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	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society Luther Manor	1500 W 38th St Sioux Falls, SD 57105

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 49238 Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI) review, record review, observation, interview, and policy review the provider failed to ensure Buprenorphine (pain medication) transdermal (TD) (delivered through the skin) patch was removed before a second Buprenorphine patch was applied to one of one sampled resident (1) whose altered mental state required evaluation at a hospital. Findings include: 1. Review of the SD DOH FRI dated 1/17/25 revealed: *There was concern regarding nursing services and the quality of care provided to resident (1) who had two Buprenorphine patches on his skin when he was evaluated at a hospital for his altered mental state. *He had an order to apply one Buprenorphine patch every 7 days. *He had a patch applied to his skin on 1/3/25 and a second patch applied on 1/11/25 because it was not available when it was due on 1/10/25. *The patch was delivered on 1/11/25. The nurse applied the patch and was not aware the previously applied patch had not been removed from the resident's skin. *The doctor at the hospital suspected the cause of resident 1's altered mental status was from having two Buprenorphine patches on his skin. *Further investigation was pending. 2. Review of resident 1's electronic medical record (EMR) revealed: *Diagnosis of a neurogenic bladder, history of urinary tract infections (UTI) and he had a super pubic catheter. *Pain level from 1/3/25-1/15/25 revealed it was between 2-5/10. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Observation and interview on 1/22/25 at 7:38 a.m. with licensed practical nurse (LPN) C revealed: *TD patches were to be signed out on the medication administration record (MAR) and the narcotic book was to be signed. *She would have removed the old patch and applied the new patch. -She would have kept the patch she removed and had another nurse destroy it with her. *She would have signed the time and date on the patch placement form . *If a medication wasn't available, she would notify clinical care leader (CCL) D. -She would have called the pharmacy if a medication was not availabl to check if it was waiting on a doctor's order or for a doctor's signature. *She would let the nurse manager know what was going on while she checked on the missing medication. 4. Interview on 1/22/25 at 7:50 AM with CCL D revealed:. *If there wasn't a medication available, they would have checked to determine if it was waiting for pharmacy delivery, if the order had changed, or if it had not been faxed to the pharmacy. *Their pharmacy delivered at 10:00 am., and had tow to four hours to deliver their orders for newly admitted residents. *Pharmacy would deliver for a stat (as soon as possible) order within one hour. 5. Interview on 1/22/25 at 10:52 a.m. with LPN C regarding the narcotic patch placement form revealed resident 1's form for his Buprenorphine TD patch had areas the placement had not been signed off as verified. 6. Interview on 1/22/25 at 2:30 PM with LPN C regarding resident 1's TD patch revealed: *Before she left her shift on 1/10/25 resident 1's TD patch had not been delivered from the pharmacy. - Pharmacy had said the TD patch was ordered Wednesday and should be delivered 1/10/25. -She reported to oncoming LPN E and instructed him to put the TD patch on resident 1 when it came in. -It was reported to her when she came to work 1/12/25 that the patch had been delivered on 1/11/25. -Resident 1's TD patch was signed out on 1/11/25 Saturday night at 3:00 p.m. as placed on the residents skin. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* He was to receive 15 micrograms per hour (mcg/hour) every week on Thursdays on the a.m. shift. *The hospital had a 10 and 5 mcg/hour patches, so they put one on each of resident 1's arms *At 8:22 AM she went to resident 1's room to apply a new patch for resident 1 for the surveyor to observe. -Resident 1 was in his wheelchair in his room, he appeared sleepy but would open his eyes occasionally when spoken to. -She stated those were the same symptoms he had the day he went out to the hospital. *His vital signs were taken and were within normal limits, his blood sugar was 129. *She removed the patches that the hospital had placed on him: - The patch removed from his left arm was 5 micrograms and the patch removed from the right arm was a 10 micrograms. -She stated that was the doses the hospital had versus one patch of 15 micrograms. *These patches were destroyed with CCL D. *She did not place the new one patch on resident 1 because she was going to call to the doctor. -She stated resident 1's nurse practitioner was coming in to see him for normal rounds that morning and would see the resident in person and labs had been ordered. -This did not occur before the end of survey. 12. Interview on 1/23/25 5 at 8:47 a.m. with director of nursing service (DNS) B revealed: *She sent the report into the SD DOH concerning the patch incident that involved resident 1. *They had not been concerned because he had a history of UTI'S and he had the symptoms his daughter had explained that he would have when he had a UTI. *She stated she talked to the nurse at the hospital about the 2 patches and that the doctor had suspected they had cause his altered mental status. *She stated his labs were pending but the urine drug analysis screen came back negative, and she was to call back the next day. *She called back the next day but he was being discharged back to the facility. *She stated she had wanted to explain to the hospitalist to have the doctor further investigate because the first patch went on 1/3/25 and the dose on 1/10/25 was a missed dose. (continued on next page)

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