

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 12/03/2015
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 <i>*Addendums noted with an asterisk per 1/15/16 per telephone with facility administrator. NK-15DDOTHEL</i>	F 000	Good Samaritan Society – Luther Manor		
F 221 SS=D	Surveyor: 33265 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 12/1/15 through 12/3/15. Good Samaritan Society Luther Manor was found not in compliance with the following requirements: F221, F280, F309, F371, F441, and F518. 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on observation, interview, record review, and policy review, the provider failed to ensure there was an initial and ongoing assessments for the use of a restrictive device (seatbelt) that might be considered a restraint for one of one sampled resident (9). Findings include: 1. Random observations and interview from 12/1/15 through 12/3/15 at the following times of resident 9 revealed: *On 12/1/15 at 2:20 p.m. she was moving down the hallway in her motorized wheelchair. A seatbelt was in place over her lap. *On 12/2/15: -At 11:50 a.m. she was seated in a motorized wheelchair near the dining room. The seatbelt was in place across her lap.	F 221	Provider #435044 Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the 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. Alternatively, due to the requirements of Federal law and without prejudice as to the facility's disagreement with this deficiency, the facility submits the following plan of correction. F 221 RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS Resident #9 was assessed for seatbelt use and the plan of care was updated accordingly on 12/2/15.		

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

Julio Marko

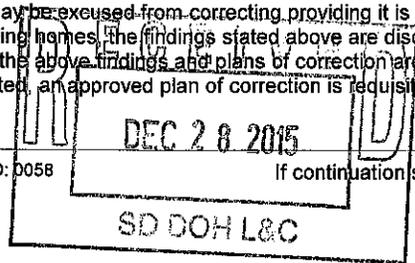
TITLE

Administrator

(X6) DATE

12/23/15

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: 435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2015
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 221	<p>Continued From page 1</p> <p>-At 1:05 p.m. she was seated in her wheelchair in the activity room with the seatbelt in place. Interview with her revealed the seatbelt was "always buckled" when she was upright in the wheelchair, and she was able to release the latch.</p> <p>Review of resident 9's medical record revealed: *She had been admitted on 8/17/09. *She had diagnoses of a neuromuscular disease (affects muscles and nerves), pain, diabetes, high blood pressure, high cholesterol, and a pressure ulcer (sore). *There was no documentation of the use of a seatbelt while in the motorized wheelchair.</p> <p>Review of resident 9's 11/9/15 Minimum Data Set (MDS) assessment revealed: *Her Brief Interview for Mental Status (BIMS) assessment was coded as a 15 indicating she was cognitively intact (no difficulty with thought processes). *Physical restraints were coded as a 0 indicating they were not used.</p> <p>Review of resident 9's undated care plan revealed no indication of seatbelt use while in the wheelchair.</p> <p>Interview on 12/2/15 at 4:45 p.m. with the director of nursing (DON) regarding resident 9 revealed she: *Could not locate an initial or ongoing assessment for the use of the seatbelt, but stated she would check with the MDS nurse. *Stated "It may have been overlooked."</p> <p>Interview on 12/3/15 at 8:05 a.m. with the DON and the administrator regarding resident 9 revealed:</p>	F 221	<p>F 221 continued:</p> <p>All residents were screened to identify use of seatbelt. Residents identified were assessed and care plan updated accordingly.</p> <p>*Any residents with a seatbelt will be assessed and reviewed quarterly. Each new resident, will be screened for seatbelt use and care-planned accordingly using the Physical Device and Restraint Assessment. Each seat belt in use will be reviewed quarterly and with significant change. → by the MDS coordinator or designee. NR/SDPOTTEL Directed in-service with information on what constitutes a restraint and required monitoring of restraints was presented at all-staff meetings on Dec. 15 and 16, 2015.</p> <p>Compliance with seatbelt assessments and reviews will be audited monthly x3 quarterly x2 by Nurse Case manager. Nurse Case manager or designee will report findings to QAPI committee monthly. The committee will determine on going interventions and monitoring.</p> <p>*The initial assessment and care plan for a resident with a seatbelt will be completed by the MDS coordinator or designee. NR/SDPOTTEL → *The DNS presented this information during the all-staff meeting on Dec 15/16, 2015. NR/SDPOTTEL</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 12/03/2015
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 221	Continued From page 2 *An initial assessment was completed by the MDS nurse on 12/2/15 after the DON met with the surveyor. *Quarterly assessments would continue to be completed to verify the device was not a restraint. *Residents and families were educated on admission that the facility did not utilize restraints.	F 221		
F 280 SS=D	Review of the provider's revised August 2014 Physical Restraints policy revealed: **"Anytime a device, material or equipment is attached or placed adjacent to the resident's body, a determination will be made by a licensed nurse as to whether it is or could be a restraint for the individual resident." **"If the device, material or equipment is not a restraint, it must be reviewed with a significant change in condition and quarterly in conjunction with the care plan to ensure that it continues to not be a restraint for the resident." 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	F 280	F 280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE C.P. <u>Resident #7 was not outside the blood sugar parameters specified by the physician. The resident's weight has been stable. The resident has not experienced any significant change or acute adverse effects.</u> The following changes have been made: Resident #7's care plan has been revised to include monitoring of A1c every 3 months, appropriate snack options, interventions for orientation and redirection when confused, and frequency of diabetic education.	1/22/16

