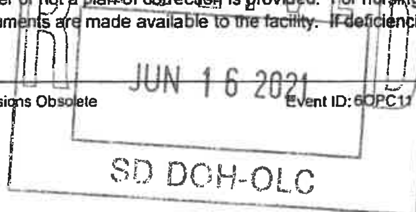
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435044	A. BUILDING ______ B. WING ______	05/20/2021

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 Surveyor: 41088 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 5/18/21 through 5/20/21. Good Samaritan Society Luther Manor was found not in compliance with the following requirements: F609, F689, and F880.	F 000	F000 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 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 disagreements with this deficiency, the facility submits the following plan of correction.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609	F609 Corrective Action: 1. Facility failed to report a resident with a burn as at the time of injury. The burn did not appear to be severe in nature and did not require	06/17/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda Studer (signed)
TITLE: Administrator
(X6) DATE: 6/16/21

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 609	Continued From page 1 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on record review, interview, and policy review, the provider failed to report a burn injury to the South Dakota Department of Health (SD DOH) for one of one sampled resident (32) who had acquired a burn injury from a heat register next to her bed. Findings include: 1. Review of resident 32's medical record revealed a 4/10/21 progress note indicated, "Resident rolled her legs in between the wall and the wall heater. When CNA [certified nursing assistant] and RN [registered nurse] moved her back into bed, a burn was noted to her left knee." Review of resident 32's 4/10/21 incident report revealed: *The report had been completed on 4/10/21 at 11:40 a.m. *"CNA called RN to room where resident was visualized to have her head in bed but torso and legs in between the wall/heater and her bed. Heater was on and residents [resident's] legs were tangled in her blanket and resting on top of wall heater." *"Resident and CNA moved her legs and torso back into bed and burn mark from heater visualized to left outer knee. Bed moved to face other wall away from heater." *The injury type was a burn on the left front knee. *Her mental status was described as lethargic and oriented to person only. *"Predisposing environmental factors: No apparent unsafe condition." *"Predisposing physiological factors: Confused,	F 609	outside intervention so appeared not to be reportable based on SD DOH guidelines. Facility consulted with Corporate Nurse Consultant who agreed it was not a reportable incident. Facility is aware of reporting requirements. The SDDOH website does not indicate all burns are reportable. State is currently aware of this incident. 2. As a review, Administrator will provide education to all staff on reporting requirements using the Mandatory Reporting Requirements for Medical Facilities from the SD Dept. of Health Website. Staff will have been educated by 6/17/21 that all burns need to be reported to DOH. 3. All burns will be reported per guidance from SD DOH. 4. DNS and/or ADM will audit all incidents at incident reporting meeting at minimum 2 x week for 4 weeks to insure burns are reported. After 4 weeks of demonstrating expectations are met, monitoring may reduce to twice monthly for one month with monitoring continuing for a minimum 2 months. Monitoring results will be reported by ADM and/or DNS to QAPI Committee and continued for	

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F 609	Continued From page 2 drowsy, impaired memory." *"Predisposing situation factors": No factors had been identified at that time. *There were no witnesses to the incident. Interview on 5/18/21 at 3:30 p.m. with director of nursing (DON) B revealed: *The resident had been found at 9:30 a.m. on a weekend day. *Staff RN H and CNA I who were interviewed at the time reported they had peeked in on the resident approximately 30 minutes before they found her between the bed and the wall. *The staff reported: -The heater was warm at the time she was found, and the resident had fragile skin. -Her knee and leg had rested against the heater for more than five minutes. *She confirmed a burn had occurred to the left knee and leg. *An event report had been completed after the burn had been identified. *Her physician and her husband had been notified of the burn. *The provider had not notified the SD DOH of the event that had caused a burn to her leg. *She stated the administration thought since resident 32 had not required medical attention in the emergency room it was not necessary to notify the SD DOH. Review of the provider's October 2020 Incident Report - Rehab/Skilled policy revealed: *An incident was an event with or without injury or a deviation from the standard of care that included physical injury. *An incident report was not required if the resident's injury was a bruise or skin tear that met all the following criteria: Did not require outside	F 609	no less than 2 months. Monitoring will continue as needed to sustain compliance as determined by QAPI committee and Medical Director.	

