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	06/04/2026

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 South Dakota Department of Health (SD DOH) complaint intake report, record review, interview, and policy review, the provider failed to ensure the staff were educated on NPWT (closed drain system that relies on the presence of vacuum to withdraw accumulated fluid from around the wound bed into the collection device) treatments for one of one sampled resident (2) whose wound vac was placed incorrectly, which resulted in the resident developing red, irritate skin above his pressure ulcer on his buttocks. Findings include:1. Review of the 5/13/26 SD DOH complaint intake report, revealed that resident 2 had voiced some concerns with the care he received at the nursing facility where he resided while he was getting a suprapubic catheter (flexible medical tube used to drain urine from the bladder) placed and a colonoscopy (diagnostic and preventative procedure to examine the lining of your rectum and colon) at the hospital. Resident 2 expressed that he did not want to the nursing facility following his hospitalization. Resident 2 was a quadriplegic (partial or total paralysis of all four limbs, (both arms, and both legs) and the torso) and was fully dependent on the staff for all care. He had multiple pressure wounds that were present upon admission to the hospital, including one on the ischium (lower and back part of the hip bone) that required a wound vac for healing. The resident and his wife voiced that the nursing facility was not meeting the resident's care needs. Resident 2 indicated that since he was on a bowel preparation for the colonoscopy procedure, he often sat in stool for an extended period (up to two hours), due to CNAs stating that they were not allowed to change the resident more frequently than every two hours. The resident stated that this prolonged contact with stool on his buttocks aggravated an existing pressure wound.Upon resident 2's arrival at the hospital, the staff discovered that his NPWT machine was not sent with him, despite the hospital's request to the nursing staff. As a result, the NPWT tubing remained attached to the resident's wound dressing but was not connected to the machine. According to the hospitals wound vac protocol, if a wound vac was not connected to the machine, the dressing and tubing must be removed. Resident 2 had reported that his primary physician recommended minimizing pressure to the wound area on his buttocks and was to use a commode (portable toilet) for bowel care. The staff at the nursing facility told him there was not enough space in the resident's assigned room to use a commode and that he had to use a bedpan (a small, stationary receptacle to collect stool or urine while lying in bed). According to records from the hospital, the number and severity of resident 2's pressure wounds had increased since his facility admission. It further indicated that the resident had a total of seven wounds, one of which required a wound vac for healing. Resident 2 had reported an incident in which his NPWT machine's alarm sounded during the night, and the staff member who responded did not understand why the alarm was beeping; they shut the device off without troubleshooting or addressing the issue.The report indicated that resident 2 stated he was frequently left without access to his call light, and when he did have access, response times were prolonged period of times. Resident 2's representative had visited him regularly in the hospital and confirmed that the concerns regarding resident 2 were accurate. The nursing facility was not previously notified of resident 2's concerns until a care conference held on 5/1/26, during which the provider stated they were unaware of any problems with his care. As of 5/13/26, the nursing facility did not submit a (continued on next page)

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	facility reported Incident (FRI) regarding the allegations of neglect.Resident 2 did not return to the nursing facility following his medical procedures at the hospital. 2. Review of resident 2's electronic medical record (EMR) revealed that admitted on [DATE]. His 4/3/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact. He had a diagnosis of injury at the C7 (damage at the seventh cervical vertebra at the base of the neck) incomplete lesion at the C4 (damage at the fourth cervical vertebra in the neck), quadriplegia (paralysis that causes total loss of motor and sensory function in all four limbs), C1-C4, neuromuscular dysfunction of bladder (neurological conditions interrupt nerve signals between the brain, spinal cord, and bladder muscles), neurogenic bowel (loss of normal bowel function due to nerve damage), and an open wound of the left buttock. His physician's wound care orders included care to his left and right heels, left and right ischium, medical coccyx, penis, and left buttock. His left buttock order was initiated on admission [DATE]) and indicated to have a NPWT with 125 millimeters of mercury (mmHg) of continuous