STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435132	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA BRULE NURSING HOME INC	408 SOUTH JOHNSTON STREET , WHITE LAKE, South Dakota, 57383

(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
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/22/25 through 7/24/24. Aurora Brule Nursing Home Inc was found not in compliance with the following requirements: F628, F657, F658, F689, F759, F760, F761, F812 and F880.	F0000	The preparation of the following plan of correction for these deficiencies does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies was executed solely because it is required by provision of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:	
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.	F0628	Administrator will review and revise as necessary the bed hold policy. The bed hold information will be sent with the resident when they go to the hospital and then a phone call will be made by the BOM or designee to the responsible party getting confirmation/ denial of bed hold. All staff that would be required to send bed hold was educated on the updated bed hold policy and procedure. Staff that would make the phone call was educated completed 8-3-25 by Administrator BOM or designated staff will audit any hospital admissions weekly for 4 weeks, then monthly for two months. Will take to QAPI for review.	9-1-2025

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 reverse for further 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
Kathleen Styles	Administrator	8/15/2025

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F0628 SS = D	Continued from page 1 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:	F0628		

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F0628 SS = D	Continued from page 2 (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the	F0628		

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F0628 SS = D	Continued from page 3 resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.	F0628		

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F0628 SS = D	Continued from page 4 (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and policy review, the provider failed to provide documentation of a signed bed-hold notice from the resident and/or their responsible party regarding a transfer to the hospital for one of two sampled resident (7) who had transferred to the hospital. Findings include: 1. Interview on 7/22/25 at 9:30a.m. with resident 7 revealed she did not think she had gone to the hospital since she admitted to the facility on 4/29/24. 2. Review of resident 7's electronic medical record (EMR) revealed: *She was transferred to the hospital on 1/26/25. -The responsible party was notified of her transfer. -There was a note that the bed hold policy was sent to the resident's responsible party. -There was no documentation that the resident or the responsible party signed a bed hold notice. 3. Interview on 7/23/25 at 8:14 a.m. with administrator A regarding resident 7 's bed hold notice revealed: *Social services designee C provided the initial bed hold policy to residents and their responsible party. *A bed hold notice was sent with the resident to the hospital on transfer. *The business office manager is responsible for sending a reminder of their bed hold policy in the mail to the responsibly party when a resident is sent to the hospital. *The business office manager sent a bed hold policy reminder to the responsible party for resident 7. *The administrator was unaware that they needed a reply from a resident or their responsible party regarding	F0628		

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F0628 SS = D	Continued from page 5 their decision about holding the resident's bed while the resident was in the hospital. *The administrator stated they had never received a reply from a resident or their responsible party about their decision on the bed notice. 4. Interview on 7/23/25 at 10:16 a.m. with social services designee C regarding the bed hold policy revealed: *She reviewed the bed hold policy on admission with residents and their responsible party. *She was unaware of resident 7's bed hold notice that was sent by mail. 5.Review of the provider's January 2024 updated Bed-Hold Policy and Procedure revealed: *"It is the policy of this facility to reserve the resident's right to return to the facility after therapeutic leave or hospitalization, to the same bed and room. This will be attained through the following procedure." *"1. All residents and/or responsible party will receive written notice of the bed-hold policy on admission to the facility." *"3. In case of hospitalization, Medicaid will pay the first five days of the [resident's] hospital stay, if the resident is Medicaid qualified. After these five days, the bed can be reserved through payment by the resident and/or responsible party at the daily Medicaid rate." *"5. At the time of a leave or hospitalization, the resident and/or responsible party will be informed of the bed-hold policy in writing."	F0628		
F0657 SS = E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F0657	Director of Nursing will review and revise as necessary the care plan policy. MDS coordinator or designated staff will check risk management for any incidents requiring care plan updates. Any care plans that need updated interventions will be completed. MDS coordinator and Social services designee were educated on policy and procedures of care plan revision timing completed 8-3-25 by administrator MDS coordinator or designated staff will do audits twice weekly for four weeks and then monthly for two months and report to QAPI.	9/1/2025

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F0657 SS = E	Continued from page 6 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to identify necessary care interventions, ensure resident care plans had been reviewed and revised, to reflect the current needs for two of two sampled residents (7 and 15) who had fallen more than once. Findings include: 1.Observation and interview on 7/22/25 at 9:30 a.m. of resident 7 in her room revealed: *She was seated in her recliner watching tv with her call light within reach. *Her walker was on the right side of her recliner with a gait belt draped over it. *She stated she walked assisted with one staff person and had fallen a few times. 2. Review of resident 7's EMR revealed: *She was admitted on 4/29/24.	F0657		

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F0657 SS = E	Continued from page 7 *She had a BIMS assessment score of 13, which indicated her cognition was intact. *Her diagnoses included repeated falls, heart failure, and chronic kidney disease (when the kidneys are damaged and cannot filter waste, fluids, and toxins from the body). *Her care plan indicated she had a high risk for falling on 7/16/2024. -The last updated revision of her fall interventions was on 7/17/24. -The interventions included providing a safe environment, educate the resident/family/caregivers about safety reminders and what to do if a fall occurs, and to review information on past falls and attempt to determine the cause of the falls. -She fell on 1/31/25, 2/6/25, and 4/20/25. -There were no interventions added to her care plan regarding her falls on 1/31/25, 2/6/25, and 4/20/25. *The nursing progress notes indicated she had fallen on 5/17/25, and the fall and fall interventions had not been added to her care plan. 3. Review of resident 15's electronic medical record (EMR) revealed: *He was admitted on 2/26/25. *He had a Brief Interview of Mental Status (BIMS) assessment score of 5, which indicated his cognition was moderately impaired. *His diagnoses included repeated falls, weakness, and abnormalities of gait (walking) and mobility. *His care plan indicated he had a high risk for falling on 3/6/25. -The last revision of interventions for his falls was on 3/6/25. -The interventions included anticipating his needs, to ensure his call light was within reach, to wear appropriate nonskid footwear when ambulating (walking), encourage him to participate in activities, follow the facility fall protocol, and for physical therapy (PT)	F0657		

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F0657 SS = E	Continued from page 8 to evaluate and treat as ordered. -He fell on 3/15/25, 3/29/25, and 4/5/25. -There were no interventions added to his care plan regarding his falls on 3/15/25, 3/29/25, and 4/5/25. *The nursing progress notes indicated he had fallen on 6/27/25, and the fall and fall interventions had not been added to his care plan. 4. Interview on 7/23/25 at 3:32 p.m. with licensed practical nurse (LPN) H revealed: *The director of nursing (DON) W, registered nurse (RN) F, and LPN I updated the residents' care plans. *It was not the responsibility of the charge nurses to update the residents' care plans. *She stated she knew how to update a care plan but had not done that in a long time. 5. Interview on 7/24/25 at 8:14 a.m. with administrator A regarding resident care plans revealed: *Each department was responsible for updating their portion of the residents' care plans. *If a nurse had resident information that needed to be updated in their care plan, the nurse would go to the DON W to update it. *The responsible department were to update the residents' care plans every quarter, for significant changes (declines in residents' health), when a resident had fallen, and when a resident had a change in their behavior/mood. *She expected resident care plans to be updated by the DON W after falls occurred to include updated interventions to prevent future falls. *She was not aware resident 7's care plan had not been updated regarding her falls on 1/31/25, 2/6/25, 4/20/25, and 5/17/25. *She was not aware resident 15's care plan had not been updated regarding his falls on 3/15/25, 3/29/25, 4/5/25, and 6/27/25.	F0657		