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F 609	Continued From page 3	F 609		

medical treatment, did not involve another resident, did not involve medical equipment such as a lift, was not caused by a fall and either an employee observed the incident or the resident was alert and oriented and could explain what had occurred.
*A copy of the untitled provider's root cause analysis form had been attached to the policy.

Review of the SD DOH Reporting of Injuries of Unknown Source and Reasonable Suspicion of Crime reporting tool revealed the seriousness of the event that lead to reasonable suspicion established two time limits for reporting to the SD DOH:
*Serious bodily injury was to have been reported within two hours.
*Serious bodily injury was defined as an injury with:
-Extreme pain.
-The possibility of loss or impairment of a bodily member, mental faculty, or organ.
-At risk of death.
-That may require surgery, hospitalization, or rehabilitation.
*When in doubt of whether the injury qualified as serious bodily injury, the provider was to report using the earlier timeline.
*All other events were to have been reported within twenty-four hours.
*Falls that involved injury of a serious nature should have been reported.
*All falls whether reportable or not should have had a thorough internal investigation.
-The investigation should ascertain any injuries, appropriate treatment, and a determination if there may have been contributing factors, including any review or revision of individual care plan or facility practices.

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F 609	Continued From page 4 Refer to F689, finding 1.	F 609		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, record review, interview, and policy review, the provider failed to ensure: *One of one sampled resident (32) had been supervised to prevent a burn from a heat register.*Twenty-five of forty-eight random and sampled residents in rooms with a heat register that was parallel to and close to their beds (rooms 101, 103 B, 108 B, 110 B, 301 B, 303 B, 305 B, 309 B, 310 B, 403 B, 404 B, 405 B, 406 B, 411 B, 502, 503 B, 504 B, 505, 513 B, 518 B, 519, 522, 602 B, 604, and 605) had been evaluated and had interventions in place to reduce the risk of burns. Findings include: 1. Observation on 5/18/21 at 3:30 p.m. of resident 32 revealed: *She was laying on her bed. *She had not acknowledged this writer when she was approached. *A mat had been placed on the floor beside her bed.	F 689	F689 Corrective Action: 1. Resident's (32) bed was moved away from register immediately when burn was discovered. 2. Currently there is no risk to any residents as boilers are off and registers are cold in summer months. Before registers are turned on, residents with decreased sensation or an inability to move away from the register independently will have their room rearranged to prevent similar incidents from occurring. Created list of those that need to be considered. All staff will be educated by the Administrator in regards of proximity of beds to registers by 6/17/21. Front line staff will receive education by the DNS for residents with decreased sensation or inability to move away independently by 6/17/21. 3. Beginning in September, facility Quality Coordinator or designee will monitor bed placement weekly x 4 weeks and monthly x 2 months. Monitoring results will be reported by Quality Coordinator to	06/17/21

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F 689	Continued From page 5 Review of resident 32's medical record revealed: *She was admitted on 3/15/21 after a hospital stay from a fall at an assisted living center. *She was placed on hospice on 3/30/21 due to continued declines and weight loss. *A 4/10/21 progress note indicated, "Resident rolled her legs in between the wall and the wall heater. When CNA [certified nursing assistant] and RN [registered nurse] moved her back into bed, a burn was noted to her left knee." Review of resident 32's 4/10/21 incident report revealed: *The report had been completed on 4/10/21 at 11:40 a.m. *"CNA called RN to room where resident was visualized to have her head in bed but torso and legs in between the wall/heater and her bed. Heater was on and residents [resident's] legs were tangled in her blanket and resting on top of wall heater." *"Resident and CNA moved her legs and torso back into bed and burn mark from heater visualized to left outer knee. Bed moved to face other wall away from heater." *The injury type was a burn on the left front knee. *Her mental status was described as lethargic and oriented to person only. *"Predisposing environmental factors: No apparent unsafe condition." *"Predisposing physiological factors: Confused, drowsy, impaired memory." *"Predisposing situation factors": No factors had been identified at that time. *There were no witnesses to the incident. Review of resident 32's 4/10/21 Wound Data Collection report revealed:	F 689	QAPI Committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee and medical director.	