suction, and a black foam dressing to be changed on Monday, Wednesday, Friday, and as needed.Resident 2's skin issues progress note, completed by DON B dated 4/23/26, that he measured the right gluteus as 0.6 centimeters (cm) long, 0.8 cm wide, with no depth. The left gluteal area measured 2.9 cm long, 2 cm wide, and 4 cm deep, with 2.3 cm of undermining (tissue under the wound edges dies or erodes).Resident 2's skin issues progress note, completed by registered nurse/minimum data set nurse (RN/MDS) H dated 4/29/26, indicated that the left heel measured 1.5 cm long, 1.3 cm wide, and 0.1 cm deep, with an area of 1.95 cm^2. The right gluteus measured 1 cm long, 1.5 cm wide, with no depth, and an area of 1.5 cm^2. The left gluteal area measured 3.5 cm long, 5 cm wide, and 6 cm deep, with an area of 17.5 cm^2 and no undermining.His undated care plan indicated he did not use the toilet and had a Foley catheter and bowel regimen at 7:30 every evening. Resident 2 had a nutritional problem related to wounds, obesity, and a history of diabetes mellitus, which increased his need for more protein and a nutritional supplement for wound healing. He had an order for a regular diet to encourage protein intake at meals, and Juven (nutritional supplement) twice daily, all initiated on 4/3/26. His weight was monitored weekly with no significant weight loss. 3. Interview on 6/4/26 at 4:35 p.m. with DON B revealed that on 4/29/26, RN/MDS H identified that the NPWT tubing for Resident 2 was placed incorrectly, which caused a reddened area above the open wound on his buttocks. After RN/MDS H identified this issue, DON B began training the facility nursing staff on NPWT procedures and care. The training was identified by DON B as needing to be completed because of the reddened area that was caused by the placement of the NPWT tubing. DON B points to the picture of the wound taken on 4/29/26, and said: This is why. RN/MDS H documented this reddened area in the skin issues progress notes dated 4/29/26.4. Interview on 6/4/26 at 6:45 p.m., with RN I revealed that over the last six months, the facility had cared for an increased number of residents receiving NPWT on the longˆterm care side of the building. She explained that the nurses on that unit were less comfortable working with wound vacs than the rehabilitation nurses in the building.5. Interview on 6/4/26 at 7:02 p.m., with RN/MDS H revealed that on 4/29/26, she recalled the area above resident 2's buttock wound being reddened, where the black foam dressing was placed. She explained that the staff were expected to bridge the black foam (creating a pathway of foam from the wound to a separate area of healthy skin where it was safe to place the track pad) because the track pad (the adhesive connector that links the dressing to the vacuum machine) should not be placed directly on the wound. If the track pad were placed directly on the wound and the resident sat in his chair, the pressure would worsen the wound area. She added that the track pad and tubing should be positioned over the resident's hip.6. Review of the provider's reviewed 8/7/25 Nursing Services Philosophy and Care policy revealed committed to the advancement of the profession practice of nursing through safe, reliable, person-centered care, in a healthy work environment, inspiring innovation and leading discovery. This comprehensive care will be planned to prevent further disability, maintain strengths, and restore any loss of function when possible. Every attempt will be made to assist the person to achieve the independence necessary to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transition to the place they desire to live in and call home. Nursing is a part of the interdisciplinary team that partners with the person to assess, plan, implement, and evaluate what is possible for the person. Objectives of Nursing Services 2. To cooperate with other team members and with the person/family using an interdisciplinary team approach in pre-admission, comprehensive care, and discharge planning, including the person/family in all phases of assessment, planning, teaching, and referral. 5. To provide the person with a relaxed, homelike, safe, and clean environment.7. Review of the provider's reviewed 7/7/25 Wound-Drain System: Open, Closed, and Negative-Pressure Wound Therapy policy revealed Negative pressure wound therapy: The negative pressure device removes excess wound fluids that may cause maceration or delayed healing and stimulates the growth of healthy granulation tissue. This should be used cautiously in residents taking anticoagulants. Negative pressure wound therapy (NPWT) Clinical Skill Checklist 18. Apply a new NPWT dressing or other appropriate absorptive dressing per the practitioner's order and following the manufacturer's instructions for packing. 22. Leave [the] resident comfortable.8. Review of the provider's reviewed 12/8/25 Pressure Ulcer/Wound Care policy revealed: promotion of healing, pain management, and prevention of complications is extremely important, as well as accurate assessment and documentation.