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 12/03/2015
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 3</p> <p>legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure one of seven sampled residents (7) with uncontrolled blood sugars (BS) related to diabetes mellitus (DM) had his care plan revised as changes occurred. Findings include:</p> <p>1. Review of resident 7's admission record revealed: *He had been admitted on 7/10/15. *His diagnoses included insulin dependent diabetes mellitus (IDDM).</p> <p>Review of resident 7's November 2015 BS monitoring revealed: *He received Novolog solution 100 units based on a sliding scale ranging from three to eleven units. *The physician was to have been notified if his BS was over 400. *His BS was checked four times a day. *During that time period it was: -Over 200, thirty-two times. -Over 300, forty-eight times. -Four of those times it was over 390.</p> <p>Review of resident 7's physician's progress notes revealed: *He had been seen on 8/8/15, 9/5/15, and 10/9/15 by his physician. Each time the physician</p>	F 280	<p>F 280 continued:</p> <p>All insulin dependent diabetic residents had their Care Plans reviewed and revised as appropriate and diabetic education was provided to each insulin dependent diabetic resident.</p> <p>Care Plans will be reviewed and revised quarterly and upon significant change. Incoming residents with insulin dependent diabetes will have care plans interventions specific to their individual diabetic management needs. RD, CDM or licensed nurse designee will provide diabetes management education to affected residents and their families during care conferences.</p> <p>Directed In-Service Training was provided on 12/15 and 12/16 for all staff responsible for diabetic resident care, assessment, identifying change and responding as needed.</p> <p>Health Information manager or designee will audit electronic medical record to ensure (1) care plan reviews are completed quarterly and with significant change in resident conditions and (2) documentation of education.</p> <p>Audits to be completed monthly x3. Health Information Manager or designee will report results to QAPI committee monthly.</p> <p>QAPI committee will review findings each month and determine on-going interventions and monitoring.</p>	<p>*by the MDS coordinator or designee. NR/SDOCH/EL</p> <p>*per month NR/SDOCH/EL</p>

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

PRINTED: 12/17/2015
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 12/03/2015
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 4</p> <p>recorded: "Plan: I have recommended the following steps for improving diabetic care and outcome to him: Referral to diabetic education department, diabetic diet discussed in detail; written exchange diet given, low cholesterol diet, weight control and daily exercise, home glucose [BS] monitoring, emphasized foot care discussed."</p> <p>Review of resident 7's registered dietitian's (RD) assessments revealed:</p> <p>*7/14/15: Admission assessment: "Visited with resident briefly in his room on his way to the restroom." -"He is served a CCHO [constant carbohydrate] diet." -"DM (blood sugars checked 4x [four times] day before meals and at HS [hour of sleep]." -"Nursing providing skin cares of pressure ulcer stage 1 on 8/29/15." *There was nothing further regarding any diet teaching.</p> <p>*9/6/15: Re-admission assessment: "Visited with resident briefly in hallway." -"He is served a CCHO diet r/t [related to] dx [diagnosis] of DM." -"Nursing providing skin cares of pressure ulcer stage 1 on 8/29/15." -"DM (blood sugars checked 4x [four times] day before meals and at HS) [hour of sleep]." *9/30/15: Quarterly nutrition assessment: There were no changes. *There were no further assessments or documentation regarding nutrition or addressing his blood sugars.</p> <p>Interview on 12/3/15 at 10:15 a.m. with the RD and certified dietary manager (CDM) regarding resident 7 revealed:</p>	F 280		

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

PRINTED: 12/17/2015
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 12/03/2015
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 5</p> <ul style="list-style-type: none"> *The RD assessed any new admission, weight losses, and resident who received tube feedings. *The RD would not necessarily assess someone who had DM. *The physician would have been the first person that would have been notified about a high BS as they might adjust the resident's medication. *If a resident's BS was abnormally high the RD should have been made aware of that. -Nursing alerted them to those things. -The RD had not been notified of resident 7's high BS. *The RD confirmed a resident's diet could impact their BS. *Neither the CDM nor the RD were aware: <ul style="list-style-type: none"> -If the resident was compliant with his diet. -If the resident had received the diabetic education the physician had recommended. *They had not participated in care conferences. <ul style="list-style-type: none"> -The CDM relied on the social worker to keep him informed of resident changes. -Nothing had been said about resident 7's BS. -The CDM had been unable to attend care conferences for over a year as he was needing to cook meals due to staffing turnover. *They agreed the care plan did not address any specific interventions for the DM. <p>Interview on 12/2/15 at 1:00 p.m. with registered nurse C regarding resident 7 revealed:</p> <ul style="list-style-type: none"> *His blood sugars ran very high. *He was non-compliant with eating, having snacks in his room. -He would deny he ate anything, but there would be snack wrappers in his room. -He thought anytime his BS was below 300 it was good. *He had a good appetite and ate a big breakfast. -Sometimes he came back to the dining room 	F 280			

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

PRINTED: 12/17/2015
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 12/03/2015
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 6</p> <p>after he ate breakfast and claimed he was hungry and had not eaten yet.</p> <p>*He had not had an A1C (blood test that evaluates blood sugar over a three month period) in his chart since he had been admitted.</p> <p>-He needed to have that done as that was done usually every three months.</p> <p>*She had tried to educate him, but she had not documented any education to the resident.</p> <p>*A referral to the RD had not been done.</p> <p>-Thought the things he ate definitely affected his blood sugars.</p> <p>*She was unsure if the resident had participated in any diabetic education program as recommended by the physician.</p> <p>Review of resident 7's 7/10/15 care plan revealed:</p> <p>*Focus: He had DM.</p> <p>*Goal was "Be free of any s/s [signs and symptoms] of hyperglycemia (high BS)."</p> <p>*Interventions included:</p> <p>- "Wash feet daily. Licensed nurse to provide foot care."</p> <p>- "Observe/monitor/document the resident/family's ability to manage the treatment program, i.e. medications, dietary, glucose monitoring, exercise and knowledge of complications."</p> <p>- "Discuss meal times, portion sizes, dietary restrictions, snacks allowed in daily nutritional plan, importance of good dietary choices."</p> <p>- There were no specific interventions to address preventing the high blood sugars.</p> <p>- There were no interventions addressing what to do when his blood sugars were high.</p> <p>*Focus: "The resident has nutritional potential for nutritional problems related to DM, dementia and special diet."</p> <p>*Interventions:</p>	F 280			