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F 689	Continued From page 6 *"Left knee burn from wall heater, first layer of skin removed." *The burn measured 9.5 centimeters (cm) by (x) 6 cm. *The area was open and red. Review of resident 32's 4/10/21 Wound RN Assessment identified the above wound as a partial thickness loss. Interview on 5/18/21 at 3:30 p.m. with director of nursing (DON) B revealed: *The resident had been found at 9:30 a.m. on a weekend day. *Staff RN H and CNA I who were interviewed at the time reported they had peeked in on the resident approximately 30 minutes before they found her between the bed and the wall. *The staff reported: -The heater was warm at the time she was found, and the resident had fragile skin. -They estimated her knee and leg had rested against the heater for more than five minutes. *A burn had occurred to the left knee and leg. *An event report had been completed after the burn had been identified. *Her physician and her husband had been notified of the burn. *The provider had not notified the South Dakota Department of Health (SD DOH) of the event that had caused a burn to her leg. *The administration thought that since resident 32 had not required medical attention in the emergency room it was not necessary to notify the SD DOH. *The staff completed a root cause analysis to identify the cause of the injury. Review of resident 32's 4/12/21 root cause	F 689		

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F 689	Continued From page 7 analysis form revealed: *The event had occurred at 9:30 a.m. on 4/10/21. *Her diagnosis was senile degeneration of the brain, dementia. *Factors that had contributed to the incident: "Resident had legs out of bed, legs were in between bed and heater resulting in burn to (L) [left] knee. *1 time occurrence." *"Corrective actions taken to prevent recurrence of this incident: -Modify environment. -Bed moved to another position in room and no longer next to heater. -Nursing education per nursing leadership staff - to keep bed away from heater with resident's fall risk and repositioning self in bed at times." *"Results of investigation: Found that heater in room was warm to touch, resident has fragile skin and when knee/leg rested between bed and heater for a period of time burn did occur to knee/leg." Review of resident 32's 5/12/21 left knee Wound Data Collection form revealed: *The burn measured 8 cm x 5 cm. *The wound bed was fully covered 100 percent with black eschar (dead tissue). Review of resident 32's 5/12/21 Wound RN Assessment revealed: *"Full thickness tissue loss. *Deterioration of wound - evidenced by red wound edges, black eschar and slough present." On 5/12/21 resident 32's physician changed her wound treatment to help with removing the eschar. Observation on 5/19/21 at 8:44 a.m. of resident	F 689		

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F 689	Continued From page 8 32's dressing change to her left leg with RN J revealed resident 32: *Was living in another room when she rolled onto the heat register, getting the burn on her leg. *Had told staff she did not feel any discomfort at the time her leg was burned. *Had slid off her bed onto the floor on 5/10/21. -After that fall they had placed a mat on the floor to prevent injuries from falls. Review of resident 32's care plan revealed: *A revised 4/10/21 skin impairment focus had identified the burn on her leg. *A revised 5/11/21 fall focus related to a fall on 3/6/21 at the assisted living and another fall on 5/10/21. -There was no indication of the fall against the heat register on 4/10/21. -Interventions for falls had included: --Appropriate footwear. --Monitor for significant changes. --Monitor for medication combinations that could predispose her to falls. --Review her status for any medical conditions that could predispose her to falls. ---The interventions had not included the use of the mat beside her bed. Interview on 5/20/21 at 10:30 a.m. with DON B regarding resident 32 revealed: *After reviewing the 4/10/21 event report and the 4/11/21 root cause analysis she confirmed she had not identified the resident had fallen on 4/10/21. *She confirmed the provider had not implemented interventions to prevent her from being burned. Interview on 5/19/21 at 4:45 p.m. with DON B regarding the resident 32's root cause analysis	F 689		

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F 689	Continued From page 9 confirmed: *The nursing department had been educated after the burn was identified by the nursing leadership to keep her bed away from the heater due to the resident's fall risk and history of repositioning herself in bed. *The root cause analysis had focused only on resident 32 and her environment. -No other beds/rooms had been observed for at-risk residents. *Administrator in training A, DON B, and social worker G who had participated in the analysis had not: -Considered the potential safety concerns for all other at-risk residents who had a bed by the window where the heating registers were located. -Implemented interventions for those residents who were at risk of burns. Review of the provider's December 2020 Falls Resource Packet policy revealed: *A fall referred to unintentionally coming to rest on the ground, floor, or other lower level, but because of an overwhelming external force, such as being pushed. *A fall committee gathered to analyze the fall data using the root cause analysis and looking for trends and patterns. *After a fall staff were to have checked the resident's care plan to determine if the cause of the fall had been addressed to avoid additional falls. *Fall reduction began with proactively recognizing potential fall risk factors and proceeded with communicating actions to reduce the possibility of falls. Review of the provider's November 2016 Resident's Rights for Skilled Nursing Facilities	F 689		