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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), record review, observation, interview, and policy review, the provider failed to ensure the safety of one of one sampled resident (1) who eloped (left the facility without staff knowledge) through the front door after visitors entered the facility and walked a block and a half east of the facility, fell with his walker, and sustained injuries.Findings Include: 1. Review of the provider's [DATE] SD DOH FRI report revealed that on [DATE] at 10:45 a.m., police alerted the staff that resident 1 was in an ambulance due to falling outside of the facility. A neighbor called 911 after seeing the resident lying on the sidewalk 1.5 blocks away from the facility. The police officer called an ambulance due to resident 1 having abrasions (scrapes in the skin) to the bilateral (both) upper and lower extremities (upper and lower limbs of the body), and notified the facility of the resident's location and condition. Registered nurse (RN) F went to see the resident in the ambulance before he was transported to the emergency department (ED). She saw his walker next to him in the ambulance. RN F called his family, notified the director of nursing (DON) B, and administrator A. Administrator A arrived at the facility to investigate the elopement. The door codes were changed on the front doors. Education was sent out to staff and family members. Signage was posted at the doors for visitors about not allowing residents to leave when the door was alarmed. Elopement drills were performed. 2. Review of resident 1's electronic medical record (EMR) revealed he admitted to the facility on [DATE]. He had a [DATE] Brief Interview for Mental Status (BIMS) assessment score of 8, which indicated his cognition was moderately impaired. His diagnoses included depression (mental health condition where a person experiences a persistent feeling of sadness or loss), altered mental status, insomnia (trouble falling or staying asleep), cognitive communication deficit (a person has trouble thinking skills that affect communication) and Sarcopenia (the gradual loss of muscle mass and strength, typically due to aging, which makes everyday activities tougher and increases the risk of falls). His [DATE] care plan (personalized plan that addresses a resident's care needs, goals, and interventions) indicated interventions to cue, reorient, and supervise the resident as needed due to impaired cognitive function and impaired thought processes. The care plan identified a communication problem related to mild cognitive impairment and directed the staff to be aware of his location during groups, activities, and in the dining room to promote effective communication. The care plan indicated that resident 1 required staff supervision with ambulation (walking), a gait belt, and the use of a frontˆwheeled walker (FWW). Resident 1 refused to wait for staff assistance with ambulation and was educated on the risks of ambulating alone and on safety awareness. On [DATE], his care plan identified a potential for elopement related to exitˆseeking behavior and a prior elopement incident. On [DATE], his care plan directed certified nursing assistants (CNAs) to walk resident 1 to the dining room. His elopement evaluations revealed that a score of 1 or higher indicated a risk for elopement. On [DATE], the resident's elopement score was 3, which indicated he was at risk for eloping. On [DATE], his elopement score was 0, which indicated he was not at risk for eloping. On [DATE], his (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	elopement score was 2, which indicated he was at risk for eloping. On [DATE], his elopement score was 6, which indicated he was at risk for eloping. On [DATE], his elopement score was 2, which indicated he was at risk for eloping. His fall risk evaluations indicated that a score of 10 or higher indicated the resident was at high risk for falling. His [DATE], [DATE], [DATE], [DATE], and [DATE] fall risk evaluation scores were all above 10, which indicated he was at risk for falling. He had a [DATE] physician's order for a wander guard (a wearable door alarming device). Nursing progress notes indicated that on [DATE], resident 1 eloped from the building. A police officer notified RN F after responding to the resident, who had fallen outside the building. RN F observed the resident on the ambulance gurney with bleeding legs and arms from the fall. The resident's walker lay folded on the ambulance floor. The resident was alert but confused. The police officer stated he would call the resident's daughter. The ambulance transported the resident to the hospital for treatment. RN F called the daughter at 11:50 a.m., and the daughter called the physician at 1:00 p.m. about the elopement. RN F indicated in resident 1's [DATE] elopement evaluation at 11:23 a.m., No to the statement, Wandering behavior likely to affect the safety or well-being of self/others. She also documented resident 1's blood pressure, temperature, pulse, respirations, and pain level on [DATE] at 2:46 p.m., when resident 1 was transported via ambulance to the ED around 10:45 a.m. On [DATE], he returned to the facility from the ED at 6:00 p.m., and on [DATE] at 6:56 a.m., staff contacted the nurse practitioner regarding the observed him have physical and verbal aggression and personality changes. At 10:20 a.m., an order was