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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435044	A. BUILDING ______ B. WING ______	C 09/08/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/6/23 through 9/8/23. Good Samaritan Society Luther Manor was found not in compliance with the following requirements: F582, F676, and F686. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/6/23 through 9/8/23. Areas surveyed included residents' personal hygiene, toileting, transfers, and staffing. Good Samaritan Society Luther Manor was found in compliance.	F 000	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 center is not in substantial compliance with federal requirements of participation this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and	F 582	After review of facility's policy/procedure, "SNF Medicare Part A Advance Beneficiary Notice of Non-Coverage (SNFABN)" (KA 10/4/23), resident 79 was given the Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNFABN) form on 9/29/23. Resident 84 was given the SNFABN form on 9/8/23. Audit of residents who had a Medicare part A covered stay end and remain in facility in the last 6 months will be conducted by Administrator or designee to identify if there were other residents requiring receipt of the SNFABN form during that period. Any residents found to be requiring receipts of the SNFABN form that have not already received it will be issued this form. To ensure systemic change, Clinical Care Leader D was educated on facility's policy/procedure, "SNF Medicare Part A Advance Beneficiary Notice of Non-Coverage (SNFABN) (KA 10/4/23) regarding when the SNFABN form is required to be provided to residents and/or resident representatives by Administrator on 9/07/23. Clinical Care Leader D tracks skilled days remaining for residents to ensure facility is aware of when a SNFABN form would be required. To monitor our performance to ensure that solutions are sustained, the Administrator or designee will conduct focus audits on all residents that have a Medicare part A covered stay end and remain in facility to verify timely receipt of the required SNFABN form bi-weekly X 2, and monthly X 2. The results of these audits will be reviewed and reported at the monthly Quality Committee meeting.	10/18/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelli Aschoff Kelli Aschoff Kelli Aschoff
TITLE: Administrator
(X6) DATE: 9/29/23 10/4/23 10/5/23

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 582	Continued From page 1 periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure the proper Medicare notices were completed and provided for two of two sampled residents (79 and 84) prior to their discharge from skilled services. Findings include:	F 582		

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F 582	Continued From page 2	F 582		

1. Review of resident 79's CMS (Centers for Medicare and Medicaid Services) SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review form provided by clinical care leader D on 9/7/23 revealed her Medicare Part A Skilled Services Episode start date was 6/14/23 and the last covered day for Part A services was on 7/11/23.

Review of resident 79's medical record revealed:
*She had been admitted on 6/14/23.
*Her 6/16/23 Brief Interview for Mental Status (BIMS) was 3 that indicated severe impairment.
*She had skilled covered days remaining and continued to reside in the facility.
*Her daughter/health care power of attorney signed the Notice of Medicare Non-coverage (NOMNC) on 7/8/23 with the benefit's expiration of 7/11/23.
- That standardized notice informs Medicare beneficiaries when their Medicare-covered services were ending and provided an opportunity to request an expedited determination from the Quality Improvement Organization (QIO).
*The resident was not given a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) form.
-That standardized notice allows Medicare beneficiaries to make informed decisions about whether to receive certain Medicare services and accept financial responsibility for those services if Medicare would not cover the cost of those services.
-The resident representative was not given their alternative payment or appeal options located on the SNFABN form.

2. Review of resident 84's CMS SNF Beneficiary

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F 582	Continued From page 3 Protection Notification Review form provided by clinical care leader D on 9/7/23 revealed her Medicare Part A Skilled Services Episode start date was 8/17/23 and the last covered day for Part A services was on 9/6/23. Review of Resident 84's medical record revealed: *She had been admitted on 8/17/23. *Her 8/22/23 BIMS score was 12 that indicated moderate impairment. *She had skilled covered days remaining and continued to reside in the facility. *She signed the NOMNC on 8/31/23 with the benefit's expiration of 9/6/23. *The resident was not given an SNFABN form. -The resident was not given their alternative payment or appeal options located on the SNFABN form. 3. Interview on 9/7/23 at 4:22 p.m. with clinical care leader D regarding Medicare notices revealed: *She was a registered nurse, who identified herself as the "Rehab Manager." *She was responsible for providing the notices to residents when they were discharged from skilled services. *The residents were only given the NOMNC forms to sign. *She did not know about providing the SNFABN form to a resident who remained in the facility after all skilled services had ended. *It was her understanding that they did not need to provide the SNFABN forms. *She confirmed the findings above and agreed that residents 79 and 84 were not provided the SNFABN form prior to their skilled services ending.	F 582		