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F 689	Continued From page 10 policy revealed: *The provider must protect and promote the rights of each resident. *The provider must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life. *The resident had a right to a safe, clean, comfortable, and homelike environment. *The resident had a right to be free from abuse, neglect, misappropriation of resident property, and exploitation.	F 689		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880	**Directed Plan of Correction** **Good Samaritan Society Luther Manor** **F880** **Corrective Action:** 1. Time cannot be turned back to a time prior to the identification of *lack of appropriate hand hygiene during resident transfer care task. *lack of appropriate cleaning and disinfecting between residents of shared mechanical lift. Administrator, DON, and infection control nurse were provided education/re-education about the identified areas cited on **June 9, 2021 by Lead Infection Preventionist.** The administrator and DON in consultation with the medical	06/17/21

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F 880	Continued From page 11 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880	director and infection control nurse and whomever else identified will review, revise, create as necessary policies and procedures to be in line with CDC and CMS recommendations about: *Hand hygiene use during resident transfer care task. *Cleaning and disinfecting between residents of shared mechanical lift. *Necessary infection control and prevention plan that includes effective compliance. All staff licensed and unlicensed who provide care and services to residents will be educated/re-educated by **6/17/21 by Clinical Learning and Development Specialist/Lead.** **Identification of Others:** 2. ALL residents have the potential to be affected if staff do not adhere to: *appropriate hand hygiene during resident transfer care task. *appropriate cleaning and disinfecting between residents of shared mechanical lift. ALL staff completing the care and/or assigned tasks have potential to be affected. Policy education/re-education	

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	435044	A. BUILDING ____ B. WING ____	05/20/2021

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 880	Continued From page 12 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: 41088 Based on observation, interview, and policy review the provider failed to: *Ensure appropriate hand hygiene had occurred with two of two sampled residents (39 and 69) during three of three observations of transfer provided by certified nurse aide (CNA) D, nurse aide (NA) E, and registered nurse (RN) F. *Ensure mechanical lift had been sanitized prior to and after use during three of three observations by CNA D, NA E, and RN F. Findings include: 1. Observation on 5/18/21 at 11:36 a.m. with CNA D and RN F during transfer of resident 39 revealed: *CNA D entered the room and was not observed performing hand hygiene or donning gloves before direct contact with her. *RN F entered the room to assist CNA D and was not observed performing hand hygiene or donning gloves prior to direct contact with her. *The resident was assisted to roll onto her side, the sling was placed underneath her, and she was rolled onto her back. *RN F exited the room and returned with the mechanical lift and was not observed sanitizing the mechanical lift or performing hand hygiene. *RN F and CNA D used the mechanical lift and completed transfer of her from bed to wheelchair. *CNA D adjusted her position in the wheelchair. *RN F rolled the mechanical lift back into the hallway and was not observed sanitizing the lift. *CNA D had not been observed performing hand	F 880	about roles and responsibilities for the above identified assigned task(s) will be provided by **6/17/21 by Clinical Learning and Development Specialist/Lead.** **System Changes:** 3. Root cause analysis conducted answered the 5 Whys: Rushing to get things done, New staff not in habit of washing hands or cleaning lifts, Hands are full when entering room, Hand Sanitizer not easily accessible, Forgetting, Wipes missing from lift due to supply issue or not getting stocked as part of normal daily tasks. Administrator, DON, infection control person, medical director and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency. **Administrator** contacted the South Dakota Quality Improvement Organization (QIN) on **6/7/21** and the QIN scheduled a call for **6/8/21.** Quality Improvement Advisor feels we have a good handle on root cause analysis as we reviewed our plan and discussed the past training we've conducted on hand hygiene and our	

