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	06/18/2025

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure staff followed the care plan regarding the hydration needs for one of two sampled residents (2). Findings include: 1. Observation and interview on 6/18/25 at 8:50 a.m. in resident 2's room with certified medication aide (CMA) G revealed: *Resident 2 was sitting in his wheelchair. *CMA G brought resident 2 his morning pills in a medicine cup with chocolate pudding in it. *He agreed to take his pills. *CMA G administered him the pills with a spoon. *She gave him a drink of water from his water mug through a straw. *She stated this was the first time she had passed medications in that hallway. 2. Review of resident 2's electronic medical record (EMR) revealed: *He was admitted on [DATE]. *He had diagnosis of: -Essential (primary) hypertension (high blood pressure). -Cerebral infarction, unspecified. -Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. -Dysphagia following cerebral infarction. *The care plan dated 4/9/25 stated: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident has order for mildly thickened liquids with meals. -OK for thin liquids in room, NO straws per speech therapy. 3. Interview on 6/18/25 at 1:00 p.m. with dietitian H and dietary manager I regarding resident 2's dietary needs revealed: *He was admitted with an ordered minced and moist therapeutic diet. *The speech therapist upgraded his diet to soft and small bites of food in January 2025. *He was also on the Frazier Free Water Protocol (he needed thickened liquids with food at meals, and thin liquids in his room after oral care was provided). *He was not to use straws to drink liquids. *His care plan stated no straws. *The no straw information had not transferred over to the Kardex (electronic report of residents' care needs) for the front-line caregiver staff to see. *They expected that information to have been on the Kardex. 4. Observation on 6/18/25 at 1:20 p.m. in resident 2's room revealed his water mug still had a straw in it. 5. Interview on 6/18/25 at 1:35 p.m. with certified nursing assistant (CNA) J regarding resident water mugs revealed: *The CNAs were responsible for replacing water mugs. *The mugs usually got straws put in them. *She would rely on the Kardex or the dietary staff to know which residents were not allowed to have straws. 6. Interview and record review on 6/18/25 at 2:00 p.m. with registered nurse (RN) K regarding resident 2's hydration status needs revealed: *Resident 2 had a history of a stroke. *He could have thin liquids in his room with no food. *He confirmed resident 2 should not have had a straw in his water mug. *That hydration information was documented in resident 2's care plan. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*The information had not been selected in the care plan to be transferred to the Kardex for the front-line caregiver staff to know. 7. Interview on 6/18/25 at 3:05 p.m. with director of nursing (DON) B regarding resident 2's care plan and hydration needs revealed: *She was not aware that he should not have used a straw. *She expected that the information the front-line caregiver staff needed to know to provide the resident's care needs should have been on the Kardex. *She agreed staff should have marked it in the care plan so it would pull over to the Kardex. 8. Review of the provider's 12/2/24 revised Care Plan policy revealed: *Residents will receive and be provided with the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. *The plan of care will be modified to reflect the care currently required/provided for the resident. *The care plan will emphasize the care and development of the whole person ensuring that the resident will receive appropriate care and services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), observation, interview, record review, and policy review, the provider failed to implement fall prevention interventions as described in the care plan for one of one (1) resident who fell and sustained injuries that required treatment at an emergency department. Findings include: 1. Review of the SD DOH FRI submitted on 2/2/25 at 10:34 a.m. revealed: *On 2/1/25 at 10:20 p.m., resident 1 was found lying face down on the floor next to his bed. -There was noticeable blood on the floor. -Resident 1 had a laceration near his right eye. -He was transported to the emergency department for further evaluation. -He received six sutures and was transported back to the facility. *The provider's investigation of the fall determined that resident 1's silent TABs alarm (a device that flashes at the nurses station to alert staff when resident stands up) was in his recliner at the time of the fall and the resident was in his bed. *The certified nursing assistant (CNA) that assisted resident 1 to bed had forgotten to move the TABs alarm when she assisted the resident to bed. *As a result of the fall, the provider updated resident 1's care plan and Kardex to have a TABs alarm in both his recliner and his bed at all times. *Director of nursing services (DNS) O placed a STOP, Wait for assistance sign in the resident's room as a reminder for resident to not get up without staff assistance. 2. Review of resident 1's electronic medical record revealed: *He was admitted to the facility on [DATE]. *His diagnoses included: repeated falls, generalized muscle weakness, Dementia (a group of symptoms affecting memory, thinking, and social abilities), use of anticoagulants (blood thinning medications). *His 6/3/25 Brief Interview for Mental status (BIMS) assessment score was 12, which indicated he was moderately cognitively impaired. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*A progress note on 3/16/25 at 11:54 p.m. regarding his TABs alarm stated Alarm not placed under resident at bedtime, alarm pad found in recliner chair and resident is sleeping in bed. Resident [was] not woke [woken] up at this time to place under him d/t [due to] [the resident] sleeping soundly. Will monitor closely, night CNAs aware of this. *A progress note on 3/19/25 at 11:35 p.m. regarding his TABs alarm stated Not under resident in bed, alarm found in recliner chair and not connected. *Resident 1's 6/18/25 Kardex stated in the Monitoring section Personal Alarm: Silent TABs alarm used to alert staff of resident's movement and to assist staff in monitoring movement. Place TABs alarm in both bed and recliner at all times. Ensure this is used, plugged in, and functioning when [the resident is] in bed or [the] recliner. *Resident 1's 6/4/25 Care Plan Report indicated: *A Focus are of The resident has had an actual fall R/T [related to] epilepsy, dementia, muscle weakness, decreased balance as E/B [evidenced by] history of falls. *Goals for that area included Resident will be free of falls through the review date. Resident will be free of minor injury through the review date. Resident will not sustain serious injury through the review date. *Interventions included PERSONAL ALARM: Silent TABs alarm used to alert staff to resident's movement and to assist staff in monitoring movement. Place TABs alarm in both [his] bed and recliner at all times. Ensure this is used, plugged in, and functioning when [resident is] in bed or [the] recliner. 3. Observation and interview on 6/17/25 at 10:45 a.m. with resident 1 in his room revealed: *Resident stated he had lived there for the past couple years. *He had no obvious observed signs of bruising or injury. *His room was free of clutter. *He was sitting on his TABs alarm and his call light was within his reach. *There was no TABs alarm on his mattress. *There was no STOP, Wait for assistance sign on his wall. 4. Observation and interview on 6/17/25 at 1:20 p.m. with resident 1 revealed he was still sitting up in his chair, with the TABs alarm under him. 5. Interview on 6/17/25 at 2:20 p.m. with certified medication aide (CMA) M revealed: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*Resident 1 should have had a TABs alarm in both his chair and on his bed. *That was to be documented in the resident's TAR (treatment administration record) by a nurse. 6. Interview on 6/17/25 at 2:30 p.m. with CMA L revealed: *There should be an alarm in the resident's chair and in his bed. *She was not aware why there was not two alarms because she was not usually assigned to that unit. 7. Interview on 6/17/25 at 3:45 with registered nurse (RN) N revealed she was the nurse assigned to work in resident 1's unit but was not aware if resident 1 should have one or two TABs alarms. 8. Interview on 6/17/25 at 3:50 p.m. with CNA E revealed: *There should have been two TABs alarms in resident 1's room. *She was aware there was only one alarm that was being transferred back and forth from his chair to his bed. *She reported that there had not been two alarms in resident 1's room recently due to a malfunction when using two alarms. *She explained that when there were two alarms, one would malfunction and alarm when the resident was not using it. *She stated that maintenance personnel had tried to repair the system but were unable to. -The solution to that was to remove the second TABs alarm from resident 1's room. *She was not aware of any other fall prevention interventions that had been put into place for resident 1. 9. Interview on 6/17/25 at 4:00 p.m. with resident 1's spouse revealed: *She felt resident 1 received good care at the facility. *She stated, I wish sometimes there were more staff, but they work very hard. *She reported that resident 1 had fallen and that required him to go to the hospital and receive sutures. 10. Interview on 6/17/25 at 4:15 p.m. with RN/clinical care leader (CCL) F revealed: *Resident 1's cognition varied (sometimes he was confused, sometimes he was not), which could make it difficult to provide his care at times. *She was aware he was care planned to have two TABs alarms in his room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*She was aware there was only one TABs alarm in his room. *She reported that the staff were performing more frequent rounding (visually checking on resident's status) to ensure their safety. 11. Observation on 6/18/25 at 9:05 a.m. revealed: *Resident 1 was not in his room. *There was one TABs alarm in his chair, and none on his bed. *There was no STOP, Wait for Assistance sign visible in his room. 12. Interview on 6/18/25 at 1:50 p.m. with DON B revealed: *She was familiar with resident 1's fall but was not employed by the facility when the fall occurred in February 2025. *She was not aware of the fall prevention interventions that were to have been put in place as a result of the February 2025 fall (additional TABs alarm and STOP, Wait for assistance sign) for resident 1. *She was not aware that only one alarm was being used for resident 1. *She agreed resident 1 could fall again. 13. Interview on 6/18/25 at 2:30 p.m. with administrator A revealed: *His goal was to eliminate the use of TABs alarms for residents in the facility. *He preferred to focus on completing more frequent rounding on the residents instead of relying on alarms. *He stated Frequent checks should have been added to resident 1's care plan after his fall. *He agreed resident 1 could fall again. 14. Review of the provider's 4/8/25 Fall Prevention and Management policy revealed: *Purpose, To promote resident well-being by developing and implementing a fall prevention and management program. To identify risk factors and implement interventions before a fall occurs. *Proactive Approach before a Fall Occurs (e.g., New Admit) procedure. -3. Care Plan the appropriate interventions, including personalizing all (SPECIFY) areas. -4. Communicate fall risks and interventions to prevent a fall before it occurs per the 24-Hour Report, care plan and Kardex, daily stand-up meeting, and/or Fall Committee meetings.