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F 582	Continued From page 4	F 582		

Interview on 9/7/23 at 4:42 p.m. with director of nursing services B revealed:
*Her expectation was that the Medicare guidelines would have been followed in providing the Medicare notices to the residents.
*She was not sure which Medicare notices were required.
*She agreed with the findings above.

4. Review of the provider's 2/13/23 "SNF Medicare Part A Advance Beneficiary Notice of Non-Coverage (SNFABN)" policy revealed:
*"The SNFABN is given to SNF beneficiaries enrolled in the Medicare fee-for-service program (Part A)."
*"The SNFABN is to be issued prior to PPS [Prospective Payment System] extended care items or services that are furnished, reduced, or terminated when the SNF believes Medicare may not pay for those extended care services based on the basis of one of the following statutory exclusions:
-Not reasonable and necessary (i.e., medical necessity)... or
-Custodial care (i.e., not a covered level of care)."
*"The SNFABN is evidence of beneficiary knowledge about the likelihood of a Medicare denial, for the purpose of determining financial liability for expenses incurred for extended care items/services furnished to a beneficiary for which Medicare does not pay."
*"If Medicare is expected to deny payment on the basis of one of the exclusions listed above, a SNFABN must be given to the beneficiary in order to transfer financial liability for the item/service."
*"Provider Delivery of the SNFABN"
-"The SNF must advise the beneficiary (verbally and in writing) before the extended care items/services are provided that, in the SNF's

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F 582	Continued From page 5 opinion, the beneficiary will be fully and personally responsible for payment of services furnished." -"Failure to provide a valid SNFABN may result in the SNF being held financially (provider) liable."	F 582		
F 676 SS=E	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks,	F 676	Resident 26 was scheduled 2 baths per week effective the week of 9/24. Residents 26, 70, and 76 restorative programs will be reviewed by Restorative RN and Restorative Aides to determine the necessity of each program or willingness to participate by the resident, and the frequency the restorative programs are to be offered. Care plans will be updated to reflect these programs. All residents will be interviewed by members of the Nursing, Social Services, HIM, and Activities departments to determine the number of baths per week that they desire. Care plans will be updated to match resident preference, and a copy of each interview will be provided to the bath aide by the interviewer in order to update the bath schedule (KA 10/4/23). All restorative programs will be reviewed by Restorative RN and Restorative Aides to determine the necessity of each program or willingness to participate by the resident, and the frequency the restorative program is to be offered. Care plans will be updated to reflect these programs. To ensure systemic change related to baths, residents will continue to be asked the number of baths per week they prefer using the "Sit-Stand-Walk Data Collection" assessment quarterly per facility's policy, "Bathing" (KA 10/4/23). The nurses will be educated by DNS to ensure the care plan is updated to reflect resident's most current preference, and the bath aide is notified of the resident's current preference in order to update the bath schedule (KA 10/4/23). To ensure systemic change related to restorative programs, Restorative RN and Restorative aides were educated by DNS 9/28/23 to (KA 10/4/23) ~~will~~ meet monthly to review restorative programs for residents to ensure the necessity of each program or willingness to participate by the resident, and the frequency the restorative program is to be offered. Care plans will be updated accordingly from this meeting. To monitor our performance to ensure that solutions are sustained, randomized focus audits of residents' baths and restorative programs being received in comparison to what is care planned will be conducted by DNS or designee weekly X 4, bi-weekly X 2, and monthly X 1. The results of these audits will be reviewed and reported at the monthly Quality Committee meeting.	10/18/23