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

PRINTED: 12/17/2015
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 12/03/2015
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 7</p> <ul style="list-style-type: none"> - "Weigh daily." - "Invite resident to food-related activities and offer food, beverages of choice to encourage intake." *It had not addressed: <ul style="list-style-type: none"> - He sometimes forgot he ate and requested a second breakfast. - What to do when his BS got higher. - What snacks would have been appropriate for food related activities, or how they monitored his snacks. - Resident and family education. - His review in the Nutrition at Risk monthly meeting. - Appropriate laboratory tests. <p>Review of the provider's September 2012 Care Plan policy revealed: *"The interdisciplinary team will be comprised of appropriate staff in various disciplines as determined by the resident's needs." *"A qualified team of persons will review care plans at least 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 regulations. This plan of care will be modified to reflect the care currently required/provided for the resident."</p> <p>Review of the provider's February 2013 Monitoring Residents with Impaired Nutrition and Nutritional Risk policy revealed: *"The center will ensure that each resident maintains acceptable parameters of nutritional status such as body weight, protein levels and hydration status unless the resident's clinical condition demonstrates that this is not possible." *"Residents with impaired nutrition or nutritional risk may be identified by nursing, dietary and other members of the care plan team."</p>	F 280		

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

PRINTED: 12/17/2015
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 12/03/2015
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 8 **Residents with newly identified impaired nutrition or nutrition risk are added to the Nutrition Risk List and discussed at the next nutrition risk committee meeting.	F 280	<p>F 280 continued:</p> <p><i>Julie Marko</i></p> <p>All insulin dependent diabetic residents had their Care Plans reviewed and revised as appropriate and diabetic education was provided to each insulin dependent diabetic resident.</p> <p>Care Plans will be reviewed and revised quarterly and upon significant change. Incoming residents with insulin dependent diabetes will have care plans interventions specific to their individual diabetic management needs. RD, CDM or licensed nurse designee will provide diabetes management education to affected residents and their families during care conferences.</p> <p>Directed In-Service Training was provided on 12/15 and 12/16 for all staff responsible for diabetic resident care, assessment, identifying change and responding as needed.</p> <p>Health Information manager or designee will audit electronic medical record to ensure (1) care plan reviews are completed quarterly and with significant change in resident conditions and (2) documentation of education.</p> <p>Audits to be completed monthly x3. Health Information Manager or designee will report results to QAPI committee monthly.</p> <p>QAPI committee will review findings each month and determine on-going interventions and monitoring.</p>	
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: 26180 Based on record review, interview, and policy review, the provider failed to ensure care and services were given for one of seven sampled residents (7) with uncontrolled blood sugars (BS) related to diabetes mellitus (DM). Findings include: 1. Review of resident 7's admission record revealed: *He had been admitted on 7/10/15. *His diagnoses included insulin dependent diabetes mellitus (IDDM). Review of resident 7's November 2015 BS monitoring revealed: *He received Novolog solution 100 units based on a sliding scale ranging from three to eleven units. *The physician was to have been notified if his BS was over 400.	F 309		

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 12/03/2015
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 9</p> <p>*His BS was checked four times a day. *During that time period it was: -Over 200, thirty-two times. -Over 300, forty-eight times. -Four of those times it was over 390.</p> <p>Review of resident 7's medical record and interview on 12/2/15 at 5:00 p.m. with the health information manager (HIM) revealed: *There were no physician's progress notes in his record. *His urine was tested once for a possible infection, since his admission. *There were no records of any laboratory results related to his diabetes in his medical record. *She was able to contact his physician's medical office and obtain copies of the physician's progress notes.</p> <p>Review of resident 7's physician's progress notes revealed: *8/18/15: -His active problem list included diabetic neuropathy (damage to peripheral nerves), DM, chronic kidney disease, and many other co-existing diagnoses. -"Patient [resident] presents today for evaluation of diabetes. Patient reports onset of diabetes to have been 14 years ago. Patient is being treated with diet, oral agents and insulin injections. Complicating factors include but are not limited to: none." -Assessment: Type 2 (adult onset) DM without complication. -Plan: "I have recommended the following steps for improving diabetic care and outcome to him: Referral to diabetic education department, diabetic diet discussed in detail; written exchange diet given, low cholesterol diet, weight control and</p>	F 309	<p>F 309 Provide Care/Services for Highest Well Being</p> <p><u>Resident #7 was not outside the blood sugar parameters specified by physician. The resident's weight has been stable. The resident has not experienced any significant change or acute adverse effects.</u></p> <p>The following corrections have been made: per facility request, Primary care physician has reviewed blood sugar levels and made changes to insulin dosing. Order obtained for A1c to be drawn and rechecked every 3 months. RD has reviewed blood sugar levels and updated care plan to include education on appropriate snacks options. Resident #7 added to be discussed by interdisciplinary team during January nutrition risk meeting.</p> <p>To identify other potentially affected residents: orders and care plan interventions for all other insulin dependent residents have been reviewed and revised as indicated. All insulin dependent diabetic residents have been added to the nutrition risk list.</p> <p>*The RD will screen all new residents for addition to the nutrition risk list using the Dietary Admin/Readmit Data Collection Tool. RD will review blood sugar data for insulin dependent residents monthly. Blood sugar report will be sent to physician for review during 60 day check-ups for on-going confirmation diabetes management goals are being met.</p>	11/22/16	