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F0657 SS = E	Continued from page 9 6. The director of nursing was not able to participate in the survey. Interview questions related to nursing services were directed towards administrator A, who was a registered nurse. 7. Review of the provider's updated 4/17/24 Comprehensive Care Plan policy revealed: *"will develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights that includes measurable objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment." *"1. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being." *The policy did not address who was responsible for updating the residents' care plans or how often that should occur. 8. Review of the provider's undated Fall Management Policy and Procedure revealed: *"11. Update the Comprehensive Care Plan with any changes or new interventions." *The policy did not address fall interventions had to be reviewed and updated each time a resident fell.	F0657		
F0658 SS = E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to ensure one of one certified medication aide (CMA) (K) followed accepted standards of practice and facility policy during medication administration that included: *Proper administration technique for two of two sampled	F0658	Administrator will review and revise the Medication Administration policy as needed. Education provided to CMA K on policies and procedures. Eye drop administration, pain documentation, proper preparation of medications, general medication administration policies and procedures, ensuring the knowledge of the 6"R" s of medication pass. Education completed on 8-8-25. CMA K med pass will be monitored for safe practices. All other CMA will be educated on updated medication administration policy. completed 8-11-25 by administrator Director of Nursing or Administrator or Designee will audit medication passes daily for two weeks, then weekly for two more weeks, then monthly for two more months bringing to QAPI for review.	9/1/2025

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F0658 SS = E	Continued from page 10 resident's (11 and 13) eye drops. *Inquiring about and accurately recording pain level for one of one resident (13) receiving a scheduled pain medication. *Not returning two stock supply acetaminophen (a pain-relieving medication) tablets back into the bottle after being prepared for administration to resident (17). *Appropriately identifying and administering medications per physician orders according to the rights of medication administration. Findings include: 1. Observation on 7/23/25 at 3:52 p.m. of CMA K administering eye drop medication into resident 11's eyes revealed that he touched the resident's eyes with the tip of the eye dropper bottle as he was squeezing the liquid out of the bottle. Review of resident 11's electronic medical record (EMR) revealed a 6/23/25 physician's order for "SYSTANE ULTR [ultra] SOL [solution,] INSTILL 1 DROP INTO EACH EYE THREE TIMES DAILY." 2. Observation on 7/23/25 at 3:57 p.m. of CMA K administering eye drop medication into resident 13's eyes revealed that he touched the resident's eyes with the tip of both eye dropper bottles as he was squeezing the liquid out of the bottle. Review of resident 13's EMR revealed physician's orders: *On 3/3/25 for "SYSTANE PRESERVATIVE FREE-UD, INSTILL 1 DROP INTO EACH EYE THREE TIMES DAILY..." *On 7/6/24 for "Alphagan P Ophthalmic [Eye] Solution 0.1 % (Brimonidine Tartrate) Instill 1 drop in right eye two times a day..." 3. Observation on 7/23/25 at 3:57 p.m. of CMA K while administering resident 13's medications revealed: *Resident 13 was scheduled to receive two acetaminophen (Tylenol) 325 milligram (mg) tablets three times per day, scheduled for 7:00 a.m., 12:00 p.m., and 5:00 p.m.	F0658		

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F0658 SS = E	Continued from page 11 *He administered two Tylenol 325mg tablets to resident 13. *CMA K did not ask resident 13 what her pain level was at. *He was observed charting in resident 13's EMR that her pain was at a level of "0," which meant that she did not have any pain. Review of resident 13's medication administration record (MAR) revealed CMA K charted resident 13's pain at a level "0" (which indicated no pain) for the scheduled 5:00 p.m. acetaminophen administration. 4. Observation on 7/23/25 at 4:09 p.m. of CMA K while preparing resident 17's medications revealed he: *Explained that resident 17 was scheduled to receive acetaminophen at that time. *Removed two 325mg acetaminophen tablets from the stock medication bottle and placed them in a medication cup. *Realized he had made a mistake, explaining that she was to have received a stronger dose from her prescription medication cards. *Placed those two acetaminophen tablets back into the stock medication bottle. *Found resident 17's medication card for 500mg acetaminophen tablets and popped one pill from the medication card into the medication cup. Review of the stock medication bottle confirmed that it contained 325mg tablets of acetaminophen. Review of resident 17's EMR confirmed she had a 7/29/24 physician's order for "ACETAMIN [acetaminophen] TAB 500MG GIVE 1 TAB BY MOUTH FOUR TIMES DAILY." 5. Observations on 7/23/25 from 3:47 p.m. to 5:04 p.m. of CMA K during medication administration revealed he was not comparing the prescription labels on the resident's medication cards or prescription bottles to verify they matched physician's orders in the residents' EMRs. He was relying on memory as to where	F0658		

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F0658 SS = E	Continued from page 12 the resident's medication cards were located at in the medication cart, without verifying the label on the medication cards matched the resident he was preparing medications for. See F759, findings 1 and 2. 6. Interview on 7/23/25 at 5:28 p.m. with administrator A revealed: *She was informed that the surveyors intervened during the medication administration observation with CMA K to prevent him from administering medications to the wrong resident. *She expected all staff who administered resident medications to follow facility policy and the "rights" of medication administration. *She confirmed that the tip of the eye drop medication bottle should not physically touch the resident's eyes. 7. Interview on 7/24/25 at 8:20 a.m. with registered nurse (RN) G and licensed practical nurse (LPN) H revealed: *They both confirmed that the person administering eye drops should not touch a resident's eye with the tip of the eye drop bottle. *They expected all staff administering medications to compare the resident's MAR with the medication prescription label to ensure the resident received the correct medication. 8. Interview on 7/24/25 at 2:08 p.m. with LPN I revealed: *She was the facility's designated infection preventionist. *She confirmed that staff should not have touched a resident's eye with the eye drop medication bottle. *She confirmed staff should have been comparing the prescription label on the resident's medication card or bottle with their physician's orders in the EMR. 9. The director of nursing was not able to participate in the survey. Interview questions related to nursing services were directed towards administrator A, who was a registered nurse.	F0658		

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F0658 SS = E	Continued from page 13 10. Review of the provider's 7/27/23 General Medication Administration Policy & Procedure revealed: *"...Procedure for Medication Pass: -2. During the Medication Pass – Nursing should always check the 6 'R's': --a. Right Resident – before administering medications, identify each according to Facility Policy; --b. Right Drug – verify in at least three ways, such as ---1. The drug's size, color and label. ---2. Verify each drug against the MAR before administering. ---3. If there is a discrepancy between the card, label and MAR, hold the medication until the Medication Pass is completed and verify with the Physician's Order Sheet; --c. Right Dose – verify against MAR; --d. Right Dosage Form – verify against MAR; --e. Right Time – administer meds according to facility standard medication administration time or personalized medication administration schedules; --f. Right Route – verify against MAR. -3. If the comparison is correct, the Medication is to be removed from the container and placed into the Medication Cup using appropriate technique. Nursing must document in the eMAR for the appropriate medication, with the appropriate date and time according to Facility Policy. -...7. If a PRN Medication is administered, nursing should document accordingly in the eMAR under the PRN tab, provide supplementary documentation as to why the med has been given, pain level, etc." 11. Review of the provider's 7/27/23 OPHTHALMIC DROPS policy revealed: *"Equipment:	F0658		

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F0658 SS = E	Continued from page 14 -Medication Administration Record (MAR) -Prescribed eye medication -Cotton ball or tissue -Gauze pads, dressings, warm water or saline solution (if applicable)" *"Procedure: -1. Verify medication order on MAR. Check against physician order. Check medication and label. Comments: Make certain medication is labeled for ophthalmic [eye] use (assumes sterility and compatibility for use in the eye). If clear bottle, observe medication for discoloration or precipitates [particles]. -2. Identify resident. Explain procedure. -3. Wash hands. -4. Determine which eye is to be instilled and verify dose for each eye. -…6. Have resident lie supine [on their back] or sit. Head should be tilted back and toward the side of the affected eye. Comments: Excess solution should drain away from inner canthus to prevent systemic absorption through nasal mucosa [the tissue inside a person's nose as the tear duct leads to the nose]. -…8. Before instilling drop, instruct resident to look up and away. Comments: Moves cornea [the dome-shaped cover over a person's iris and pupil] up and away from conjunctival sac [the space between the eyelid and white of the eye] and minimizes risk of touching cornea with dropper, particularly if patient blinks. -9. Gently pull down lower lid to expose conjunctival sac. -10. Eye drops: Hold dropper in dominant hand approximately [one-half to three-quarters inches] above conjunctival sax. Do not touch dropper to eye. Shake suspensions well. Comments: The eye can retain maximum of two drops at one time…"	F0658		
F0689 SS = E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F0689	Director of Nursing will review and revise as necessary the policy on gait belt usage. Gait belts will be used according to policy by all staff. All residents will have a gait belt accessible to them.	9-1-2025