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F 880	Continued From page 13 hygiene after transferring her. Observation on 5/19/21 at 9:41 a.m. with CNA D and NA E during transfer of resident 39 revealed: *CNA D and NA E entered the room to transfer her from her wheelchair into bed. -CNA D was not observed to perform hand hygiene before direct contact with the resident. *NA E exited the room, got the mechanical lift from the hallway, and moved it into the room. -She had not sanitized the mechanical lift before returning. -She used the lift to raise her out of the wheelchair and over her bed. *CNA D guided the resident into position while NA E lowered her onto her bed. *NA E moved the mechanical lift to the hallway. -She had not sanitized the mechanical lift or performed hand hygiene. *CNA D removed the sling from under her, covered her with a blanket, and then exited the room. -She was not observed to perform hand hygiene. -She had not sanitized the mechanical lift. 2. Observation on 5/19/21 at 9:49 a.m. during resident 69's personal care by CNA D and NA E revealed: *The resident had been in her room seated in her wheelchair. *CNA D and NA E entered the room and were ungloved. *No hand hygiene was observed by CNA D or NA E before direct contact with the resident. *NA E exited the room, got the same mechanical lift from the hallway and took it into resident 69's room. -She had not sanitized the lift before moving it into the room.	F 880	process for lift cleaning. Education, re-education and frequent auditing around the core principles of infection control being viewed as a priority area post this survey. Suggested "secret shopper" concept in monitoring of hand hygiene so that people don't know you are watching. Share tools that might be helpful for tracking/ auditing and link to Targeted COVID-19 Training for Nursing Homes. **Monitoring:** 4. Administrator, DON, infection control person, and whomever else determined will conduct auditing and monitoring for areas identified. Monitoring of determined approaches to ensure effective infection control and prevention include at a minimum weekly for 8 weeks, administrator, DON, and/or infection prevention nurse making observations across all shifts to ensure staff compliance with: *Necessary infection control and prevention plan that includes compliance in the above identified areas. *Any other areas identified thru the Root Cause Analysis.	

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

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F 880	Continued From page 14 *The resident had been transferred to her bed from the wheelchair using the lift. *NA E removed the lift from the room and placed it into the hallway. -She was not observed to perform hand hygiene. -She had not sanitized the mechanical lift after parking it in the hallway. *CNA D exited the room. -She was not observed to perform hand hygiene. -She had not sanitized the mechanical lift. Observation during the above transfers revealed the mechanical lift had not been sanitized prior to or after use. There had been a bag attached to the lift for storage of sanitizing wipes. The bag had been empty. Interview on 5/19/21 at 10:02 a.m. with CNA D and NA E regarding hand hygiene revealed: *They had received training on infection control and hand hygiene. *Staff could wash their hands inside of the resident rooms. *Hand sanitizer dispensers were available for use in the hallway. *They also had small bottles of sanitizer that they carried with them if needed. *They were expected to perform hand hygiene before and after resident contact. Interview on 5/20/21 at 10:01 a.m. with assistant director of nursing/infection prevention C regarding infection control concerns revealed: *All employees were expected to perform hand hygiene before and after contact with residents. *Any equipment used to assist residents should be sanitized after use. Interview on 5/20/21 at 3:42 p.m. with	F 880	After 8 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum 2 months. Monitoring results will be reported by administrator, DON, and/or infection control person to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee and medical director.	

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F 880	Continued From page 15 administrator in training A and director of nursing B regarding the above observations revealed: *CNA D, NA E, and RN F had received current training on infection prevention and proper hand hygiene. *All staff should perform appropriate hand hygiene to prevent the spread of infections. *Any equipment used to assist residents should be sanitized after its use. Review of the provider's 4/6/21 Hand Hygiene and Handwashing policy revealed: *"The goal is to prevent the spread of infection between residents. Handwashing and changing gloves occurs after care is delivered to prevent the spread of organisms to other residents. Sanitizers are used in patient care areas. *Wash hands with plain soap and water or with anti-microbial soap and water: -If hands are visibly soiled. -If hands are visibly contaminated with blood or body fluids. -Before eating. -After using the restroom. -When a build-up of emollients (moisturizers such as ointments, lotions, or creams) is felt on hands (usually after five to 10 applications of a gel). *If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based hand rub for routinely cleaning hands: -Before having direct contact with residents, patients, and children. -After having direct contact with another person's skin. -After having contact with body fluids, wounds, or broken skin. -After touching equipment or furniture near the resident/patient. -After removing gloves."	F 880		

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F 880	Continued From page 16 Review of the provider's 12/16/20 Environmental Cleaning Principles policy revealed: *"Environmental cleaning plays an important role in an infection control program. While most infections result from person-to-person transmission, the spread of infections from contaminated surfaces is significant and supports the need for good procedures and practices related to cleaning and disinfecting of surfaces. All staff members play a role and should be aware of the general principles of environmental cleaning and safety." *"There should be an emphasis on frequently cleaning high touch areas. For example, between resident, patient, or child contact with equipment."	F 880		