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

PRINTED: 12/17/2015
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 12/03/2015
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 10</p> <p>daily exercise, home glucose monitoring, emphasized foot care discussed."</p> <p>*9/5/15: A nursing home visit: -Plan: "I have recommended the following steps for improving diabetic care and outcome to him: Referral to diabetic education department, diabetic diet discussed in detail; written exchange diet given, low cholesterol diet, weight control and daily exercise, home glucose monitoring, emphasized foot care discussed."</p> <p>*10/9/15: -Plan: "I have recommended the following steps for improving diabetic care and outcome to him: Referral to diabetic education department, diabetic diet discussed in detail; written exchange diet given, low cholesterol diet, weight control and daily exercise, home glucose (BS test) monitoring, emphasized foot care discussed."</p> <p>Review of resident 7's registered dietitian's (RD) assessments revealed: *7/14/15: Admission assessment: "Visited with resident briefly in his room on his way to the restroom." -"He is served a CCHO [constant carbohydrate] diet." -"DM (blood sugars checked 4x [four times] day before meals and at HS [hour of sleep]." -"Nursing providing skin cares of pressure ulcer stage 1 on 8/29/15." -There was nothing further regarding any diet teaching. *9/6/15: Re-admission assessment: "Visited with resident briefly in hallway." -"He is served a CCHO diet r/t [related to] dx [diagnosis] of DM." -"Nursing providing skin cares of pressure ulcer stage 1 on 8/29/15." -"DM (blood sugars checked 4x [four times] day</p>	F 309	<p>F 309 continued:</p> <p>Directed In-Service Training was provided on 12/15 and 12/16 for all staff responsible for diabetic resident care, assessment, identifying change and responding as needed.</p> <p>Health Information Management or designee will audit EMR monthly for 3 months to confirm (1) Dietary Admit/Readmit Data collection tool is completed for all new residents, (2) documentation for blood sugar review by RD (3) order in place for A1c and lab results on file (4) physician acknowledgement of blood sugar report.</p> <p>HIM or designee will report findings to monthly QAPI meetings and the committee will determine on-going interventions and monitoring.</p>	

**Five Residents Not Included*

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

PRINTED: 12/17/2015
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 12/03/2015
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 11 before meals and at HS) [hour of sleep]." *9/30/15: Quarterly nutrition assessment: There were no changes. *There were no further assessments or documentation regarding nutrition or addressing his blood sugars.</p> <p>Interview on 12/3/15 at 10:15 a.m. with the RD and certified dietary manager (CDM) regarding resident 7 revealed: *The RD assessed any new admission, weight losses, and resident who received tube feedings. *The RD would not necessarily assess someone who had DM. *The physician would have been the first person that would have been notified about a high BS as they might have adjusted the resident's medication. *If a resident's BS was abnormally high the RD should have been made aware of that. -Nursing alerted them to those things. -The RD had not been notified of resident 7's high BS. *The RD confirmed a resident's diet could impact their BS. *Neither the CDM nor the RD were aware: -If the resident was compliant with his diet. -If the resident had received the diabetic education the physician had recommended. *A resident's A1C (average control of blood glucose level over a period of the past three months) was checked usually every three months. -The RD was unsure if this resident's A1C had been checked, but she was unable to find a record of one in the medical record. *They had not participated in care conferences. -The CDM relied on the social worker to keep him informed of resident changes.</p>	F 309		

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

PRINTED: 12/17/2015
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 12/03/2015
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 12</p> <p>-Nothing had been said about resident 7's BS. -The CDM had been unable to attend care conferences for over a year as he was needing to cook meals due to staffing turnover.</p> <p>Interview on 12/2/15 at 1:00 p.m. with registered nurse C regarding resident 7 revealed: *His blood sugars ran very high. *She had just called his physician and had one of his DM medications changed. *He was non-compliant with eating, having snacks in his room. -He would deny he ate anything, but there would be snack wrappers in his room. -He thought anytime his BS was below 300 it was good. *He had a good appetite and ate a big breakfast. -Sometimes he came back to the dining room after he ate breakfast and claimed he was hungry and had not eaten yet. *She was unaware if he had any laboratory work done regarding his blood sugars such as an A1C *She reviewed his medical record and acknowledged they did not have an A1C (blood test that evaluates BS over a three month period) since he had been admitted. -He needed to have that done. *She had tried to educate him, but she had not documented any education to the resident. *A referral to the RD had not been done but would have beneficial. -Thought that the things he ate definitely affected his blood sugars. *She was unsure if the resident had participated in any diabetic education program as recommended by the physician.</p> <p>Review of resident 7's medication review report revealed he received the following medications</p>	F 309		

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

PRINTED: 12/17/2015
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 12/03/2015
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 13 for DM:</p> <ul style="list-style-type: none"> *Lantus solution 100 unit/ml twelve units in the morning (a.m.). *Lantus solution 100 unit/ml eight units one time per day. *Novolog solution 100 unit/ml per sliding scale zero to eleven units. -The physician was to be notified if the BS was over 400. <p>Review of resident 7's 7/10/15 care plan revealed:</p> <ul style="list-style-type: none"> *Focus: He had DM. *Goal "Be free of any s/s [signs and symptoms] of hyperglycemia (high BS). *Interventions included: <ul style="list-style-type: none"> -"Wash feet daily. Licensed nurse to provide foot care." -"Observe/monitor/document the resident/family's ability to manage the treatment program, i.e. medications, dietary, glucose monitoring, exercise and knowledge of complications." -"Discuss meal times, portion sizes, dietary restrictions, snacks allowed in daily nutritional plan, importance of good dietary choices." *Focus: "The resident has nutritional potential for nutritional problems related to DM, dementia and special diet." *Interventions: <ul style="list-style-type: none"> -"Weigh daily." -"Invite resident to food-related activities and offer food, beverages of choice to encourage intake." *It had not addressed individualized interventions to prevent the high BS. *It had not been updated when his BS got higher. *It had not addressed what snacks would have been appropriate for food related activities. <p>Review of resident 7's nursing progress notes</p>	F 309			