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F 676	Continued From page 6	F 676		

§483.24(b)(5) Communication, including
(i) Speech,
(ii) Language,
(iii) Other functional communication systems.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and policy review, the provider failed to provide bathing and nursing restorative services in accordance with the care plan for three of five sampled residents (26, 70, and 76). Findings include:

1. Observation and interview on 9/6/23 at 3:20 p.m. with resident 26 revealed:
*She was temporarily unable to do anything with her right hand due to a recent surgical procedure.
*Her right hand was wrapped with dressings, and it was positioned on a pillow on her lap as she reclined in her chair.
*A gait belt was fastened around her middle torso.
*The gait belt was used when she walked with staff, and it was still there because, "They just don't take it off."
*She participated in some exercises to maintain her abilities.
*She would prefer to have two baths a week like she had received after she first moved in.

Interview on 9/7/23 at 11:42 a.m. with certified nursing assistant (CNA) G revealed:
*The frequency of resident bathing was determined by a resident's choice.
*The bath CNA put the bathing schedule together.
*If a resident would tell CNA G that he or she wanted a change in bathing frequency, she would report that request to the bath CNA or the nurse on duty.

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F 676	Continued From page 7	F 676		

*There were two residents who kept the gait belts on when they were not actively walking for fall prevention, but those names did not include resident 26.
*The restorative CNA was currently on leave, but there were a couple of other CNAs that had been trained to do restorative exercises with residents.

Interview on 9/7/23 at 11:58 a.m. with social services coordinator (SSC) F revealed:
*She had been involved in discussions with residents regarding their preferences for daily routines, but those conversations did not specifically include the topic of bathing.
*The topic of bathing may have come up if a resident had a strong preference about bathing, but usually the resident or family member would go to nursing with that topic.
*She was not aware of any current resident that had requested changes or had concerns about bathing.

Interview on 9/8/23 at 11:35 a.m. with clinical care leader (CCL) E revealed:
*She was responsible for the CNA schedule.
*There were two bath CNAs scheduled every day, one for each side of the building (east and west).
*The bath CNAs figure out the schedule for which residents get baths, on which days, and how often.
*There were usually two restorative CNAs, but one CNA had "just given notice."
*There were two other restorative CNAs that had been trained.

Interview on 9/8/23 at 11:40 a.m. with senior CNA I, who worked as the bath CNA on the west side of the building, revealed:
*There were nine residents scheduled each day

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F 676	Continued From page 8	F 676		

for baths.
*Resident 26 had two baths a week, then she moved to the east side of the building.
*The frequency of her baths might have been changed because of the room change, and it "just never went back to twice a week after moving back" to the west side.

Interview on 9/8/23 at 11:53 a.m. with registered nurse (RN) K revealed:
*The nurses completed a quarterly assessment using the "Sit-Stand-Walk Data Collection Tool."
*The assessment included a section called, "Bathing Safety and Preferences."
*The residents should have been interviewed, if possible, by the nurse about their type and frequency of bathing preferences.

Interview on 9/8/23 at 12:02 p.m. with director of nursing services (DNS) B and MDS nurse C revealed:
*The interdisciplinary care team participated in a quarterly "quality of life review" to "identify any concerns" before the next MDS assessment was due for a resident.
*Documentation about participation in restorative therapy would be in the quality of life notes.

Interview on 9/8/23 at 1:57 p.m. with MDS nurse C revealed the quality of life progress notes were displayed in the EMR as an "Other Progress Note."