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F0689 SS = E	Continued from page 15 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: Based on observation, record review, interview, and policy review, the provider failed to ensure the safety of one of one sampled resident (15) who was transferred without the use of a gait belt (a waist strap gripped as support for safe mobility and transfers) by five of five staff members (certified nursing assistant (CNA) M, administrator A, CNA N, certified medication aide (CMA) J, and registered nurse (RN) G) observed. Findings include: 1. Observation on 7/22/25 at 11:17 a.m. of resident 15 revealed: *He stated he needed to use the restroom quickly. *CNA M was walking by and stopped to help him. -She positioned his wheelchair next to the recliner and locked the brakes. -She grabbed resident 15 by his right arm and began hoisting him up. -Administrator A came out of her office and grabbed resident 15 by his left arm and assisted CNA M with transferring him into his wheelchair. -No gait belt was used during that transfer. 2. Observation on 7/22/25 at 12:11 p.m. of resident 15 revealed he was transferred out of the recliner to his wheelchair without a gait belt by administrator A and CNA N. 3. Observation on 7/22/25 at 3:04 p.m. of resident 15 revealed he was transferred out of the recliner to his wheelchair without a gait belt by administrator A and CNA N.	F0689	Education provided to staff CNA M, N . CMA J, RN G, and administrator A on 7-25-25 by Director of nursing. All staff that would be transferring/ ambulating residents educated on any updated policy and procedures. 8-11-25 by Director of Nursing Director of nursing or designated staff will do audits five times weekly for four weeks, then weekly for two more months. And report to QAPI for review.	

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F0689 SS = E	Continued from page 16 4. Observation on 7/22/25 at 4:30 p.m. of resident 15 revealed he was transferred out of the recliner to his wheelchair without a gait belt by CMA J and RN G. 5. Review of resident 15's electronic medical record (EMR) revealed: *He was admitted on 2/26/25. *He had a Brief Interview of Mental Status (BIMS) assessment score of 5, which indicated his cognition was moderately impaired. *His diagnoses included repeated falls, weakness, and abnormalities of gait (walking) and mobility. *His care plan indicated he had a high risk for falling on 3/6/25. *He requires "partial/mod assist [the helper provides less than half of the effort needed for the transfer] of staff to move between surfaces as necessary. Stand aid [a device designed to help people who have difficulty rising from a seated position to a standing position] needed at times. Focus on stand pivot transfers [a method of moving a person from one surface to another by first standing and then helping the person pivot to another surface before sitting again]." 6. Interview on 7/23/25 at 3:32 p.m. with licensed practical nurse (LPN) H regarding resident 15 revealed: *Staff had been using a two-person assisted stand and pivot transfer (involves two staff members assisting a person with limited mobility to move between surfaces using a combination of standing and pivoting) between surfaces with him. *She did not know if he was care planned to need a gait belt, but thought it was always a good idea to use one for residents. 7. Interview on 7/23/25 at 3:45 p.m. with CNA Q revealed: *She stated resident 15 was a stand and pivot transfer between surfaces with a gait belt. *When he needed to be transferred out of the recliner, it was easier for two staff members to assist him	F0689		

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F0689 SS = E	Continued from page 17 because he was unsteady. *She had never needed to use a lift to help him stand. 8. Interview on 7/24/25 at 10:08 a.m. with administrator A revealed: *Resident 15 should have had a gait belt on when transferred between surfaces. *She stated that gait belt usage for resident transfers has been an issue. *She had informed the staff at their meetings to use gait belts when assisting residents with transferring. *She expected all staff to use gait belts when assisting all residents with transferring. 9. The director of nursing was not able to participate in the survey. Interview questions related to nursing services were directed towards administrator A, who was a registered nurse. 10. Review of the provider's reviewed 7/27/23 Gait Belt Safety policy revealed: *"All Physical, Occupational, & Speech Therapy personnel are to use a gait belt for all patients involving transfer from one surface to another or to come to standing." *"The gait belt provides a firm grasping surface for the staff person and protects the resident. The gait belt gives the patient a sense of security as it is tightened. The belt also allows [the] staff person to gradually lower a patient [resident] to the floor (if necessary) without injuring self or patient." *The policy did not address non-therapy staff and the use of gait belts when transferring residents.	F0689		
F0759 SS = E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its-	F0759	Director of Nursing and Administrator will review and revise the policy and procedures on General Medication Administration. CMA K was provided education with General medication administration. Educated on the 6"R"s of medication pass. Completed 07/28/25 by Director of Nursing. All other staff that pass medication were educated on updated policies and procedures for general medication administration. Completed 08/11/25 by Director of Nursing. Director of Nursing or Administrator or Designee will audit medication passes daily for two weeks, then weekly for two more weeks, then monthly for two more months bringing to QAPI for review.	9-1-2025

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F0759 SS = E	Continued from page 18 §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to ensure the medication error rate remained under 5%. Certified medication aide (CMA) K had three errors out forty-one total medication administration observations, including failing to verify resident physician orders with the medication prescription label, failing to document he had given a PRN (as needed) eyedrop medication, and preparing one sampled resident's (15) medications to administer to another sampled resident (39). This resulted in a calculated error rate of 7.3%. Findings include: 1. Observation and electronic medical record (EMR) review on 7/23/2025 at 3:57 p.m. with CMA K while preparing resident 13's medications revealed: *CMA K grabbed an orange medication bottle. The label on that bottle read, "artificial tears, instill 1 drop into each eye PRN [as needed]." *CMA K did not check the physician's order in the resident's EMR to ensure the prescription label on the bottle matched the physician's order before administering the eye drops into resident 13's eyes. *Resident 13's EMR revealed a physician's order on 8/13/24 for "ARTIFICIAL DRO [drop] TEARS, INSTILL 1 DROP INTO EACH EYE AS NEEDED." -CMA K did not document that the PRN artificial tears were administered. 2. Observation and interview on 7/23/25 at 4:42 p.m. of CMA K revealed: *CMA K was preparing medications for resident 39. *CMA K grabbed two medication cards out of the medication cart. He did not check the prescription label on the medication cards to ensure that the cards he grabbed were for resident 39. *Those medication cards were for resident 15 instead of resident 39. -One medication card contained levothyroxine sodium (a	F0759		

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F0759 SS = E	Continued from page 19 thyroid hormone replacement medication) 75mcg (micrograms). -The other medication card contained propranolol (a medication to slow down the heart rate) 10mg (milligram) tablets. *CMA K was not able to describe the "rights" of medication administration when asked. *When asked to verify if the medication cards he grabbed were correct or not, CMA K realized the medication cards he grabbed were not for resident 39. -He thanked the surveyors for pointing that out to him and stated that he "would have already popped those" open to administer to the wrong resident. -He stated that the resident's medication cards were usually in the same spot in the medication cart. -He guessed that the night shift staff might have rearranged the medication cards in the medication cart when they were replenishing their supply. 3. Interview on 7/24/25 at 8:20 a.m. with registered nurse (RN) G and licensed practical nurse (LPN) H revealed: *They expected all staff administering medications to compare the resident's medication administration record (MAR) with the medication prescription label to ensure the resident received the correct medication. *If there were discrepancies between the prescription label and the MAR, the pharmacy and resident's physician should have been contacted. 4. Interview on 7/24/25 at 9:06 a.m. with administrator A revealed she expected staff to contact the nurses on duty if there were discrepancies between the medication prescription label and the resident's MAR, and all staff administering medications were expected to perform the rights of medication administration to ensure residents were receiving the correct medications. 5. Interview on 7/24/25 at 2:08 p.m. with LPN I revealed she confirmed staff should have been comparing the prescription label on the resident's medication card or bottle with their physician's orders in the	F0759		