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

PRINTED: 12/17/2015
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 12/03/2015
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 14</p> <p>revealed on 11/22/15 a fax was sent to the physician regarding "high blood sugars and current insulin orders." On 11/27/15 the physician replied to the fax with "Increase Lantus to 15 units in AM (a.m.) and 10 units PM (p.m.)."</p> <p>Interview on 12/2/15 at 11:30 a.m. with the director of nursing regarding resident 7 revealed: *The nurses should have notified the physician more quickly regarding his high blood sugar levels. *She agreed dietary should have been addressing his nutritional status. *With his high blood sugars they should have reviewed him at their monthly Nutrition at Risk meeting, but they had not.</p> <p>Review of the provider's diabetes information revealed: *"Complications of diabetes can include blindness, kidney disease, cardiovascular disease, and amputations. *In order to prevent the serious complications of diabetes mellitus, individuals with diabetes and their caregivers are encouraged to: -1. Control Blood Glucose." "Target blood glucose levels for people with diabetes should be 90-130 mg/dL before meals and under 180 mg/dL, one-two hours after meals."</p> <p>Review of the provider's February 2013 Monitoring Residents with Impaired Nutrition and Nutritional Risk policy revealed: *"The center will ensure that each resident maintains acceptable parameters of nutritional status such as body weight, protein levels and hydration status unless the resident's clinical condition demonstrates that this is not possible." *"Residents with impaired nutrition or nutritional</p>	F 309			

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 12/03/2015
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 15 risk may be identified by nursing, dietary and other members of the care plan team." ***Residents with newly identified impaired nutrition or nutrition risk are added to the Nutrition Risk List and discussed at the next nutrition risk committee meeting." Review of the provider's September 2014 RD job description revealed "The RD oversees and assures appropriate nutritional care for all residents according to physician orders, state/federal regulations, resident care plans, center policy and procedure and scope of practice for dietitians."	F 309		
F 371 SS=D	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: 34030 Based on observation, interview, record review, and policy review, the provider failed to ensure sanitary conditions were maintained in the kitchen for: *Four of four hood panels above the stove. *Three drawers and two cupboards. *The floor.	F 371	F 371 FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY All hood filters were cleaned All drawers and cupboards in kitchen were cleaned on 12/3/15 All flooring in kitchen and storage area was cleaned on 12/1/15 Hoods have been listed on the weekly cleaning schedule Drawers and cupboards continue to be on the weekly schedule. *Directed In-service held for all staff responsible for the assigned tasks to ensure the kitchen is maintained in a sanitary manner. Education held on 12/15/15 and 12/16/15.	1/22/16

The DNS provided NK/SDD/HJEL

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

PRINTED: 12/17/2015
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 12/03/2015
--	---	--	---

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 16 Findings include:</p> <p>1. Observation on 12/1/15 in the kitchen from 8:04 a.m. through 8:45 a.m. revealed: *Four hood filters above the stove had a small to moderate accumulation of grease on them. *Those drawers and cupboards (one by the toaster and one above the microwave) with clean kitchen supplies had a moderate amount of crumbs in them. *The floor outside of main traffic areas and in the storage room had dirt and food particles on them. *A posted cleaning schedule with only the last week of November filled in with initials.</p> <p>Interview on 12/1/15 at 8:30 a.m. with the food service supervisor revealed they prepared and served breakfast for the residents every day. The other meals were brought over from the main facility to be served.</p> <p>Review of the above kitchen cleaning schedules for November 2015 revealed: *The missing weeks of November had been on a different form. That was obtained and reviewed. *Cleaning of the hood and filters had been on the schedule for the first three weeks then taken off of the new form going forward, and so had not been done. *Days when cleaning tasks had not been completed included: -Week three cleaning of cupboards and drawers. -Two out of four weeks that floors had not been cleaned.</p> <p>Interview on 12/2/15 at 3:00 p.m. with the food service supervisor revealed: *The hood panels above the stove were cleaned every six months by a contracted company. They</p>	F 371	<p>F 371 continued:</p> <p>Administrator or designee will complete audits to ensure compliance with cleaning schedule and documentation. Audits will be completed weekly for 3 months.</p> <p>Administrator or designee will report audit findings to monthly QAPI meetings and the committee will determine on-going interventions and monitoring.</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 12/03/2015
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 17 were not currently cleaned at any other time. *He agreed they could be cleaned in-between the above. *He agreed the staff cleaning schedule had not been consistently followed, and he was looking into it. Review of the provider's revised March 2009 Cleaning-Sanitation of Non-Food Contact Surfaces policy revealed the provider should have stored, prepared, distributed, and served food under sanitary conditions at all times. Review of the provider's February 2013 dietary services Sanitation Cleaning Schedules policy revealed: *"It will be the responsibility of the director of dietary services (DDS)/designee to post daily, weekly, and monthly cleaning assignments in the dietary area." *"Each dietary staff person will be responsible for knowing his or her assigned duty and carrying it out during the designated work shift." *"Each staff person then will initial the schedule after completing his or her cleaning duties." *"The DDS will maintain a record of cleaning." *"The DDS is responsible for monitoring staff to ensure that cleaning duties are completed satisfactorily and within the proper timelines."	F 371			
F 441 SS=D	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.	F 441	F 441 INFECTION CONTROL, PREVENT SPREAD, LINENS. DNS provided education to C.N.A. A, C.N.A. B and C.N.A. C, regarding proper use of PPE for resident with contact isolation as well as hand hygiene and when to change gloves.	<i>CH DEC. 3, 2015 NH/SP/CH/EL 1/22/16</i>	

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

PRINTED: 12/17/2015
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 12/03/2015	
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 18</p> <p>(a) Infection Control Program The facility must establish an Infection Control 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 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: 33265 A. Based on observation, interview, procedure review, and guidelines review the provider failed to maintain the sanitary condition of linen used for residents' routine personal hygiene on one of five wings (400) of the facility. Findings include:</p>	F 441	<p>F 441 continued:</p> <p>Hygiene carts will no longer include coolers for personal hygiene in resident rooms.</p> <p>A reference guide for determining level/frequency of PPE need will be provided to aid nurses in establishing isolation precautions.</p> <p>Directed In-Service Education has been provided to all staff on contact precautions and what PPE is required depending on type of infection and location as well as maintaining sanitary conditions for personal use linens.</p> <p>During new staff orientation, staff will be assessed for competency in hand washing and given education on changing soiled gloves and what constitutes the soiling of gloves. Infection Preventionist or designee will review new-staff checklist for completion of competency of handwashing and glove use.</p> <p>Compliance will be monitored by audits of hand washing, and gloves use every 2 weeks x4, then monthly x2.</p> <p>Infection Preventionist or designee will audit findings and results will be reported to the QAPI meeting monthly. The committee will review findings to determine on-going interventions and monitoring.</p>	

was provided by the DNS on Dec 15, 2015 to NK [signature]

