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 _____	10/26/2022

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 10/24/22 through 10/26/22. Good Samaritan Society Luther Manor was found not in compliance with the following requirements: F880.	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 880 SS=E	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; §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	F 880	Directed Plan of Correction Good Samaritan Society Luther Manor F880 1. Corrective Action: For the identification of lack of: *Appropriate procedural technique during dressing change in hand hygiene and glove use as well as protective barrier use. *Appropriate maintenance and care of oxygen, nebulizer, continuous positive air pressure (CPAP) supplies and equipment. The administrator, DON, and Infection Preventionist in consultation with the medical director has reviewed and revised facility's procedure for respiratory equipment cleaning and maintenance to include scheduling of these tasks on the MAR, and has developed training for staff performing dressing changes to address proper hand hygiene and the concept of "clean" versus "dirty." All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by 11/24/22 by DNS or Infection Preventionist	11/23/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelli Aschoff
TITLE: Administrator
(X6) DATE: 11/18/22

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F 880	Continued From page 1 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. §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: Based on observation, interview, record review,	F 880	2. Identification of Others: ALL residents and staff have the potential to be affected by lack of: *Appropriate procedural technique during dressing change in hand hygiene and glove use as well as protective barrier. *Appropriate maintenance and care of oxygen, nebulizer, CPAP supplies and equipment. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by DNS or designee. 3. System Changes: Root cause analysis conducted indicated the following: *Regarding dressing changes: Staff member not cleaning hands after removing gloves was caused by not having enough training to ensure staff has habitualized the procedure. Staff members not identifying clean and dirty practices was caused by not having enough training on what is "clean" and what is "dirty." *Regarding Respiratory Equipment Cleaning and Maintenance: the root cause was found to be not having a process for getting equipment cleaning and oxygen tubing replacement on the MAR. Administrator, DON, 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 and documentation. Administrator contacted the South Dakota Quality Improvement Organization (QIN) on 11/17/22 and the root cause analyses were reviewed, as well as discussion was had on infection control best practices which will be incorporated into facility's re-education.	

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F 880	Continued From page 2 and policy review the provider failed to ensure: *Two of two resident (1 and 46) with oxygen requirements had tubing, nebulizer sets changed weekly as well weekly, and cleaning of continuous positive air pressure (CPAP) mask. *Two of two residents (2 and 20) had received dressing changes completed by two of two registered nurses (RNs) (D and E) consistent with appropriate infection control practices. Findings include: 1. Observation and interview on 10/25/22 at 10:55 a.m. of resident 46 sitting up in her wheel chair revealed: *She was wearing oxygen using an nasal cannula connected to an oxygen concentrator in her room. *There was also a portable oxygen tank on the back of her wheel chair. *A second nasal cannula tubing was coiled up and connected to the portable oxygen tank on her wheel chair. *She wore oxygen all the time and used a continuous positive air pressure machine (CPAP) at night while sleeping. *She was not sure when her CPAP mask had been cleaned last. *A nebulizer machine was on her bedside table with a mask connected to the nebulizer set and tubing. Futher observation of resident's oxygen tubing, nebulizer mask and CPAP mask revealed: *Oxygen tubing connected to the concentrator and the portable oxygen tank was cloudy and contained white material. *Her CPAP mask was cloudy with white material. *The mask connected to the nebulizer set was cloudy with white material.	F 880	4. Monitoring: Administrator, DON, and/or designee will conduct auditing and monitoring of above identified items 1-2 time weekly. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. *Staff compliance with wound care and maintenance and care of respiratory equipment. 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 for 2 months. Monitoring results will be reported by administrator, DON, and /or designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	

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F 880	Continued From page 3 Record review of resident 46's electonic medical record (EMR) revealed: *No order for cleaning of resident's CPAP mask. *No order for changing resident's oxygen tubing and nebulizer tubing including mask. Interview on 10/26/22 at 2:00 p.m. with assistant director of nursing (DON)/Infection Prevention (IP) C regarding oxygen, nebulizer tubing changes, and cleaning of CPAP mask revealed: *Oxygen tubing and nebulizer sets were to be changed every Sunday. *Cleaning of CPAP mask were to be done weekly. *The nursing order was to be placed, which would trigger the tasks on the treatment record. *Task would include: -Change oxygen tubing and nebulizer sets every Sunday. -Clean CPAP masks with warm soapy water and pat dry. *He agreed no nursing order was placed to: -Change resident's oxygen tubing and nebulizer set weekly. -Clean resident's CPAP mask weekly. Interview on 10/26/22 at 3:55 p.m. with DON B regarding changing oxygen tubing, nebulizer sets, and cleaning of CPAP's revealed: *She had spoken with the assistant DON/IP C about the indentified concerns. *Agreed that no nursing order had been initiated to trigger that task. *She would expect staff to change oxygen tubing, nebulizer sets, and clean CPAP mask weekly. Review of provider's June 2022 Oxygen Administration,Safety, MaskTypes revealed: *Cleaning of concentrator and filters per manufactures' recommendation would be	F 880		