Review of the EMR for resident 26 revealed:
*Her admission date was 10/21/22.
*The 6/13/23 quarterly MDS revealed she was:
-Cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15.
-Needed the assistance of one staff person for

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F 676	Continued From page 9 bed mobility, transferring, and walking. -Had upper and lower extremity impairments on one side. *The "Sit-Stand-Walk" assessments noted the resident's preference for bathing frequency was 2 or more each week on 10/21/22, and 1 a week on the 12/30/22 and 9/2/23 assessments. *The 12/30/22 revised care plan for activities of daily living (ADL) self-care performance deficit noted the intervention, "BATHING: Resident requires assist of 1. Prefers Whirlpool baths 2x/week [two times per week]." *Documentation for bathing occurred only once a week between 8/9/23 and 9/4/23. *The use of a gait belt was an intervention for toilet use, transfer, and nursing rehab. *The 12/27/22 revised care plan included a focus for "restorative intervention due to: ADL self-care performance deficit/limited mobility R/T [related to] back, knee and neck pain, HX [history of] falls, and weakness. *The nursing rehab interventions included: -Revised on 3/13/23, active range of motion (AROM) to upper extremity using the "Arm bike," a "dumbell" [sic] and "body weight," and "Group Exercise. Do up to 6 days a week for 15 minutes. Document days and minutes." -Revised on 3/13/23, "Walking with FWW [front wheeled walker], 1 [staff member] assist...Do up to 6 days per week." -Revised on 7/3/23, "Walking with FWW/[with] gait belt and assist of one [staff member] to meals." -Revised on 7/3/23, lower extremity strengthening with weights, marches, and leg kicks up to 6 times per week. -Revised on 8/1/23, "NuStep...for 15 minutes, up to 6 days per week." *An 8/16/23 "Quality of Life meeting" progress	F 676		

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F 676	Continued From page 10 note documented, "Resident participated in restorative 1/14 [1 day of 14 days] for AROM and 6/14 [6 days of 14 days] for NuStep. Interview on 9/7/23 at 2:44 p.m. with Minimum Data Set (MDS) nurse C revealed documentation of completed restorative exercises were found in the electronic medical record (EMR) by clicking on the history (H) link next to the care plan interventions labeled "NURSING REHAB." Further review of the documentation history for 30 days between 8/9/23 and 9/7/23 of completed restorative nursing rehab interventions for resident 26 revealed: *AROM to upper extremity was documented on 2 days as completed and 1 day as refused. "Walking with FWW" was documented only 1 day as "refused." *Walking with FWW to meals had not occurred. *Lower extremity strengthening had not occurred. "NuStep...for 15 minutes" had been completed on 8 days. 2. Observation and interview on 9/6/23 at 4:59 p.m. with resident 70 revealed he: *Was seated in a wheelchair in his room. *Had a stroke that affected his right hand, arm, and leg. *Had not received any exercises to maintain or improve his movement on that side. *Would like to regain some ability to draw or play his guitar. *Lifted his right arm and hand to show how the stroke affected his movement. Observation and interview on 9/7/23 at 11:33 a.m. with resident 70 revealed: *He was seated in his recliner in his room.	F 676		

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	435044	A. BUILDING ____ B. WING ____	C 09/08/2023

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

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F 676	Continued From page 11	F 676		

*A gait belt was fastened around the middle his torso.
*He stated the staff had "probably forgot to take it off."

Interview on 9/7/23 at 11:42 a.m. with CNA G revealed there were two residents who kept the gait belts on when they were not actively walking, but those names did not include resident 70.

Interview on 9/7/23 at 12:20 p.m. with SSC F revealed:
*Leaving the gait belts on a resident when not using them would not be a normal practice.
*Hooks had been put "on the back of the doors so [the gait belts] would always be available."

Review of the EMR for resident 70 revealed:
*His admission date was 12/16/22.
*The 6/13/23 quarterly MDS revealed he:
-Was cognitively intact with a BIMS score of 15.
-Needed the weight-bearing assistance of one staff person for bed mobility, and two persons for transferring and walking.
-Had upper and lower extremity impairments on one side.
-Had participated in restorative range of motion (ROM), active and passive, for a total of 5 days and training and skill practice for walking on 5 days during the 14 days prior to and including 6/13/23.
*A 6/22/23 "Care Conference Note" documented, "Restorative Therapy - Does PROM [passive ROM] and AROM."
*The 1/16/23 revised care plan included a focus for "restorative intervention due to: ADL self-care performance deficit/limited physical mobility R/T stroke, CHF [congestive heart failure].
*The nursing rehab interventions included:

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F 676	Continued From page 12 -Revised on 3/17/23, walking with platform walker, 2 people to assist for 15 min (minutes) up to 6 days week. -Revised on 3/17/23, PROM "to right shoulder, hand, wrist." for 15 min up to 6 days per week. -Revised on 5/19/23, AROM using "arm bike or dumbbells," "towel slides," "bed exercises," "NuStep," and "group therapy" up to 6 days per week for 15 minutes, and the history link documented AROM had not occurred between 8/9/23 and 9/7/23. *A 3/28/23 revised care plan intervention was for "gait belt used for transfers" related to falls. *An 8/9/23 "Quality of Life meeting" progress note documented, "Did 3/10 [3 days of 10 days] with restorative therapy." Further review of the documentation history for 30 days between 8/9/23 and 9/7/23 of completed restorative nursing rehab interventions for resident 70 revealed: *Walking with platform walker had been offered on 11 days with 8 days completed. *PROM "to right shoulder, hand, wrist" had been offered on 7 days with 4 days refused. *AROM had not occurred. 3. Observation and interview on 9/6/23 at 10:38 a.m. with resident 76 revealed he: *Was lying in bed with a trapeze transfer aide attached to the head of his bed. *Had a stroke and his left leg, hand, and arm were affected. *Lifted his hand and arm to show the effect of the stroke. *Would use the restorative therapy equipment, but "they are always pulling therapy staff onto the floor, so I cannot use that room."	F 676		

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F 676	Continued From page 13 Review of the EMR for resident 76 revealed: *His admission date was 4/6/23. *The 7/19/23 significant change in status MDS revealed he: -Was cognitively intact with a BIMS score of 15. -Needed the weight-bearing assistance of two staff persons for bed mobility, and one staff person for transferring and toileting. -Had upper and lower extremity impairments on one side. -Had received speech therapy between 4/21/23 and 6/21/23, occupational therapy between 4/24/23 and 7/13/23, and physical therapy between 4/22/23 and 7/7/23. -Had not received restorative nursing; the ROM, splint/brace assistance, and training and skill practice had been coded as 0 [zero] days. *The 4/6/23 revised care plan included a focus on limited physical mobility with acute left sided weakness, with a 7/13/23 revised intervention for "Nursing staff to donn [put on] left hand splint. Resident is to wear for 3 hours." *The 7/10/23 revised care plan focus for restorative intervention included nursing rehab interventions as follows: -Revised on 5/12/23, "wear left hand splint at night-place edema glove on before the splint. Splint off in the morning." -Revised on 7/10/23, AROM to "stretch left leg out to side and stretch calf for 15 min/day up to 6 times per wk (week)." -Revised on 7/10/23, "Transfers: Stand at bar as long as can x [times] 3 reps [repetitions]. Stand at bar and transfer to another chair x 3 reps up to 6 times per week." -Revised on 7/13/23, AROM to right upper extremity for 15 minutes 6 days per week and PROM Left UE as tolerates. *A quarterly "Quality of Life meeting" progress	F 676		

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F 676		F 676		

Continued From page 14
note was not documented in resident 76's record.

Further review of the documentation history for 30 days between 8/9/23 and 9/7/23 of completed restorative nursing rehab interventions for resident 76 revealed:
*Nursing order documentation for putting on the splint was noted on only 6 days in August 2023 and 2 days in September 2023.
*AROM to "stretch left leg out to side and stretch calf" had not occurred.
*Transfers to "stand at bar" and "transfer to another chair" had not occurred.
*AROM to right upper extremity and PROM to left upper extremity had not occurred.

4. Interview on 9/8/23 at 12:02 p.m. with DNS B and MDS nurse C revealed:
*DNS B had "already taken care of" the gait belts that remained fastened around residents when not in use.
*The practice of leaving them on had been with "residents that took walks with [the] restorative [CNAs]."
*DNS B had provided education to the CNAs and was conducting ongoing monitoring to ensure gait belts were removed after use.
*They were not aware of existing discrepancies between nursing rehab care plans and documentation for the residents who participated in restorative nursing.
*The restorative CNAs would need to be reminded to "document refusals" if residents were choosing to not do the care planned exercises.