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F0759 SS = E	Continued from page 20 EMR. 6. The director of nursing was not able to participate in the survey. Interview questions related to nursing services were directed towards administrator A, who was a registered nurse. 7. Review of the provider's 7/27/23 General Medication Administration Policy & Procedure revealed: *"Policy: The facility will assure that medications are administered safely and accurately to Residents for whom they are prescribed." *Procedures: -"…C. Medications are administered in accordance with written orders of the attending physician…" -"…D. All current medications, dosage schedules, [self-administration]/bedside medications counts are recorded on the Resident's Medication Administration Record (MAR)." -"…F. All Residents are/will be identified prior to the administration every time a medication is given. Residents should be identified by use of the following: --Verifying Resident's identity with another Facility Employee familiar with the Resident; --Asking the Resident their Name and Birth Date" -"…H. The Resident's MAR is immediately documented after medications are administered to the resident in eMAR [electronic medication administration record]. At no time will any medications be pre-documented before medication administration has actually occurred." -"I. Medications supplied for one Resident will not be administered to any person other than for whom that medication was prescribed." -"K. Procedure for Medication Pass: --…2. During the Medication Pass – Nursing should always check the 6 'R's': ---a. Right Resident – before administering medications, identify each according to Facility Policy;	F0759		

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F0759 SS = E	Continued from page 21 ---b. Right Drug – verify in at least three ways, such as ----1. The drug's size, color and label. ----2. Verify each drug against the MAR before administering. ----3. If there is a discrepancy between the card, label and MAR, hold the medication until the Medication Pass is completed and verify with the Physician's Order Sheet; ---c. Right Dose – verify against MAR; ---d. Right Dosage Form – verify against MAR; ---e. Right Time – administer meds according to facility standard medication administration time or personalized medication administration schedules; ---f. Right Route – verify against MAR. --3. If the comparison is correct, the Medication is to be removed from the container and placed into the Medication Cup using appropriate technique. Nursing must document in the eMAR for the appropriate medication, with the appropriate date and time according to Facility Policy. --...7. If a PRN Medication is administered, nursing should document accordingly in the eMAR under the PRN tab, provide supplementary documentation as to why the med has been given, pain level, etc."	F0759		
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of thirteen sampled residents (39) observed during medication administration observation were free from significant medication errors when certified medication aide (CMA) K would have administered the wrong resident's medications without surveyor intervention.	F0760	Director of Nursing and Administrator will review and revise the policy and procedures on General Medication Administration. CMA K was provided education with General medication administration. Educated on the 6"R"s of medication pass completed 7-25-25 by DON All other staff that pass medication were educated on updated policies and procedures for general medication administration completed 8-11-25 by DON Director of Nursing or Administrator or Designee will audit medication passes daily for two weeks, then weekly for two more weeks, then monthly for two more months bringing to QAPI for review.	9-1-2025

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F0760 SS = D	Continued from page 22 Findings include: 1. Observation and interview on 7/23/25 at 4:42 p.m. of CMA K revealed: *CMA K was preparing medications for resident 39. *CMA K grabbed two medication cards out of the medication cart. He did not check the prescription label on the medication cards to ensure that the cards he grabbed were for resident 39. *Those medication cards were for resident 15 instead of resident 39. -One medication card contained levothyroxine sodium (a thyroid hormone replacement medication) 75mcg (micrograms). -The other medication card contained propranolol (a medication to slow the heart rate) 10mg (milligram) tablets. *CMA K was not able to describe the "rights" of medication administration when asked. *When asked to verify if the medication cards he grabbed were correct or not, CMA K realized the medication cards he grabbed were not for resident 39. -He thanked the surveyors for pointing that out to him and stated that he "would have already popped those" open to administer to the wrong resident. -He stated that the resident's medication cards were usually in the same spot in the medication cart. -He guessed that the night shift staff might have rearranged the medication cards in the medication cart when they were replenishing their supply. 2. The director of nursing was not able to participate in the survey. Interview questions related to nursing services were directed towards administrator A, who was a registered nurse. 3. Review of resident 39's electronic medical record (EMR) revealed the following medication orders related to thyroid hormone replacement and heart/cardiovascular medications:	F0760		

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F0760 SS = D	Continued from page 23 *"ELIQUIS TAB [tablet] 5MG GIVE 1 TAB BY MOUTH TWO TIMES DAILY." *"LEVOTHYROXINE SOD [sodium]-100MCG-TA GIVE 1 TAB BY MOUTH ONCE DAILY BEFORE BREAKFAST." *She was not prescribed any beta-blockers or other cardiovascular-related medications. *Had she received resident 15's propranolol, her heart rate and blood pressure may have decreased, which potentially increased her risk of falls and injury. *Had she received resident 15's levothyroxine, she would have received a total of 175mcg for that day as she had already received her prescribed levothyroxine dose that morning. 4. Review of the provider's 7/27/23 General Medication Administration Policy & Procedure revealed: *"...Procedure for Medication Pass: -2. During the Medication Pass – Nursing should always check the 6 'R's': --a. Right Resident – before administering medications, identify each according to Facility Policy; --b. Right Drug – verify in at least three ways, such as ---1. The drug's size, color and label. ---2. Verify each drug against the MAR before administering. ---3. If there is a discrepancy between the card, label and MAR, hold the medication until the Medication Pass is completed and verify with the Physician's Order Sheet; --c. Right Dose – verify against MAR; --d. Right Dosage Form – verify against MAR; --e. Right Time – administer meds according to facility standard medication administration time or personalized medication administration schedules; --f. Right Route – verify against MAR. -3. If the comparison is correct, the Medication is to	F0760		

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F0760 SS = D	Continued from page 24 be removed from the container and placed into the Medication Cup using appropriate technique. Nursing must document in the eMAR for the appropriate medication, with the appropriate date and time according to Facility Policy. -…7. If a PRN Medication is administered, nursing should document accordingly in the eMAR under the PRN tab, provide supplementary documentation as to why the med has been given, pain level, etc."	F0760		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure insulin pens had pharmacy labels on them that included the required identifying and instructional information for one of three sampled resident (24) who used insulin. Findings include: 1. Observation and interview on 7/24/2025 at 7:54	F0761	Director of Nursing will review and revise as necessary the label/store drugs and biologicals policy to ensure safeguards are in place. RN G and LPN H educated on any updates to the label/storage of drugs and biologicals policy. 7-25-25 by DON All other staff responsible for labeling of drugs/biologicals will be reeducated on the labeling and storing policy of medications to ensure safeguards are in place for resident safety of medications. 8-11-25 by DON Director of Nursing or designated staff will audit labeling of medications on all medications weekly for four weeks, then monthly for two months. DON will present audit findings to QAPI for review and considerations.	9-1-2025

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F0761 SS = D	Continued from page 25 a.m. with registered nurse (RN) G and licensed practical nurse (LPN) H during the morning medication pass revealed: *RN G removed a plastic tube from the medication cart with resident 24's name handwritten on it. *She removed a Novolog insulin pen from that plastic storage tube. The pen did not have a pharmacy prescription label on it with identifying information, such as the resident's name, the name and dose of the medication, and instructions for use. *She did now know why there was no pharmacy prescription label on that insulin pen. *LPN H then went to the medication storage room to grab the bag of resident 24's insulin pens that came from the pharmacy. There were at least three insulin pens in that bag. The plastic bag had a pharmacy prescription label on it, but there were no pharmacy labels on any of those individual insulin pens. *When asked how they knew that that particular insulin pen was resident 24's, both LPN H and RN G said because it was stored in the plastic tube with his name on it, they knew it was resident 24's insulin pen. -There was no indication on that insulin pen that it was specifically for resident 24. *The pharmacy usually placed the prescription labels on the insulin pens. *RN G stated they should have called the pharmacy to confirm the insulin pens were for resident 24 and to obtain prescription labels for all of his insulin pens. *RN G stated that the insulin pen was almost empty, which indicated that insulin pen had been used consistently without a pharmacy prescription label on it. 2. Review of resident 24's electronic medical record (EMR) revealed he was to receive scheduled doses of Novolog insulin injections three times daily and additional doses up to three times daily based on his blood sugar levels. 3. Interview on 7/24/2025 at 9:06 a.m. with administrator A revealed:	F0761	completed bycompleted	