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F 880	Continued From page 4 documented. *Disposable equipment including: oxygen tubing, nebulizer sets would be changed weekly. 2. Observation and interview on 10/25/22 at 11:03 a.m. with registered nurse (RN) D performing a dressing change for resident 2 revealed she: *Placed a disposible moisture barrier under resident's left leg elevated on a chair. *Put a new pair of gloves on to removed the old dressing from the resident's left leg. *Also removed dressing from his right leg as well. *Removed her gloves and washed her hands. *Put a new pair of gloves on. *Removed adhered dressing to resident's left leg with saline and continue to irrigate wounds with saline and used gauze to clean wound. *Removed her gloves and used hand sanitizer and applied new gloves. *Patted dry the wounds with gauze to both legs and removed her gloves. *Did not perform hand hygiene. *Grabbed supplies out of a zip lock bag and placed them on top of the zip lock bag. *Put a new pair of gloves on without performing hand hygiene and began applying non adherent dressing and gauze to his right leg. *Then used the same pair of gloves and: -Opened three packages of non adherent gauze and applied them to the wounds on his left leg. --Wrapped kerlix around the non adherent dressings. -Taped kerlix in place and removed her gloves. *Put a new pair of gloves on without hand hygiene and picked up empty dressing packages and placed them in the garbage. *Removed her gloves without performing hand hygiene, gathered the trash bag and took trash to the dirty utility room.	F 880		

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F 880	Continued From page 5 Interview with RN D following the above observation of missed hand hygiene and working from clean areas to dirty areas revealed: *She agreed that she had miss opportunities for hand hygiene and glove changes. *Had agreed that opening dressing packages and applying the dressings with the same glove would not be a clean procedure. Interview 10/26/22 at 2:00 p.m. with assistant director of nursing (ADON)/IP C regarding the above observation revealed: *He had sent out an infection control wound care email to all direct care staff regarding: -Proper glove changes and hand hygiene. *He agreed that opening dressing packages and applying dressings with the same pair of glove would not be a clean practice. Interview on 10/26/22 at 3:57 p.m. with DON B regarding above observations revealed her expectation of staff would be that hand hygiene would be performed with glove changes. Review of the provider's October 2021 Wound Dressing Change policy revealed: *The purpose was to promote wound healing and to help wounds to remain free of infection. *Equipment required for dressing changes include: -Gloves. -Dressings. -Tape. -Plastic bag for disposal of soiled dressings. -Solution to clean wound. -Gauze wipes. *Procedure is the following: -Check physician's order and review previous	F 880		

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F 880	Continued From page 6 assessment notes. -Position resident for comfort and to accomodate dressing change. -Put on gloves, -Remove soiled dressing and discard in the plastic bag, avoiding contact contamination with other surfaces. -Remove gloves and perform hand hygiene. -Create field with equipment/dressing wrappers. Use sterile technique if required. -Open all supplies and pour solutions if ordered. -Put on a new pair of gloves. -Assess wound and surrounding area thoroughly to ensure the selection of the appropriately-sized dressing. -Cleanse the skin and wound thoroughly with normal saline using gauze wipes, wound cleanser or ordered antiseptic solution. -Remove gloves and perform hand hygiene. -Allow skin to dry completely before applying the new dressing. -Remove the dressing from the inner wrapper, and avoid finger contact with the clean dressing. -Place all disposable items in plastic bag with dressings, seal and discard according to procedure. -Identify time, date, and intials on dressing. -Chart dressing change and wound observation on the Wound Data Collection. -If the RN needs to assess due to change in the wound status and/or review the treatment choices, documentation should be completed on the Wound RN Assessment. Review of provider's Hand Hygiene policy revealed hand hygiene is a general term that applied to either handwashing or applying hand sanitizer.	F 880		

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F 880	Continued From page 7	F 880		

3. Observation and interview on 10/25/22 at 10:44 a.m. with resident 1 revealed:
*She was seated in her wheelchair with oxygen on while watching television.
*She was wearing a nasal cannula connected to an oxygen concentrator nearby.
*The oxygen tubing had been resting on the floor next to her wheelchair.
*There was a sticker in place around the tubing that had "change on Sunday" and 10/16/22 written in black ink.
*She had been on hospice care and spent most of her time in her room.
*She had breathing difficulty because of her diagnosis of congestive obstructive pulmonary disease (COPD) and asthma.
*Her breathing worsened with activity or exertion.
*She used oxygen when she slept and as needed.
*Some days were worse than others.
*When asked if the oxygen tubing had been changed on a regular basis, she could not recall staff changing it.