** by the staff development coordinator or designee NK [signature]*

** the infection preventionist doing NK [signature]*

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

PRINTED: 12/17/2015
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 12/03/2015
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 19 1. Observation on 12/2/15 from 8:09 a.m. through 8:29 a.m. with certified nursing assistant (CNA) D in the 400 wing hallway and resident 6's room revealed she: *Put on clean gloves. *Got a wet wash cloth out of the cooler that contained warm soapy water. *Placed the wash cloth in a clean, clear plastic bag. *Picked up a clean hand towel and entered the resident's room. *Placed the plastic bag on the bed and the towel on top of the plastic bag. *Removed the blanket from the resident's lap and laid it on top of the clean towel and plastic bag containing the wash cloth. *Put a gait belt around the resident and assisted resident to the bathroom and toilet. *Took off her gloves and threw them in the garbage. *Washed her hands for twelve seconds. *Put on clean gloves. *Threw the used adult incontinence brief that was on the floor of the bathroom into the garbage. *Took off the gait belt and placed it on a towel rack in the bathroom. *Assisted the resident with removing her night shirt. *Picked up the used blanket from on top of the bed and moved the garbage and soiled linen out of the bathroom. *Picked up the unused hand towel and plastic bag containing the clean wash cloth and placed it on the edge of the bathroom sink. *Unwrapped the wash cloth from plastic bag and handed it to the resident to use. Interview on 12/3/15 at 8:35 a.m. with CNA D	F 441	Infection Preventionist or designee will monitor, by staff interview, of understanding reference cards and contact precaution policy. Infection Preventionist or designee will monitor by observation of staff compliance with contact precaution during resident interactions every 2 weeks x4, then monthly x2. The Infection Preventionist or designee will report the findings to the QAPI committee which will review findings each month and determine on-going interventions and monitoring.		

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

PRINTED: 12/17/2015
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 12/03/2015
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 revealed:</p> <p>*The use of the warm, soapy washcloth and clean towel observed yesterday had been her usual process.</p> <p>*She agreed she had touched the clean towel and washcloth after she had moved the garbage bag and the dirty linen.</p> <p>2. Observation on 12/3/15 from 7:02 a.m. to 7:22 a.m. in the hallway, on the 400 wing of the facility revealed:</p> <p>*From 7:02 a.m. through 7:13 a.m. the lid was open on the cooler with the warm soapy water and wash cloths used for the residents' personal hygiene (cleaning).</p> <p>*There was constant heavy traffic of employees and residents through this hallway during this time frame.</p> <p>-Anyone could have reached into the cooler with their hands.</p> <p>-Anyone could have thrown something into the cooler.</p> <p>*At 7:22 a.m. the lid on the cooler had been closed.</p> <p>Interview on 12/3/15 at 8:35 a.m. with the administrator, the director of nursing, and administrator-in-training revealed:</p> <p>*Agreed the CNA should have had clean gloves on before touching the clean towel and washcloth.</p> <p>*Agreed the cooler lid should have been kept closed to keep the soapy water with the wet wash cloths in sanitary condition.</p> <p>Review of the provider's June 2014 Hand Hygiene and Handwashing guidelines and procedure revealed the hands should have been washed for at least twenty seconds.</p>	F 441		

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

PRINTED: 12/17/2015
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 12/03/2015
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>Review of the provider's September 2012 Gowning, Gloves, Masks, Goggles procedure had not addressed when to change gloves and wash hands.</p> <p>Review of provider's undated Hygiene Carts guidelines revealed it had not addressed keeping the cooler's lids closed.</p> <p>Surveyor: 34030 B. Based on observation, interview, record review, and policy review, the provider failed to maintain isolation by two of two observed certified nursing assistants (CNA) for one of one resident (2) on isolation. Findings include:</p> <p>1. Observation on 12/1/15 at 10:10 a.m. of resident 2 in her bedroom revealed: *A sign on her door that read "see nurse before entering room." *An isolation cart was sitting outside of her room.</p> <p>Review of resident 2's medical record revealed: *She had a Brief Interview for Mental Status (BIMS) score indicating severe thought and memory impairment. *She wore incontinent (unable to control bowel or bladder) briefs. *She needed extensive assistance of one to two staff for care. *She had an infectious disease in her urine and was currently on contact (use gown and gloves when working with a resident) isolation.</p> <p>Observation on 12/1/15 at 3:45 p.m. of two CNAs assisting resident 2 revealed: *Without gowning or gloving CNA A went into the</p>	F 441			

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

PRINTED: 12/17/2015
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 12/03/2015
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 22 resident's room and proceeded to change her bed linens. *Without gowning or gloving CNA B went into the resident's room with the lift to assist CNA A place her into bed. *The lift was a resident multi use equipment and was not noted by this surveyor to be cleansed when it was removed from the room. Interview immediately after the above observation with CNA A revealed she would gown and glove "only with changing the resident's brief." Interview on 12/2/15 at 4:30 p.m. with the director of nursing (DON) regarding contact isolation and resident 2 revealed she agreed contact isolation had not been maintained. Review of the provider's revised November 2014 Contact Precautions policy revealed: *"Contact precautions will be used in addition to standard precautions for residents with known or suspected infections or evidence of syndromes that represent an increased risk for contact transmission." *Gowns and gloves should have been worn with direct contact with a resident or potentially contaminated environmental surfaces or equipment in close proximity to the resident. **"If common use of equipment for multiple residents is unavoidable, clean and disinfect such equipment before use on another resident."	F 441			
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing	F 518	F 518 TRAIN ALL STAFF – EMERGENCY PROCEDURES/DRILLS DNS educated C.N.A. E, R.N. F and C.N.A G On emergency procedure and reviewed Disaster Manual.	1/22/16	