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F0761 SS = D	Continued from page 26 *The pharmacy supplied the insulin pens for resident 24. The pens should have had the complete pharmacy prescription labels on them. *She expected the licensed nurses to have contacted the pharmacy if the prescription labels were missing and to follow the pharmacy's recommendations. 4. The director of nursing was not able to participate in the survey. Interview questions related to nursing services were directed towards administrator A, who was a registered nurse. 5. Review of the provider's 8/2023 Medication Ordering and Receiving from Pharmacy policy revealed: *"Policy: Medications are labeled in accordance with facility requirements and state and federal laws. Only the dispensing pharmacy/registered pharmacist can modify, change, or attach prescription labels." *Procedures -"A. Labels are permanently affixed to the outside of the prescription container. No medication is accepted with the label inserted into a vial. If a label does not fit directly onto the product, e.g., eye drops, the label may be affixed to an outside container or carton, but the resident's name, at least, must be maintained directly on the actual product container. -B. Each prescription medication label includes: --1. Resident's name. --2. Specific directions for use, including route of administration… --3. Medication name… --4. Strength of medication… --5. Prescriber's name. --6. Date dispensed. --7. Quantity of medication. --8. 'Beyond use' (or expiration) date of medication. --9. Name, address, and telephone number of dispensing pharmacy.	F0761		

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F0761 SS = D	Continued from page 27 --10. DEA number of dispensing pharmacy, if required. --11. Prescription number. --12. Accessory labels indicating storage requirements and special procedures. Example: 'Shake well' 'Take on an empty stomach, one hour before or 2 hours after meals.' --13. Container number and total number of containers (e.g., 1 of 3, 2 of 3, 3 of 3) when multiple containers are dispensed for one prescription/order. --14. Initials of [the] dispensing pharmacist. --15. Lot number of [the] medication dispensed… -...E. Improperly or inaccurately labeled medications are rejected and returned to the dispensing pharmacy. -...I. Medications dispensed by physicians must conform [to] the above labeling requirements."	F0761		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F0812	Dietary Manager will review and revise as necessary the policy on Food Preparation and Handling. Education provided on reviewed policy and procedures on food safety was provided to CMA K and cook T. completed 8-8-25 by Dietary Manager All staff that would be responsible for Food Preparation and Handling was educated on reviewed policy and procedures to ensure all food items served to the residents will be handled and stored appropriately. completed 8-11-25 by Dietary Manager Dietary Manager or designated staff will perform weekly audits for four weeks, then monthly for two months to ensure all food items served to residents will be safe and report to QAPI for review.	9-1-2025

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F0812 SS = E	Continued from page 28 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to follow food safety standards by not having monitored and documented food temperatures for 29 of 153 meals served from 6/1/25 through 7/21/25, and not having stored applesauce at or below 40 degrees Fahrenheit for three sampled residents (9, 20, and 39) who were given applesauce with their medications administered by certified medication aide (CMA) (K). Findings include: 1. Observation and interview on 7/22/25 at 9:10 a.m. with dietary manger D in the kitchen revealed: *A clipboard hanging on a cupboard labeled temperature log. *Dietary manager D stated kitchen staff were to check and document the food temperatures from each meal on that log. *He expected the cooks to document all food temperatures checked for each meal on the food temperature log. Review of the temperature logs from 6/1/25 through 7/22/25 revealed: *29 of the 153 meals served did not have the food temperatures recorded. *Dietary manager D agreed there were some missing temperatures on the food temperature log and there was no way to know if those foods were served at a safe temperature. Interview on 7/23/25 at 3:35 p.m. with cook T regarding food temperature documentation revealed: *He would sanitize the thermometer and would check the temperature of the food a few minutes before serving it.	F0812		

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F0812 SS = E	Continued from page 29 *He would document the temperatures on the temperature log. *He was aware of safe serving temperatures for food. *He stated if food was not at the proper temperature he would put it back in the oven and continue to heat it unit it was at the proper temperature. Interview on 7/24/25 at 1:20 p.m. with administrator A regarding food temperature monitoring and documentation revealed: *Staff should be checking and documenting the food temperatures for every meal. *She expected the dietary staff to follow the provider's policy regarding safe food temperatures. Review of the provider's undated Food Preparation and Handling policy revealed: *"All food items served to the residents are prepared in a central kitchen according to standardized recipes. Food items are prepared using methods and techniques that are designed to preserve maximum nutritive value, enhance flavor, and assure that what is served is free of injurious organisms and substances." *"20. Food temperatures are taken and recorded daily, by [the] cook, for each meal, and [the] temp log [is] kept on file in [the] kitchen." 2. Observation and interview on 7/23/25 at 4:21 p.m. of CMA K during medication administration pass revealed: *There was an opened cup of applesauce on the 200-hallway medication cart. The lid was labeled "7/22 10:17 am." *A second opened cup of applesauce was on the 100-hallway medication cart. The lid was labeled "6:40pm 7/22." *CMA K stated the nursing staff used the applesauce to help residents take their medication.	F0812		

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F0812 SS = E	Continued from page 30 *Whoever opened the applesauce cup was supposed to write the date and time it was opened on the lid. *Once the cup was opened, the lid was loosely placed back on the cup, and it was stored on top of the medication cart for continued use throughout the day. *They did not keep the applesauce on ice during medication pass or store the opened cups of applesauce in the refrigerator when it was not in use. *He was not aware that the applesauce was considered a potentially hazardous food (food that can grow germs and make people sick) once it was opened and should have been stored at or below 40 degrees Fahrenheit. *He continued to use the applesauce from the cup that had been opened on 7/22/25 at 6:40 p.m. throughout the observed medication pass. -He gave a spoonful of that applesauce to resident 20 at 4:30 p.m., which was 21 hours and 50 minutes after the cup was marked as opened. -He gave a spoonful of that applesauce to resident 9 at 4:34 p.m., which was 21 hours and 54 minutes after the cup was marked as opened. -He gave a spoonful of that applesauce to resident 39 at 4:42 p.m., which was 22 hours and 2 minutes after the cup was marked as opened. Interview on 7/23/25 at 5:28 p.m. with administrator A revealed that she was unaware that the applesauce should have been stored in the refrigerator after it had been opened. Review of the provider's 1/10/25 Storage Area Policy revealed there was no description of potentially hazardous food storage guidelines. Review of the FoodKeeper App from the U.S. Department of Health & Human Services FoodSafety.gov revealed that commercially prepared applesauce should not be kept at room temperature after opening and should be consumed within seven to ten days if refrigerated after opening.	F0812		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F0880		

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F0880 SS = E	Continued from page 31 §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 §483.71 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 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	F0880	Infection preventionist and designated staff will review and revise infection prevention and control, storage of supplies, hand hygiene, cleaning of mechanical lift, contact precautions, and glove use policies and procedures. Education provided to staff CNA M , CNA R, CMA K, LPN H, RN G, on infection control, storage of supplies, hand hygiene, cleaning of mechanical lift, contact precautions, and glove use policies and procedures. completed 7-25-25 by DON All other staff educated on infection control, hand hygiene, and glove use policies and procedures. completed 8-21-25 by Administrator Infection preventionist or designated staff will perform audits weekly for four weeks, then monthly for two more months and will report to QAPI for review.	9-1-2025

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F0880 SS = E	Continued from page 32 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, and policy review, the provider failed to follow infection prevention and control processes to ensure: *Resident personal care products were properly stored and labeled in one of two resident shared bathrooms (shared by sampled residents 3, 16, 19, and 27) reviewed. *Staff (certified nursing assistant (CNA) M, certified medication aide (CMA) K, licensed practical nurse (LPN) H, and registered nurse (RN) G) performed proper hand hygiene and glove use during resident care activities for sampled resident 31, and medication administration for sampled residents 3, 6, 9, 11, 13, 17, 19, 20, 24, 39, and 46. *Proper cleaning and sanitizing of one of one mechanical lifts (a mechanical lift used to assist from a seated to standing position) used to transfer resident 31 to the toilet by CNAs M and R. *Contact precautions protocols were followed by one of three staff observed (CMA K) during medication administration for sampled resident 13 related to a bacterial infection in her urine. *Resident care supplies such as nebulizer machines and	F0880		