Administrator A provided daily nurse staffing reports from 8/1/23 through 9/8/23 and highlighted the "restorative nursing aide" assignments for the "West Station." Review of

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

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F 676	Continued From page 15	F 676		

these reports revealed:
*Of 39 days, only 13 of those day were covered with 2 restorative CNAs.
*19 days had only 1 CNA assigned.
*7 days had no CNA assigned.

Review of the provider policy, "Restorative - Nursing Care Implementation and Screening," reviewed and revised on 11/28/22, revealed:
*The purpose was to:
-"Provide appropriate restorative nursing care to each resident"
-"Identify the residents appropriate for restorative nursing program"
-"Provide appropriate treatment for the resident's activities of daily living"
*The policy stated,
-"Each resident will receive restorative nursing care to the extent possible, based on individual strengths, needs and problems as defined in nursing assessments....outlines in the resident's nursing care plan."
-"Care includes safe measures to prevent complications and contractures, maintain strength and self-care abilities including eating and dressing, promote mobility and a feeling of well-being."
-"Residents are not allowed in the therapy/restorative treatment areas without supervision. No use of equipment by any resident or outside individual may be done without supervision."
-"Any resident who is unable to carry out independent activities of daily living will receive necessary services to prevent further diminishing of independent abilities."
-"The goal of restorative nursing care is to attain and maintain the maximum possible independence and/or prevent rapid declines

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F 676	Continued From page 16 through their interventions for each resident." *The procedures included: -Determining a "start-up strategy for restorative program" related, in part, to: --Assignment and training of an RN, who has overall responsibility and accountability for the restorative program. --Identification of "restorative aide(s) (RNA), CNAs for cross-training and consistent assignment." --The "projected number of hours necessary." --The "list of services" based on the "nature of residents being seen." --Reviewing the "current residents for appropriateness of service and potential changes to meet individual needs." -Nursing assessment for ADL or ROM deficits and need for a therapy screen. -"Changes in condition of lack of progress are reported to the restorative nurse in a timely manner." -"The resident's plan of care is reviewed at least quarterly and PRN [as needed] by the restorative nurse for potential changes/problems."	F 676		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686	Physician notification completed 6/5, and treatment orders and wound assessments were initiated for resident 63 on 6/6/2023. Interventions were in place and care planned upon resident 63's 5/11/23 admission to attempt to prevent skin breakdown including a pressure reducing mattress. Resident 63 admitted to hospice services 6/28/23 (KA 10/5/23). Skin Observations from the past month for all residents will be reviewed to ensure if the Skin Observation reflects a new wound, that physician notification, treatment orders and assessments were initiated per protocol. Any found to be lacking appropriate follow-up will be addressed. To ensure systemic change, all nurses will be educated by DNS on the proper protocol per facility's policy/procedure "Skin Assessment Pressure Ulcer Prevention and Documentation Requirements" (KA 10/4/23) for what to do when a wound is noted, including completion of physician notification, family notification, and treatment orders and wound assessments being initiated. Nurses are responsible for ensuring these steps are taken, and the DNS or designee is responsible for overseeing this process (KA 10/4/23). Skin observations are completed upon admission, readmission, with change in condition, or weekly when a resident is noted to have an abrasion, bruise, or skin tear and/or when a resident's Braden score is 18 or lower to monitor for signs of skin breakdown. DNS or designee will educate nursing staff to continue to put interventions in place upon admission or change in condition to prevent skin breakdown as they did for resident 63. Interventions are available to nurses and CNAs via the resident's care plan and Kardex. Facility has a wound RN that rounds weekly and oversees ensuring notification of physician to potentially change treatment plans when a wound is not showing signs of improvement (KA 10/5/23). To monitor our performance to ensure that solutions are sustained, focus audits of Skin Observations and corresponding follow-up will be conducted by DNS or designee weekly X 4, bi-weekly X 2, and monthly X 1. The results of these audits will be reviewed and reported at the monthly Quality Committee meeting.	10/18/2023