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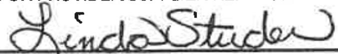
E 000	Initial Comments Surveyor: 41088 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities, was conducted from 5/18/21 through 5/20/21. Good Samaritan Society Luther Manor was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda Studer 
TITLE: Administrator
(X6) DATE: 06/14/21

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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	435044	A. BUILDING 01 - MAIN BUILDING 01 (INCLUDES 1990 ADDITION) B. WING	05/18/2021

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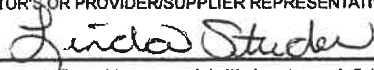
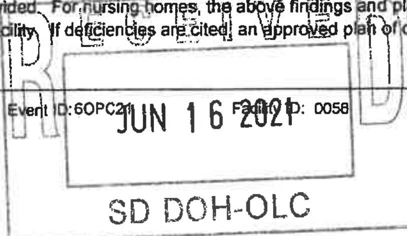
K 000	INITIAL COMMENTS Surveyor: 40506 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 5/18/21. Good Samaritan Society Luther Manor was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K233 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	K000 Provider 435044 Preparation and Execution of this Response and plan of correction does not constitute and Admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.	06/17/21
K 233 SS=E	Clear Width of Exit and Exit Access Doors CFR(s): NFPA 101 Clear Width of Exit and Exit Access Doors 2012 EXISTING Exit access doors and exit doors are of the swinging type and are at least 32 inches in clear width. Exceptions are provided for existing 34-inch doors and for existing 28-inch doors where the fire plan does not require evacuation by bed, gurney, or wheelchair. 19.2.3.6, 19.2.3.7 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the provider failed to maintain unobstructed corridors in three of five wings (100 wing, 300 wing, and 400 wing). Findings include: 1. Observation and interview on 5/18/21 at 1:20 p.m. revealed the 300 wing eight foot wide egress corridor was obstructed due to equipment	K 233	K233 Plan of Correction: 1) Medication Carts, W/Cs, charting stations, housekeeping carts, lifts, etc. will be placed on window side of hall in 100, 300 and 400 halls to allow a direct path for egress in event of an emergency. Plan in place and education provided for moving items on the one side of the halls in the event of an emergency. Note that in case of a fire or an emergency all items will be removed from the corridor. 2) Education will be provided by the Administrator to all staff on the importance of keeping a path of egress and that all items will be on one side of the hall or stored in vacant rooms by	06/17/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda Studer 
TITLE: Administrator
(X6) DATE: 06/16/21

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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	435044	A. BUILDING 01 - MAIN BUILDING 01 (INCLUDES 1990 ADDITION) B. WING ______	05/18/2021

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K 233	Continued From page 1 storage. Four carts, five wheelchairs, and a patient lift were left in the exit corridor. The obstructive items extended up to four feet into the corridor reducing the egress corridor width to four feet. 2. Observation and interview on 5/18/21 at 1:30 p.m. revealed the 400 wing was an eight foot wide corridor. The corridor was obstructed due to equipment storage. Three wheelchairs, a patient lift, and a computer on wheels desk were left in the 400 wing corridor. The obstructive items extended up to four feet into the corridor reducing the egress corridor width to four feet. 3. Observation and interview on 5/18/21 at 2:00 p.m. revealed the 100 wing was an eight foot wide corridor. The corridor was obstructed due to equipment storage. Two wheelchairs, two patient lifts, and a nursing cart (large) were left in the 100 wing corridor. The obstructive items extended up to five feet into the corridor reducing the egress corridor width to three feet. 4. Interview with the director of environmental services at the time of the observations confirmed those findings. The deficiencies had the potential to affect 100% of the occupants in each smoke compartment.	K 233	6/17/21. Education will include the need for removing all items in emergency situations. 3) DNS or designee, will audit daily for 2 weeks and weekly for 4 weeks. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum 2 months. Monitoring results will be reported by DNS the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee and medical director.	

South Dakota Department of Health

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	10681	A. BUILDING: ______ B. WING ______	05/20/2021

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S 000	Compliance/Noncompliance Statement Surveyor: 41088 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 5/18/21 through 5/20/21. Good Samaritan Society Luther Manor was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Linda Studer *Linda Studer*	Administrator	06/14/21