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F0880 SS = E	Continued from page 33 tube feed pumps were stored in a manner that minimized risk of contamination from plumbing under the sink in one of one medical supply room. *Resident care supplies, such as catheters, cleaning products, and bath products, were discarded according to the manufacturer's expiration dates in one of one medical supply room, one of two soiled utility rooms, and one of one salon. *One of one salon and one of three shared resident shower rooms were maintained in a clean and sanitary manner. Findings include: 1. Observation on 7/22/25 at 11:10 a.m. in residents 3, 16, 19, and 27's shared bathroom revealed: *One container of antifungal powder. *One tube of barrier cream (a cream to keep moisture away from the skin). *One tube of Gold Bond brand healing lotion. *One bottle of Medline Remedy brand lotion. *Two packages of opened wet wipes. *There were no labels to indicate which resident the above products belonged to. *There were approximately five incontinence briefs sitting on top of a short plastic drawer on the floor next to the toilet, uncovered, which potentially increased the risk of contamination from urine and fecal matter splash from the toilet. Interview on 7/23/25 at 1:58 p.m. with certified nursing assistant (CNA) O revealed: *The residents' personal care products were not consistently labeled with which resident they belonged to. *They stored the residents' personal care products on each resident's assigned side of the sink. -Such as, the resident who resided on the left side of the room had the left side of the sink. *She did not know why the above products were stored in	F0880		

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F0880 SS = E	Continued from page 34 the residents' shared bathroom. *She said that the packages of wipes should only have been used for one resident. 2. Observation on 7/22/25 at 11:27 a.m. of CNAs M and R revealed: *CNA M brought a sit-to-stand mechanical lift (a mechanical lift used to assist from a seated to a standing position) from the shower room to resident 31's room. -She did not clean the lift beforehand. *CNA M did not perform hand hygiene (handwashing) before putting on a pair of gloves. *CNA M helped resident 31 get strapped into the sit-to-stand mechanical lift, took her gloves off, did not perform hand hygiene, and put on a new pair of gloves. *CNAs M and R then assisted the resident to the toilet. After they got the resident situated, CNA M removed her gloves and left the room without performing hand hygiene. *CNA R brought the sit-to-stand mechanical lift back to the shower room without cleaning and sanitizing the lift or sling straps at 11:54 a.m. Interview on 7/22/25 at 11:56 a.m. with CNA R about the above observation revealed: *She confirmed the sling straps for the sit-to-stand mechanical lift were used for multiple residents. *The purple-top wipes (the Sani-Cloth brand of sanitizing wipes with a purple lid) were available to clean the lifts and sling straps. *She said that the lifts should have been cleaned between each resident's use. Interview on 7/22/25 at 4:46 p.m. with registered nurse (RN) G and licensed practical nurse (LPN) I revealed: *RN G was not aware if the sling straps were laundered or not.	F0880		

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F0880 SS = E	Continued from page 35 *LPN I said that the staff were to wipe the sling straps with the sanitizing wipes after every use. Interview on 7/23/25 at 11:08 a.m. with CNA M revealed she: *Explained that the resident lift equipment should have been cleaned in the resident's room before it was taken back to the storage area. *Acknowledged that she missed several opportunities for hand hygiene during the above observations. Observation on 7/23/25 at 3:52 p.m. of CMA K during medication administration revealed: *He placed resident 11's bottle of eye drops into his pocket. *He did not perform hand hygiene before entering resident 11's room or before putting on a pair of gloves. *With those gloved hands, he removed resident 11's eye drops from his pocket and then touched the resident's face. *He touched the resident's eye and inner lower eyelid with the tip of the eye dropper. He then placed the lid back onto the dropper. *After he administered resident 11's medications, CMA K removed his gloves, walked back to the medication cart, and did not perform hand hygiene. *He placed resident 11's eye drop medication bottle back into the medication cart. Continued observation on 7/23/25 at 4:06 p.m. of CMA K revealed: *He did not perform hand hygiene before preparing resident 13's medications. *Resident 13 was on contact precautions (used to prevent spreading infections through touch), according to the sign on her door. *CMA K did not put on a gown, entered resident 13's room, did not perform hand hygiene, and put on a new pair of gloves.	F0880		

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F0880 SS = E	Continued from page 36 *He administered resident 13 her medications and instilled the eye drops in her eye. He touched the resident's eye and inner eyelid with the tip of the eye dropper bottle. He then placed the cap back on the eye dropper medication bottle. *After he administered resident 13 her medications, he removed his gloves, exited the room, and performed hand hygiene at the medication cart. Continued observation on 7/23/25 at 4:09 p.m. of CMA K revealed: *He did not perform hand hygiene when he entered resident 17's room or before putting on a pair of gloves. *He applied a topical medication to her right shoulder, left shoulder, and back. *He removed his gloves and did not perform hand hygiene before he left the room. Continued observation on 7/23/25 at 4:30 p.m. of CMA K revealed he performed hand hygiene before he administered resident 20's medications, but did not perform hand hygiene when he entered or exited the resident's room. Continued observation on 7/23/25 at 4:40 p.m. of CMA K revealed he performed hand hygiene at the medication cart before he prepared resident 9's medications, but he did not perform hand hygiene when he entered or exited the resident's room. Continued observation on 7/23/25 at 4:46 p.m. of CMA K revealed he performed hand hygiene at the medication cart before he prepared resident 39's medications, but he did not perform hand hygiene when he entered or exited the resident's room. Continued observation on 7/23/25 at 4:54 p.m. of CMA K revealed he did not perform hand hygiene when he entered resident 46's room. Continued observation on 7/23/25 at 4:57 p.m. of CMA K revealed:	F0880		

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F0880 SS = E	Continued from page 37 *He did not perform hand hygiene before preparing resident 6's medications. *CMA K wiped his forehead with the back of his bare hand and again, did not perform hand hygiene. *He did not perform hand hygiene upon entering the resident's room, then he filled the resident's water cup and administered resident 6's medications into the resident's mouth with a spoon. Interview on 7/23/25 at 5:28 with administrator A revealed that she expected staff to perform hand hygiene before starting to prepare a resident's medications, as staff entered the room, and as staff exited the room. She said it was not proper procedure to touch the resident's eye or eyelid with the tip of the eye dropper bottle. Observation on 7/24/25 at 7:38 a.m. of LPN H while preparing and administering insulin for resident 19 revealed: *LPN H did not perform hand hygiene before putting a pair of gloves on. She prepared insulin doses with two separate insulin pens. She then touched the medication cart's surface and lock with her gloved hands. She did not change those gloves or perform hand hygiene. *She entered resident 19's room. With those gloved hands, she administered one insulin in the resident's right upper arm and the second insulin in her left lower abdomen. LPN H did not remove those gloves or perform hand hygiene before exiting the resident's room. Observation on 7/24/25 at 7:46 a.m. of RN G while preparing and administering medications revealed: *At 7:47 a.m., RN G prepared two separate insulin medications at the medication cart. *At 7:52 a.m., RN G entered resident 3's room. She removed her gloves, did not perform hand hygiene, and then put new gloves on. *RN G administered one insulin into the right lower abdomen and one into the left lower abdomen. *RN G did not perform hand hygiene when leaving the	F0880		