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

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F 686	Continued From page 17 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to follow their policy to ensure: *A thorough wound assessment or wound data collection form by a registered nurse (RN) had been completed for resident 63 when a right heel ulcer was identified on 5/30/23. *Physician notification occurred and had not been delayed one week, with no treatment orders. Findings include: 1. Observation and interview on 9/8/23 at 8:42 a.m. with assistant director of nursing services (ADNS) J during wound care of a right heel for resident 63 revealed: *The right heel wound had opened up and was bleeding. *The resident verbalized her right heel hurt during wound care. *The ADNS verbalized he was unable to complete the order to apply betadine since the wound had opened and he had to notify the physician and get new treatment orders. *The wound had been documented as identified on a skin observation form dated 5/30/23. *The ADNS stated the procedure was once a wound was identified it was documented on a skin observation form, the nurse was to notify the physician, obtain and initiate orders, complete a wound RN assessment and a wound data collection form. *There was no documentation the physician had been notified of the right heel wound and no treatment orders were obtained or initiated on	F 686		

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F 686	Continued From page 18 5/30/23. *There was no completed wound RN assessment or wound data collection forms dated on 5/30/23. *There was documentation of the right heel wound on a skin observation form, wound RN assessment form, a physician communication fax regarding the right heel, and treatment orders dated on 6/5/23, and a wound data collection form dated 6/6/23. *The treatment orders dated 6/5/23 had not been initiated until the following day on 6/6/23. *The ADNS agreed the facility procedure had not been followed and completed on 5/30/23 and the resident's treatment for her wound had been delayed until 6/6/23. Interview on 9/8/23 at 12:29 p.m. with RN K regarding the facility's skin assessment process revealed: *Certified nursing assistants reported any resident skin concerns to nurses. *Nurses completed skin observations for residents during their scheduled bathing times. *If a nurse identified a resident skin wound it was to be documented on the skin observation form. -The nurse was to notify the physician, obtain and initiate treatment orders. -A wound data collection form and a wound RN assessment form was completed. -The next shift and the wound care nurse were notified. Interview on 9/8/23 at 2:11 p.m. with DNS B regarding resident 63 revealed: *She agreed there had been no documentation the resident's physician had been notified or treatment orders were initiated when the initial documentation of the resident's right heel wound was identified on 5/30/23.	F 686		

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F 686	Continued From page 19 *She would have expected the nurse who documented the initial identification of a wound to the resident's right heel on the skin observation form dated 5/30/23 should have followed the providers policy and: -Notified the residents physician and obtained treatment orders. -Implemented the wound treatment orders. -Notified the residents family/representative. -Notified the wound care nurse. -Completed the wound RN assessment and wound data collection forms. Review of resident 63's medical record revealed: *She had a 5/11/23 Brief Interview for Mental Status score of 4 indicating her cognition was severely impaired. *Diagnoses included protein calorie malnutrition and a blister of the right heel. *The nursing admission skin assessment dated 5/11/23 had documented her skin was intact. *The nurse skin observation forms had documented: -"Right heel bruise noted approximately 50 cent size" on 5/30/23. -"Right heel with blood blister and right toes 2nd and 3rd toe tips with discolored purple area" on 6/5/23. *The wound data collection assessment dated 6/6/23 revealed "right heel with intact blister, also tips of right 2nd and 3rd toes discolored. Received orders for betadine twice daily." *Progress Notes included: -"6/5/2023 09:37 Communication/Visit with Physician Note Text: Communication fax to provider regarding blood blister noted to right heel and discolored area to tips of 2nd and 3rd toes right foot. Will initiate heel protectors."	F 686		