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

PRINTED: 12/17/2015
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 12/03/2015
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 518	<p>Continued From page 23 staff; and carry out unannounced staff drills using those procedures.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on interview and manual review, the provider failed to ensure three of three randomly interviewed staff members (certified nurse assistant [CNA] E, registered nurse [RN] F, and CNA G) were knowledgeable of the response to emergency situations. Findings include:</p> <p>1. Interview on 12/1/15 at 3:50 p.m. with CNA E revealed she: *Was not sure if a fire alarm sounded for the 100 wing, where the residents of the 600 wing were supposed to go. *Was not sure if there were certain electrical outlets to use if the electricity went out or not. *Went to a nurse for information regarding the above and was told: -Residents should be moved into their rooms when a fire alarm sounded. -The red electrical outlets were to be used when there was a power failure.</p> <p>Interview on 12/1/15 at 4:02 p.m. with RN F revealed she: *Had not been able to identify the person in charge who the fire chief could talk to regarding a fire. *Identified a nearby community center as the place to evacuate residents from the 400 wing if directed to evacuate the wing by the fire chief. *Would not use any electrical outlets if the electricity went out.</p>	F 518	<p>F 518 continued:</p> <p>*Education on Emergency response including Power loss and back-up generator, tornado watch and warning procedures, responsibilities in fire and evacuation vs relocation within the building, provided to all staff during in-service on 12/15/15 and 12/16/15.</p> <p>Annual disaster training will increase to semi-annual disaster training in the months of April and October.</p> <p>Safety Coordinator or designee will conduct audits in May and November to confirm compliance with training and report findings</p> <p>☑ QAPI meeting for review and recommendations.</p> <p>The QAPI committee will review findings each month and determine on-going interventions and monitoring.</p>		

**DNS provided NR/SDDott/el*

at the next NR/SDDott/el

**by environmental services and DNS NR/SDDott/el*

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

PRINTED: 12/17/2015
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 12/03/2015
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 518	<p>Continued From page 24</p> <p>Interview on 12/2/15 at 10:30 a.m. with the maintenance director regarding the above answers from staff revealed he would have expected them to respond:</p> <ul style="list-style-type: none"> *During a fire alarm on 100 wing, the residents on 600 wing needed to stay in their wing, but would not have been expected to stay in their rooms. *Any outlets would work off the back-up generator if the electricity failed, not just the red ones. *There was a nurse in charge of each wing. *Evacuation of the 400 wing during a fire would be to another safe area of the facility not the nearby community center. <p>Interview on 12/2/15 at 2:15 p.m. with CNA G revealed she:</p> <ul style="list-style-type: none"> *Had not been able to identify what to do if a tornado warning was announced. She would have to ask a nurse. *Had not been able to identify what outlets could be used if the electricity failed. <p>Interview on 12/3/15 at 8:40 a.m. with the administrator, administrator-in-training H, and the director of nursing regarding the above emergency responses from staff revealed the administrator agreed the staff should have been able to identify what to do in the emergency situations.</p> <p>Review of the provider's undated Disaster Manual revealed:</p> <ul style="list-style-type: none"> *There were to be identified charge nurses who were to work with the fire department personnel. *The evacuation plan was for incidents identified as disasters. *There was an electrical generator for emergency electrical power. 	F 518			

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

ORIGINAL

PRINTED: 12/17/2015
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2015
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
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 12/1/15. Good Samaritan Society Luther Manor (building 01) 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Julie Markle* TITLE *Administrator* (X6) DATE *12/23/15*

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 28 2015
SD COM LSC

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

ORIGINAL

PRINTED: 12/17/2015
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 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2015
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
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 12/1/15. 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *12/23/15*

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 28 2015
SD DOM L&C

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 12/03/2015
--	--	---	---

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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S 000	Compliance/Noncompliance Statement Surveyor: 33265 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, and Article 44:74, Nurse Aide requirements for nursing facilities, was conducted from 12/1/15 through 12/3/15. Good Samaritan Society Luther Manor was found not in compliance with the following requirement: S281.	S 000		
S 281	44:73:06:05 Resident Care PLans and Programs The facility shall provide nursing services that provide safe and effective care from the day of admission through the ongoing development and implementation of written care plans for each resident. The care plan shall address medical, physical, mental, and emotional needs of the resident. The facility shall establish and implement procedures for assessment and management of symptoms including pain. The care plan shall be based on the resident assessments required in §44:73:06:10 and shall be developed and approved by the resident's physician, physician assistant, or nurse practitioner; the resident, the resident's family, or the resident's legal representative; the interdisciplinary team consisting of at least a licensed nurse, the facility's social worker or social service designee, the dietary manager or dietitian, the activities coordinator, and other staff in disciplines determined by the resident's needs. The care plan shall describe the services necessary to meet the resident's medical, physical, mental or cognitive, nursing, and psychosocial needs and shall contain objectives and timetables to attain and maintain the highest level of functioning of the resident. The care plan shall be completed within seven days after the	S 281	<p>S 281 RESIDENT CARE PLANS AND PROGRAMS:</p> <p><u>Documentation shows that Resident #7 care plan was reviewed and signed by nursing, social services, dietary and activities, as stipulated by 44:73:06:05, on 7/22/15 and 10/9/15.</u></p> <p>The following corrections have been made: Resident #7's care plan has been revised to include monitoring of A1c every 3 months, education on appropriate snack options, interventions for orientation and redirection when confused, and frequency of diabetic education. Per facility request, Primary care physician has reviewed blood sugar levels and made changes to insulin dosing.</p> <p>Order obtained for A1c to be drawn and rechecked every 3 months. RD has reviewed blood sugar levels. Resident #7 discussed by interdisciplinary team during January nutrition risk meeting. To identify other potentially affected residents, orders and care plan interventions for all other insulin dependent residents have been reviewed and revised as needed. Those with poor intake or blood sugars outside physician specified parameters are added to the nutrition risk list.</p>	1/22/16