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F0880 SS = E	Continued from page 38 resident's room. She carried the two insulin pens in her hand without the protective caps on them. Continued observation on 7/24/25 at 7:54 a.m. with RN G revealed: *She prepared resident 24's insulin dose in an injection pen and brought it to the dining room where the resident was located. *RN G touched the resident's wheelchair handles and brought him to the nurse's station. *She pulled two gloves out of her scrub top pocket. She did not perform hand hygiene before putting those gloves on. *With her gloved hands, she then reached into her scrub top pocket to remove an alcohol wipe. She opened the package and cleansed the resident's skin to prepare for the injection. *With those same gloved hands, she administered the insulin to resident 24 and placed the protective cap back on the insulin pen. RN G then placed the insulin pen in her scrub pants pocket. She removed those gloves and did not perform hand hygiene. *She performed hand hygiene after she exited the nurse's station. *At 8:20 a.m., she removed the insulin pen from her pants pocket and placed it into the medication cart. Interview on 7/24/25 at 8:20 a.m. with RN G revealed: *She was not aware that patient care items such as gloves, insulin pens, alcohol wipes, etc., were not supposed to be stored in personal clothing. *She confirmed that she knew the standards of when to perform hand hygiene. She said she "didn't even realize" that she was not performing hand hygiene at the appropriate times that were listed in the facility's policy. *She expected staff to refrain from touching the resident's eyes with the eye drop medication bottle when administering eye drops. Review of the provider's 3/2023 Hand Hygiene Policy and	F0880		

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F0880 SS = E	Continued from page 39 Procedure revealed: *"Policy: Handwashing/hand hygiene is generally considered the most important single procedure for preventing healthcare associated infections. Antiseptics control or kill microorganisms contaminating skin and other superficial tissues..." *"...When to use alcohol-based hand rub -Only when visible soil is absent -After contact with a resident's intact skin (as in taking a pulse or blood pressure) -After contact with inanimate objects (including medical equipment) -Before donning [putting on] gloves -After doffing [taking off] gloves -Before entering a resident's room -Before exiting a resident's room -Have residents use prior to eating or group activities." Review of the provider's 8/21/23 Glove Use policy revealed: *"Policy: Glove will be worn whenever there is potential to come into contact with bodily secretions, blood, body fluids, mucous membranes, non-intact skin, drawing blood, accessing ports, starting IVs." -"...B. Miscellaneous --...5. Perform hand hygiene after removing gloves. --...6. Disposable (single-use) gloves must be replaced as soon as practical when contaminated, torn, punctured, they exhibit signs of deterioration, or then their ability to function as a barrier is compromised. -...When to use gloves --...1. Gloves should be used ---...c. When cleaning up skills or slashes of blood or body fluids	F0880		

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F0880 SS = E	Continued from page 40 ---…d. When handling potentially contaminated items ---…e. When it is likely that hands will come in contact with blood, body fluids, or other potentially infectious material." Review of the provider's 3/2023 Mechanical Lift Policy and Procedure revealed: *"…All Slings are to be wiped down between resident uses, at the end of every shift, and as needed when soiled. The lifts are to be wiped down in the doorway of [the resident's] room before entering into the hallway. If not visibly soiled staff may wash with a germicidal disposable wipe. Allow sling to dry before contact with resident. If sling is visibly soiled sling will be washed by laundry department. *All lifts with [will] have a bag where the wipes are to be placed. *…All new nursing employees will be educated on use of stand aide and hoyer [Hoyer, a lift brand] lift at [the] start of employment and annually." 3. Observation on 7/22/25 at 4:14 p.m. of RN G assisting resident 13 to the bathroom revealed: *There was a sign on resident 13's door that indicated she was on contact precautions. *RN G performed hand hygiene and put on a gown and a pair of gloves. *She assisted resident 13 into the bathroom and with personal hygiene after resident 13 was done using the toilet. RN G removed the gloves and, without performing hand hygiene, put on a new pair of gloves. Interview on 7/22/25 at 4:46 p.m. with RN G revealed: *She confirmed she should have performed hand hygiene before putting on a clean pair of gloves. *She expected all staff to perform hand hygiene before putting on gloves and after removing gloves, and to clean the resident lift equipment after each use. Observation 7/23/25 at 10:44 a.m. of CNA R performing catheter cares for resident 13 revealed:	F0880		

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F0880 SS = E	Continued from page 41 *CNA R performed hand hygiene and put on a pair of gloves and a gown. She gathered a measuring container, a water-resistant pad, and sanitizing alcohol wipes. *She drained the urine out of the catheter bag into the measuring container. She wiped the catheter tubing with the sanitizing alcohol wipe and snapped the tube back into place on the bag. *The date "6/27/25" was handwritten on the catheter bag. *She measured the urine in the measuring container and drained the urine into the toilet. *Two plastic garbage bags were tied to the resident's bathroom towel bar. CNA R placed the measuring container into one of the plastic garbage bags without rinsing or sanitizing the measuring container. *The other plastic garbage bag contained a leg bag (a small catheter collection bag that could be secured to a person's lower leg) that had yellow colored liquid, potentially urine, sitting in the leg bag. There was no date on that bag. *CNA R stated she was not sure when those catheter bags or hanging garbage bags were last changed. *When asked if there were face shields or splash guards available for face protection, CNA R said she had never been offered one to use while providing a resident with catheter cares. Review of resident 13's current care plan revealed: *She was placed on contact precautions on 3/13/25 due to a bacterial infection in her urine. The bacteria were resistant to antibiotics. -Another urine culture completed on 5/27/25 indicated the bacterial infection was ongoing. *Interventions included: -"Clean hands when entering and leaving the room." -"Wear gloves and a gown for the following High-Contact Resident Care activities: Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting. Wound care: any skin opening requiring a dressing."	F0880		

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F0880 SS = E	Continued from page 42 Review of the provider's 12/31/2012 Contact Precautions and Isolation Procedure policy revealed: *"In addition to Standard Precautions, use Contact Precautions in the care of Residents known or suspected to have a serious illness easily transmitted by direct Resident contact or by indirect contact with items in the Resident's environment. *Illness requiring contact precautions may include, but are not limited to: gastrointestinal, respiratory, skin or wound infections. Applies to blood, all body fluids, secretions and excretions (except sweat) whether or not they contain visible blood; non-intact skin; and mucous membranes. *Contact precautions are required to protect against either direct or indirect transmission. *Direct Contact Transmission: Involves body surface to body surface contact and physical transfer of microorganisms between a susceptible person and the infected or colonized person. *Indirect Contact Transmission: Involves contact of a susceptible person with a contaminated object. *Personal Protective Equipment (PPE) to carry out standard precautions includes; gloves, gowns, masks and eye protection. *Contact Precautions Include: Standard Precautions plus, Mandatory Isolation/Cohorting, Gloves and Gown. *Standard Precautions Include: -Hand Hygiene: Wash hands for 20 seconds with soap and water, especially if visibly soiled. Clean hands with alcohol based hand rub if not visibly soiled. -Gloves: Apply clean, non-sterile gloves before touching or coming in contact with blood, body fluids, secretions and excretions. Remove gloved promptly after use and discard before touching non-contaminated items or environmental surfaces and before providing care to another Resident. Wash hands immediately after removing gloves. -Gowns: Apply non-sterile fluid resistant gown to protect clothing during activities that may generate splashes or sprays of blood, body fluids, secretions, and excretions. Remove gown promptly after use and	F0880		

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F0880 SS = E	Continued from page 43 discard before providing care to another Resident. -Mask, face shield, eye protection: Protect eyes, nose, mouth, and mucous membranes from exposure to sprays or splashes of blood, body fluids, secretions and excretions. Apply appropriate protection prior to performing such activities. -Resident Care Equipment: Avoid contamination of clothing and the transfer of microorganisms to other Residents, surfaces, and environments. Clean, disinfect or reprocess non-disposable equipment before reuse with another Resident. Discard single-use items properly…" 4. Observation on 7/23/25 at 10:21 a.m. in the shower room on the 200-hallway revealed: *The grout around the toilet had turned brown. *Two partially used bottles of perineal cleansing spray were not labeled with any resident's name or initials to identify which resident they belonged to. *The handle on the shower wall had a buildup of hard water deposits, potentially making it an uncleanable surface. *The shower spout was extensively rusted. *There were anti-slip tape strips on the floor. Several of the strips had been worn away, leaving a sticky residue. *The call light string in the shower did not reach near the floor. If a person fell, they would not have been able to reach the call light string. Observation on 7/23/25 at 10:30 a.m. in the soiled utility room on the 200-hallway revealed the following expired products: *One container of the Super Sani-Cloth brand sanitizing wipes with an expiration date of "05/2025." *One container of germicidal (kills germs) alcohol wipes with an expiration date of "2025-06-06." *One bag of antibacterial foaming skin cleaner with an expiration date of "2021-OC-01." Observation on 7/23/25 at 11:15 a.m. and 1:44 p.m. in	F0880		