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F 686	Continued From page 20 -"6/5/2023 13:01 Communication/Visit with Physician Note Text: Doctor's office called, and they will see resident tomorrow on rounds and okay to initiate heel protectors." -"6/6/2023 09:30 Communication/Visit with Physician Note Text: CNP [Certified Nurse Practitioner], on unit to see resident's right heel. Orders received to put betadine BID [twice daily], and when/if pops to notify provider for additional orders. Resident to wear heel protectors at all times unless ambulating." *The physician orders included: "-Heel protectors bilateral at all times. May wear shoes only when ambulating every shift for wound healing" initiated on 6/6/23. -"Betadine to intact blister right heel twice daily. Call provider for additional orders if/when blister pops" initiated on 6/6/23. *The Care plan included: -"The resident has actual impairment to skin integrity evidenced by stage three pressure ulcer to right heel related to weakness and abnormalities of gait and mobility" initiated on 6/6/23. -"Monitor location, size, and treatment of skin injury. Report abnormalities, failure to heal, s/s [signs/symptoms] of infection, maceration, etc. to health care provider" initiated on 5/11/23. *Physician communication fax dated 6/5/23 revealed the physician was notified of "resident with blood blister to entire right heel. Also 2nd & 3rd toes discolored. Will initiate heel protectors. Visit scheduled for 6/6/23." *The providers policy and procedure had not been followed when the resident's right heel ulcer was initially documented in the medical record on 5/30/23 but had been implemented appropriately	F 686		

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F 686	Continued From page 21 from 6/6/23, following the second instance of documentation of the resident's right heel wound on 6/5/23. *The resident was admitted to hospice on 6/28/23. Review of the providers Skin Assessment Pressure Ulcer Prevention and Documentation Requirements policy dated 4/26/23 revealed: *7. If a pressure ulcer is identified, the registered nurse should record the type of wound and the degree of tissue damage on the Wound RN Assessment and Wound Data Collection forms. *8. Notify the physician/practitioner of the ulcer and resident's condition to obtain orders for treatment. *9. Notify resident and/or family of the pressure ulcer, orders, and planned interventions. *10. Dietary is notified by an alert that occurs when the Wound Data Collection is signed and locked. *11. The interdisciplinary team should determine any modifications that are necessary to the resident's plan of care.	F 686		

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

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FORM APPROVED
OMB NO. 0938-0391

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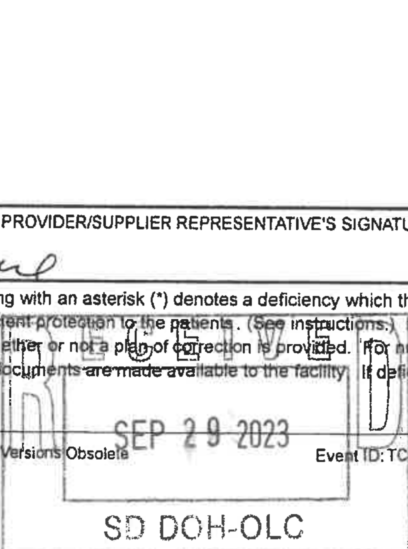
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 9/6/23 through 9/8/23. Good Samaritan Society Luther Manor was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelli Amme
TITLE: Administrator
(X6) DATE: 9/29/23

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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SEP 29 2023
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PRINTED: 09/21/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435044	A. BUILDING **01 - MAIN BUILDING 01 (INCLUDES 1990 ADDITION)** B. WING ______	**09/06/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 9/6/23. Good Samaritan Society Luther Manor was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelli amu
TITLE: Administrator
(X6) DATE: 9/29/23

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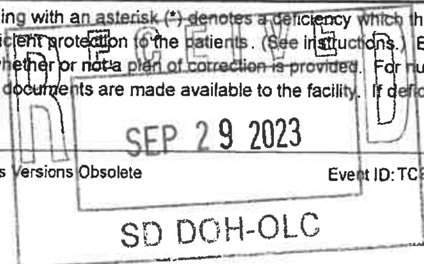

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10681	A. BUILDING: ________ B. WING ________	09/08/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 9/6/23 through 9/8/23. Good Samaritan Society Luther Manor was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 9/6/23 through 9/8/23. Good Samaritan Society Luther Manor was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kelli amo	Administrator	9/29/23