Handwritten notes:
KRD, CDM, Wanda Nurse, Social services, and administrative NR/SPD/H/EC

Handwritten notes:
Addendums noted with an asterisk per 1/15/16 per telephone with facility administrator. NR/SPD/H/EC

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

Julie Markov

TITLE

Administrative

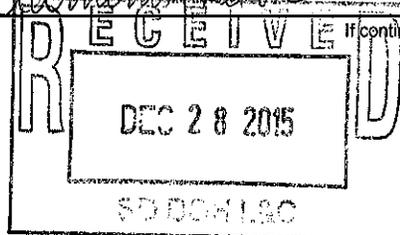
(X6) DATE

12/23/15

STATE FORM

6899

TF0J11



If continuation sheet 1 of 4

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 12/03/2015
--	--	--	---

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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S 281	<p>Continued From page 1</p> <p>completion of each resident assessment required in §44:73:06:10.</p> <p>Each facility shall provide restorative care services to meet resident needs.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure the care plan for one of seven sampled residents (7) at nutritional risk had included all members of the interdisciplinary team when it was developed. Findings include:</p> <p>1. Review of resident 7's entire medical record revealed: *He had been admitted on 7/10/15. *His diagnoses included insulin dependent diabetes mellitus (IDDM). *His blood sugar (BS) was checked four times a day. *During that time period it was: -Over 200, thirty-two times. -Over 300, forty-eight times. -Four of those times it was over 390. *His physician was to have been notified if his BS was over 400.</p> <p>Review of resident 7's 10/7/15 care plan revealed neither the certified dietary manager (CDM) nor the registered dietician (RD) had participated in the care conference.</p> <p>Interview on 12/3/15 at 10:15 a.m. with the RD and the CDM regarding resident 7 revealed: *They had not been notified of the resident 7's high BS. *The RD confirmed a resident's diet could impact</p>	S 281	<p>S 281 RESIDENT CARE PLANS AND PROGRAMS</p> <p>the Dietary Admit/ Readmit Data Collection tool, all new residents will be screened for addition to the nutrition risk list and dietary care plan interventions will be developed. Care Plans will be reviewed and revised quarterly and when significant changes in resident condition occur.</p> <p>incoming residents with diabetes will have care plan interventions specific to their individual diabetic management needs. RD, CDM or licensed nurse will provide diabetes management education to affected residents and their families during care conferences. RD will review blood sugar data for insulin dependent residents monthly and make care plan updates and diet recommendations as indicated.</p> <p>Health information manager or designee will audit these processes to ensure compliance. Audits to be completed monthly x3.</p> <p>Health Information manager or designee will report results to QAPI and QAPI committee will review findings each month and determine on-going interventions and monitoring.</p> <p>*by nursing, dietary, activities, and social services departments. NR/SDDOT/EL</p> <p>*Data collection will be completed by the CDM and RD. Education → NR</p>	<p>With NR/SDDOT/EL</p> <p>*to screen NR/SDDOT/EL</p> <p>*every other month NR/SDDOT/EL</p> <p>*all NR/SDDOT/EL</p>
-------	---	-------	---	---

The CDM and RD will use the [unclear] [unclear]

**see next page*

**all NR/SDDOT/EL*

**every other month NR/SDDOT/EL*

**by nursing, dietary, activities, and social services departments. NR/SDDOT/EL*

**Data collection will be completed by the CDM and RD. Education → NR*

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 12/03/2015
--	--	---	---

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) COMPLETE DATE
S 281	Continued From page 2 their BS. *Neither the CDM nor the RD were aware: -If the resident was compliant with his diet. -If the resident had received the diabetic education the physician had recommended. *They had not participated in the care conferences. -They were aware someone from dietary should have participated in the care conferences. -The CDM relied on the social worker to keep him informed of resident's changes. -Nothing had been said about the resident's BS being high. -The CDM had been unable to attend care conferences for over a year as he was needing to cook meals due to staffing turnover. -The RD had recently returned from an extended leave of absence. She only worked part-time in this facility, and her hours had not allowed her to do everything. Review of resident 7's 7/10/15 care plan revealed it had not addressed: *Specific nutritional considerations for preventing his BS from being higher. *What to do when his BS was higher. *What snacks would have been appropriate for food related activities. *Diet teaching and how to involve his family in nutrition. Review of the provider's February 2013 Monitoring Residents with Impaired Nutrition and Nutritional Risk policy revealed: *"The center will ensure that each resident maintains acceptable parameters of nutritional status such as body weight, protein levels and hydration status unless the resident's clinical condition demonstrates that this is not possible." *"Residents with impaired nutrition or nutritional	S 281	→ .. to nursing and dietary staff was provided by the DNS on December 15, 16, 28, 30, 2015. NK/SDDOTHEL *(If the diabetic management was included on the care plan, if there was a significant change, if the plan reflects the change in the diabetic's needs, if the record showed education was provided at the care conference on five residents per month.) NK/SDDOTHEL	

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 12/03/2015
--	--	---	---

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) COMPLETE DATE
S 281	<p>Continued From page 3</p> <p>risk may be identified by nursing, dietary and other members of the care plan team." **Residents with newly identified impaired nutrition or nutrition risk are added to the Nutrition Risk List and discussed at the next nutrition risk committee meeting."</p> <p>Review of the provider's September 2012 care plan policy revealed: **The interdisciplinary team will be comprised of appropriate staff in various disciplines as determined by the resident's needs." **A qualified team of persons will review care plans at least quarterly."</p>	S 281		