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F0880 SS = E	Continued from page 44 the storage room near the dining room revealed: *There was one tube feeding pump and one nebulizer machine stored underneath the sink. *Five packages of Cure brand closed system catheters with an expiration date of 6/28/25. *16 packages of uncoated intermittent catheters, size 14Fr (French, a unit of size measurements), with an expiration date of 5/31/24. *Three packages of coude-tipped Foley catheters, size 16Fr, with an expiration date of 6/28/24. *Two packages of silicone coated Foley catheters, size 16Fr, with an expiration date of 11/28/20. *One box of skin prep protective wipes with an expiration date of 4/1/25. *One tube of Coloplast brand ostomy (a surgical opening connecting an organ to the abdomen) paste in the ostomy care supply drawer with an expiration date of 10/1/22, that tube was leaking inside the box it was in. -It was in the ostomy care supply drawer. *Three drawers of loose abdominal pads. *One package of "Rocket IPC 1000mL [milliliter] bottle [a type of bottle used to suction materials out of the body]" with an expiration date of 7/20/25. *One container of germicidal surface wipes with an expiration date of August 2023. Observation on 7/23/25 at 1:09 p.m. in the salon room revealed: *There were several used makeup compacts of eye shadow and blush in the drawers. None of the compacts were labeled with a resident's name or initials to identify who they belonged to. -There were loose makeup brushes in the drawers with no identifying labels of who they belonged to. *There were loose cotton-tipped swabs in another drawer. *There was a collection of hair in the sink drain.	F0880		

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F0880 SS = E	Continued from page 45 *The hair styling irons, hair curlers, and other heat styling tools were covered in hair and unidentifiable brown and black crusted substances. *The brown upholstered salon chair had several rips in the material. -Some rips were covered by black duct tape. -Other rips were not covered and had fabric strings coming out of the rips. -The metal arms of the chair were covered in rust, creating a non-cleanable surface. -The top of the chair, where a head would rest, was corroded and cracked and had a milky-white residue on it. *There were four gallons of "Cen-Sol II" bath oil with an expiration date of 12/7/12 in the bottom shelf of the cupboard. *There was another gallon jug of a bath additive skin softener that had no manufacturer's date or expiration date on the bottle. The bottle appeared to have been old as the label was wearing off. Interview on 7/23/25 at 1:40 p.m. with administrator A revealed: *She was aware of the condition of the salon chair. -One of the staff members had a plan to reupholster the chair but had not completed that yet. *The salon stylist was responsible for keeping the salon clean. *All the makeup products and hair styling tools belonged to the stylist. *If the makeup compacts and brushes were for resident use, she expected those products to have been used for only one resident. The makeup and brushes should not have been shared among more than one resident. *She said that the staff "don't usually go back to that area" because the salon was the stylist's area. Interview on 7/24/25 at 2:08 p.m. with CNA L revealed:	F0880		

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F0880 SS = E	Continued from page 46 *She was the designated staff person who assisted residents with bathing (bath aide). *There was one whirlpool bathtub in the building located on the 300-hallway. *She had not used the whirlpool bathtub for residents in at least six months because the tub leaked water. *She was not aware of the gallon jugs of bath oil located in the salon or that they had expired in 2012. Interview on 7/24/25 at 1:40 p.m. with LPN I revealed: *She was the provider's designated infection preventionist. *To her knowledge, the patient care equipment had always been stored under the sink since she had been working at that facility. *She confirmed there was a risk for contamination from leaking pipes and infection with resident care items stored under the sink. *Everyone in the building was responsible for keeping the storage room organized and discarding outdated products. *She was primarily responsible for monitoring the wound care supplies and discarding the expired items. *She had performed a Performance Improvement Project (PIP) on expectations for hand hygiene with facility staff. She expected staff to have been performing hand hygiene according to the facility's Hand Hygiene Policy. *She said that the tip of an eye drop applicator should not touch the resident's eye to prevent infection and contamination of the applicator bottle. *If staff were going into a contact isolation room and did not touch anything, she did not expect them to wear personal protective equipment (PPE). *She expected staff to wear a gown and gloves when completing any activity with the resident on contact precautions. A request was made on 7/23/25 at 5:50 p.m. for the provider's medical supply storage policy. The policy	F0880		

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F0880 SS = E	Continued from page 47 was not provided by the end of the survey on 7/24/25 at 4:09 p.m. The director of nursing was not able to participate in the survey. Interview questions related to nursing services were directed towards administrator A, who was a registered nurse.	F0880		

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(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
E0000	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 on 7/23/25. Aurora Brule Nursing Home Inc was found in compliance.	E0000		

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 reverse for further 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
Kathleen Styles	Administrator	8/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435132	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2025

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K0000	INITIAL COMMENTS A recertification survey was conducted on 7/23/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Aurora Brule Nursing Home Inc was found in compliance.	K0000		

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 reverse for further 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
Kathleen Styles	Administrator	8/15/2025

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
	10709	A. BUILDING: _____ B. WING _____	07/24/2025

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 7/22/25 through 7/24/25. Aurora Brule Nursing Home Inc was found in compliance.	S 000	The preparation of the following plan of correction for these deficiencies does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies was executed solely because it is required by provision of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:	
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 7/22/25 through 7/24/25. Aurora Brule Nursing Home Inc was found not in compliance with the following requirement: S199.	S 000		
S 199	44:73:04:04 Personnel The facility shall have a sufficient number of qualified personnel to provide effective and safe care. Healthcare personnel on duty must be awake at all times. Any supervisor must be eighteen years of age or older. The facility shall make available written job descriptions and personnel policies and procedures to personnel of all departments and services. The facility may not knowingly employ any person with a conviction for abusing another person. The facility shall establish and follow policies regarding healthcare personnel on contract. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review the provider failed to perform background checks on three of five sampled employees (H, S, and V) for compliance. Findings include:	S 199	The Business Manager will review and revise as necessary the policy and procedure of Employee background screening. Employees H,S, and V background screenings have been completed 8-4-2025 by business manager Business Manager and nurse manager educated on any revisions of policy and procedure of Employee background screening. Business Manager or designated employee will audit five employee files weekly and any new employees until all files are audited and findings will be brought to QAPI for review and consideration.	9/1/2025

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

Kathleen Styles | Administrator | 8/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 199	Continued From page 1 1. Employee record review for annual education, health screening, and background checks revealed: *Employee H was hired on 8/14/24. *There was no documentation a criminal background check was performed. *Employee S was hired on 10/1/24. *There was no documentation a criminal background check was performed. *Employee V was hired on 5/20/24. *There was no documentation a criminal background check was performed. *Interview and record review on 7/24/25 at 1:20 p.m. with administrator A revealed: *A new business office manager was hired 5/12/25. *Employee background checks were to be completed by the business office staff. *Administrator A had completed government exclusion background checks for employees H, S, and V dated 7/24/25. *She confirmed no other employee background checks were completed for employees H, S. and V. *She expected that employee background checks would be completed with the hiring process to ensure no employment of someone with a known history of a conviction for abusing another person. Review of the provider's revised 7/26/23 Employee Background screening policy revealed: *"[Provider] will not knowingly hire any individual who has a history of abusing other persons." *"This facility will conduct employment background screening checks, and will conduct criminal background checks on individuals	S 199		

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S 199	Continued From page 2 making application for employment." *"The administrator, department head or human resource director will conduct employee background screening which will include employment references, reference checks, and contacting licensing."	S 199		