of the two medication rooms on 11/5/14 from 1:50 p.m. through 2:30 p.m. and review of two randomly selected Change of Shift Controlled Substances Count Sheets revealed they were missing fourteen of eighteen signatures required of the nurse arriving on duty.</p> <p>Interview with RN B during the above medication cart and room observation review regarding the above count sheets revealed:                      *The Change of Shift Controlled Substances Count Sheets were to have been signed by both the oncoming and off going nurses when a dual count had been made.                      *Both nurses were required to sign the sheets.                      *She was unsure why the nurses had not been signing them.                      *She agreed it looked as if only one nurse had performed the count for the unsigned days.</p> <p>Interview on 11/5/14 at 4:00 p.m. with the director of nursing regarding the above unsigned Controlled Substances Count Sheets revealed:                      *It had been her expectation all staff were to follow facility policy in having dual signoff of drug counts.</p>	F 431			

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  11/06/2014
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 19 *She was unsure why the nurses had not signed them. *The sheets were to be audited for compliance regularly but "obviously they had not."	F 431	Laundry staff were informed immediately of the policy to cover linens and personal clothing by the Administrator and Laundry Supervisor.	* [Redacted] 11/20/14
F 441 SS-E	Review of the provider's June 2014 Controlled Substances policy revealed one nurse counted the medication and the other nurse was responsible to verify that count. <b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  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 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (3) The facility must require staff to wash their	F 441	The policy to cover linens and personal clothing was reviewed at the all staff meeting by the Administrator on 11/6/14. The Laundry/Housekeeping Supervisor will audit to ensure the linens and personal clothing are appropriately covered weekly for four weeks then monthly for three months. Results will be forwarded to the QAPI Committee for review* <i>by the laundry/housekeeping supervisor monthly.</i>	* [Redacted] 11/20/14

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  11/08/2014
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 20</p> <p>hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens 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: 29354 Based on observation, interview, and policy review, the provider failed to ensure clean laundry was covered when stored and transported to prevent possible contamination. Findings include:</p> <p>1. Observations from 11/4/14 through 11/6/14 revealed: *On 11/4/14 at: -7:43 a.m. outside room 515 was a cart that contained uncovered resident hand towels and wash cloths. -10:19 a.m. outside room 304 was a cart that contained uncovered resident personal clothing. *On 11/5/14 at: -7:40 a.m. in the 400 wing hallway was a cart that contained uncovered resident hand towels and wash cloths. -8:25 a.m. in the 300 wing hallway was a cart that contained uncovered resident hand towels and wash cloths. -1:45 p.m. laundry aide E was transporting a cart on wheels that contained resident wash cloths, towels, and hand towels. There was a drape over the top of the laundry, but the sides of the cart were exposed.</p>	F 441			

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  11/06/2014
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 21</p> <p>*On 11/6/14 at:                      -7:10 a.m. in the 400 wing hallway was a cart that contained uncovered resident hand towels and wash cloths.                      -7:25 a.m. outside room 601 was a cart that contained uncovered resident hand towels and wash cloths.</p> <p>Interview on 11/5/14 at 1:45 p.m. with laundry aide E regarding that observation of laundry confirmed:                      *This was the way she had always delivered clean laundry.                      *Laundry was never fully covered when delivered to the residents.</p> <p>Interview on 11/5/14 from 2:00 p.m. through 2:40 p.m. with the Interim director of nursing and Minimum Data Set registered nurse H revealed they agreed linen was to be covered when transported or stored down the hallways.</p> <p>Interview on 11/5/14 at 2:45 p.m. with the Interim administrator revealed she agreed linen was to be covered when transported or stored down the hallways.</p> <p>Review of the provider's revised November 2008 Laundry/Linen Distribution policy revealed "Cover clean linen. Keep covered during transportation to other areas."</p>	F 441			

**ORIGINAL**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  11/05/2014
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY LUTHER MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 W 38TH ST SIOUX FALLS, SD 57105
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180                      A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 11/5/14. Good Samaritan Society Luther Manor (Building 1) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Administrator Patricia (X6) DATE: 11.25.2014

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  436044	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02  B. WING _____	(X3) DATE SURVEY COMPLETED  11/05/2014
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY LUTHER MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 W 39TH ST SIOUX FALLS, SD 57105
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14160 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 11/5/14. Good Samaritan Society Luther Manor (Building 2) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *D. A. S.* TITLE *Administrator* (X6) DATE *11.25.2014*

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.

**ORIGINAL**

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  10681	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  11/06/2014
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY LUTHER MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 W 38TH ST SIOUX FALLS, SD 57105
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 11/4/14 through 11/6/14. Good Samaritan Society Luther Manor was found not in compliance with the following requirement: S130.	S 000	Initial Comments Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.	
S 130	44:04:02:06 FOOD SERVICE  Food service must be provided by a licensed facility or food establishment that is inspected by a local, state, or federal agency. The facility must meet the safety and sanitation procedures for food service in chapters 44:02:07:01, 44:02:07:02, and 44:02:07:04 to 44:02:07:95, inclusive, the Food Service Code. In addition, a mechanical dishwasher must be provided in all facilities of 20 beds or more. The facility must have the space, equipment, supplies, and mechanical systems for efficient, safe, and sanitary food preparation if any part of the food service is provided by the facility.  This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32331 Based on observation and interview, the provider failed to ensure the food preparation two-compartment sink in the kitchen with a physical air break on the drain line. Findings include:  1. Observation on 11/4/14 at 7:40 a.m. revealed the two compartment sink in the kitchen was not	S 130	The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State law. For the purpose of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with Section 7305 of the State Operations Manual.	

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

*D.A.S.*

TITLE

Administrator  
Interim

(X6) DATE

11.25.2014

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  10681	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  11/06/2014
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY LUTHER MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 W 38TH ST SIOUX FALLS, SD 57106
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 130	<p>Continued From page 1</p> <p>provided with a one inch physical air break in the drain line.</p> <p>Interview on 11/4/14 at 4:00 p.m. in the kitchen with the certified dietary manager (CDM), maintenance supervisor, and the registered dietitian (RD) regarding the two compartment sink revealed:</p> <ul style="list-style-type: none"> <li>*The maintenance supervisor agreed there was not a one-inch physical air break in the drain line.</li> <li>*The CDM and the RD agreed that sink had been used for cleaning fruit and other food preparation.</li> <li>*The maintenance supervisor stated he was unaware of any policy for the physical air break on the drain line.</li> </ul> <p>Interview on 11/5/14 at 3:25 p.m. with the CDM and the RD regarding the two compartment sink in the kitchen revealed they confirmed the provider had no policy for the physical air break on the drain line.</p>	S 130	<p>The Director of Dietary Services immediately stopped the use of the two compartment sink.</p> <p>The Environmental Services Director will ensure that there is a physical air break on the drain line for the two-compartment sink.</p> <p>The Environmental Services Director will notify the QAPI Committee upon completion of it.</p>	<p>* 11/20/14 [Redacted] 11/20/14 [Redacted] 11/20/14 [Redacted]</p>