written to transfer to the ED for further evaluation. He was admitted to the hospital on [DATE] due to his altered mental status (a person is not thinking, acting, or responding within a person's normal limits) and delirium (sudden change in a person's thinking and awareness), and was discharged on [DATE] from the hospital back to the facility. His [DATE] hospital records indicated that resident 1 was diagnosed with cellulitis (a bacterial infection of the deeper layers of skin and underlying tissue that causes redness, swelling, warmth, and pain in the affected area) of the left lower extremity, altered mental status due to hepatic encephalopathy (liver can no longer remove toxins from the blood), and acute kidney injury (AKI) (kidneys suddenly stop filtering waste from the blood causing waste to build up and fluid or electrolyte imbalances). The progress noted indicated had multiple bruises on his torso and extremities. 3. Review of the [DATE] camera footage of the facility's front entrance door revealed that at 10:21 a.m., resident 1 was standing at the doorway when a family entered the facility. Resident 1 then walked out past the first set of sliding glass doors. He was wearing his wander guard, and the device activated the door alarm. Another visitor entered the facility, and resident 1 walked out of the second set of sliding glass doors. At 10:25 a.m., a CNA /medication aide (MA) K walked to the front entrance, looked out the doors while standing by the doorˆcode keypad, and deactivated the alarm before leaving the camera's view. 4. Observation and interview on [DATE] at 10:58 a.m. with resident 1 revealed that he had Mepilex dressings (a soft foam bandage used to cover and protect wounds) on both of his knees, each labeled with a date and signature. Bruising was noted across his body. The bruising was on the bilateral lower legs and forearms. He was wearing shorts, knee-high socks, a thin jacket with arms pulled up to his elbows, and a t-shirt on top of that. This left his lower legs and forearms visible. The bruising (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	was in various stages. The resident stated he was looking for his wife, but later referred to her as having been deceased for several years. The wander guard on his four-wheeled walker had a date of [DATE]. The resident indicated that the wander guard was a meter to tell you how far you go, referring to walking. He had an electric recliner and was able to demonstrate its use. He stated that the staff encouraged him to get up on his own. The resident stated that it was his first day at the facility. 5. Interview on [DATE] at 1:51 p.m. with Administrator A revealed that the code yellow (the overhead page for a possible resident elopement) was not initiated on [DATE] when resident 1 eloped out of the facility. 6. Review of the facility's Quality Assurance and Performance Improvement (QAPI) interdisciplinary (IDT) meeting on [DATE] revealed that the team identified the root cause of resident 1's elopement incident was a family member letting the resident out of the facility, and the staff not responding to the door alarm. The review indicated that resident 1 was wearing a coat, shorts, and shoes at the time of the incident, and the weather temperature ranged between 68 and 70 degrees on [DATE]. 7. Interview on [DATE] at 10:52 a.m. with contracted travel RN G revealed she was not aware of how the door alarms were turned off at each exit within the facility, but believed there was a code that the staff entered. The alarm panel at the nursing station displayed the location of an activated alarm so the staff could respond to that area, and displayed the alarms for the entire building. She did not know whether there was a process that the staff was to follow when there was a potential elopement. 8. Interview on [DATE] at 11:00 a.m. with RN F revealed she was aware of which residents were at risk for wandering because the resident's treatment administration record (TAR) identified which residents had a wander guard that the nursing staff checked to ensure it was on the resident or device used by the resident and that the wander guard was functioning. 9. Interview on [DATE] at 11:06 a.m. with certified CNA L revealed she was informed of which residents were at risk for elopement during report (information that one nurse gives to another staff member about a patient's condition, care, and any important events), by reviewing the resident's care plan, or by visibly seeing a wander guard on a resident or their assistive device such as a walker or wheelchair. 10. Interview on [DATE] at 11:11 a.m. with contracted travel licensed practical nurse (LPN) J revealed she did not know how to identify which residents in the building were at risk for elopement and that she would need to ask someone. If an alarm alerted the staff, she would check the alarm panel at the nurses' station and go to the alarming door. She was not aware of any process to follow when a possible elopement occurred. 11. Interview and observation on [DATE] at 11:34 a.m. with the supervisor of ancillary services (SAS) C at the front sliding door revealed that the door code to the facility's doors had to be changed immediately after an incident or concern. After opening the front sliding door, it remained open for approximately five seconds when closing without interruption. 