Observation on 10/26/22 at 3:20 p.m. and again 10/27/22 at 10:45 a.m. of resident 1's oxygen tubing revealed it appeared to have the same sticker dated 10/16/22 and had not been changed.

Review of resident 1's EMR revealed:
*She admitted 4/10/21.
*Her diagnoses of COPD, asthma, lung cancer and kidney cancer.
*She had a brief interview for mental status (BIMS) score of 14 which indicated her cognition

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F 880	Continued From page 8 was intact. *There had been no documentation of nursing staff changing the oxygen tubing on Sundays. Interview on 10/26/22 at 3:29 p.m. with RN G regarding resident 1 revealed: *She had been an RN at the facility for 7 years. *Resident 1 was well known to her. *The oxygen tubing was to be changed by nursing staff on Sundays for all residents who required oxygen. *It had not been an assigned task. *The nurse who had the time would change the tubing for all residents on oxygen. *Their practice had been to put a sticker on the new tubing with the date it had been changed. *If the tubing was dated 10/16/22, it had not been changed this past Sunday. *The correct date on the oxygen tubing should have been 10/23/22. *She had not usually worked on Sundays. *She was unsure of where the tubing change had been documented, but thought it should have been marked on the treatment administration record (TAR). Interview on 10/26/22 at 4:05 p.m. with DON B revealed: *Oxygen tubing for all the residents on oxygen therapy was changed on Sundays. *Their facility practice was to put a sticker with the date the oxygen was changed on the new tubing. *The nurse that changed the tubing was to document in the resident's record it had been changed. *She agreed that if the tubing was dated 10/16/22, it had not been changed that Sunday. *Her expectation would be for nursing staff to document the oxygen tubing had been changed	F 880		

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F 880	Continued From page 9 on the TAR. *If this had not been documented it should have been. 4. Observation and interview on 10/25/22 at 10:55 a.m. with RN E revealed: *He was going to change resident 20's dressing. *Once in her room he: -Grabbed an absorbant pad off of her bed, with a visible brown stain on it. -Folded it in half so the absorbant/stained side was on the inside, and he laid it under her left calf. -Put all of his wound treatment items on her unclean bedside table. -Sat down in the resident's wheelchair, and rolled up to her leg as she was sitting in her recliner. -Had not washed his hands and put on a pair of gloves that had been laying on the resident's bed. -Removed the resident's socks and touched the warts on the bottom of the resident's feet. -Wearing the same soiled gloves he removed her ace wrap on her lower left calf. -Opened up the dressing packages. -Sprayed wound cleanser on wound. --The bloody wound cleanser ran off onto the floor. -Wiped the bloody wound cleanser with some paper towels. -Had not cleaned his hands or performed hand hygiene at any time during the dressing changes. Interview on 10/25/22 at 11:12 a.m. with RN E revealed: *They usually used a barrier when performing dressing changes. *He forgot to use a barrier, clean the bedside table, wash his hands, and change his gloves.	F 880		

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F 880	Continued From page 10 Interview on 10/26/22 at 2:03 p.m. with ADON/IP C revealed he confirmed RN E had: *Received the appropriate education regarding infection control practices. *Not followed the policy and procedures related to dressing changes and infection control.	F 880		

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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 10/24/22 through 10/26/22. Good Samaritan Society Luther Manor was found in compliance.	E 000		

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

TITLE
Administrator

(X6) DATE
11/18/22

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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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 10/25/22. Good Samaritan Society Luther Manor (building 01) was found not in compliance with 42 CFR 483.90 (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 the deficiencies identified at K351 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 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.	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by:	K 351	To ensure compliance with the standard for the installation of sprinkler systems, the Environmental Services Supervisor will coordinate with Service First Fire Sprinkler to install a sidewall sprinkler system at the bottom of the elevator shaft to be installed by 12/09/22.	12/09/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelli Aschoff
TITLE: Administrator
(X6) DATE: 11/18/22

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 _____	**10/25/2022**

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 351	Continued From page 1 Based on observation and interview, the provider failed to provide sprinkler protection throughout the facility as required. The elevator shaft did not have sprinkler system protection. Findings include: Observation on 10/25/22 at 11:42 a.m. revealed the elevator to the basement was a hydraulically driven elevator. Further observation revealed that elevator shaft was not provided with the required sidewall sprinkler at the bottom. Interview with the supervisor of ancillary services at the time of the observation confirmed that finding. He stated he was not aware of the requirement for fire sprinkler coverage at the bottom of hydraulically driven elevator shafts. The deficiency could affect 100% of the smoke compartment occupants.	K 351		

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 _____	10/26/2022

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 10/24/22 through 10/26/22. Good Samaritan Luther Manor was found in compliance.	S 000		

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

TITLE
Administrator

(X6) DATE
11/18/22

STATE FORM 6899 GQJ811 If continuation sheet 1 of 1