12. Interview on [DATE] at 12:15 p.m. with the director of nursing (DON) B revealed that resident 1 was considered a very atˆrisk resident for eloping, and he did not want to remain in the facility since (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	his admission, as he did not understand why he needed to be there. DON B expected the charting completed by RN F on resident 1's [DATE] elopement evaluation to be accurate. He reported the response to the question, Wandering behavior likely to affect the safety or well-being of self/others, should have been Yes, as the resident had eloped from the facility earlier that morning. 13. Interview on [DATE] at 12:27 p.m. with RN F revealed she was the nurse assigned to care for resident 1 on [DATE]. She reviewed her charting from [DATE] at 11:23 a.m. and confirmed the answer to the statement, Wandering behavior likely to affect the safety or well-being of self/others, should have been Yes. 14. Interview on [DATE] at 4:13 p.m. with Administrator A revealed the facility did not complete staff education on code yellow procedures, and what residents are at risk for elopement for contracted travel staff. 15. Interview on [DATE] at 5:03 p.m. with DON B revealed the facility had a process in which all staff were expected to be aware of and use a yellow clipboard to identify the residents who may have potentially eloped. This clipboard contained the information and pictures of residents at risk for elopement. He confirmed the staff did not use this process as expected on [DATE]. 16. Interview on [DATE] at 9:31 a.m. with RN F revealed resident 1 did not return to the facility on [DATE] during her shift. She should not have charted his vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) at 2:46 p.m.as he was not in the facility. 17. Interview on [DATE] at 11:23 a.m. with CNA/MA K revealed he was working on [DATE] in the [NAME] Lane hallway. He heard the door alarm sounding and went toward the front door, where it was alarming. CNA/MA K entered the code on the keypad to turn off the door alarm and peeked out the door because he believed it was only an accidental alarm. He returned to his hallway and told his coworkers, It was the alarm going off by accident or misfiring. CNA/MA K then went on his break after turning off the front door alarm on [DATE], and then learned while he was on break that resident 1 was outside. Administrator A gave him education on elopement processes at the facility on [DATE] after the elopement had occurred. CNA/MA K identified residents at risk for elopement by visually observing whether they were wearing a wander guard. 18. Interview on [DATE] at 7:20 p.m. with DON B revealed he expected the nursing staff to review a resident's care plan (personalized plan that addresses a resident's care needs, goals, and interventions) or Kardex (a report of the resident's care needs and interventions) to ensure they provided appropriate resident care. He did not expect the staff to chart vital signs on a resident who was not present in the facility. Resident 1 was never alert and oriented; he was consistently confused and did not understand the amount of assistance he needed from the staff. DON B thought resident 1's elopement could have been prevented if the facility had a better door system in place and acknowledged the facility had experienced previous elopements related to the doors. 19. Review of the provider's reviewed/revised [DATE] Elopement-Rehab/Skilled & Adult Day Services police revealed purpose to assess and identify residents/clients at risk for elopement. To clearly define the mechanisms and procedures for monitoring residents/clients at risk for elopement. To provide a system of documentation for the prevention of, and in the event of, elopement. To (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	minimize risk for elopement through individualized interventions. Definition of elopement: when a resident/client who needs supervision leaves the premises or safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. The SNF location and each Adult Day Program will be responsible for maintaining a system that clearly defines the mechanisms and procedures for monitoring residents/clients at risk for elopement. These include identifying, evaluating and analyzing environmental hazards and risks; and implementing, monitoring, and modifying interventions as needed. 20. Review of the provider's reviewed [DATE] Nursing Services Philosophy and Care policy revealed committed to the advancement of the profession practice of nursing through safe, reliable, person-centered care, in a healthy work environment, inspiring innovation and leading discovery. This comprehensive care will be planned to prevent further disability, maintain strengths, and restore any loss of function when possible. Every attempt will be made to assist the person to achieve the independence necessary to transition to the place they desire to live in and call home. Nursing is a part of the interdisciplinary team that partners with the person to assess, plan, implement, and evaluate what is possible for the person. Objectives of Nursing Services 2. To cooperate with other team members and with the person/family using an interdisciplinary team approach in pre-admission, comprehensive care, and discharge planning, including the person/family in all phases of assessment, planning, teaching, and referral. 5. To provide the person with a relaxed, homelike, safe, and clean environment.