DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435043	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET , SPEARFISH, South Dakota, 57783

(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 8/26/25 through 8/28/25. Spearfish Canyon Healthcare was found not in compliance with the following requirements: F584, F684, F689, F755, F812, and F880.	F0000		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident	F0584	Corrective Action: Resident (39) has been moved to another room as of August 28, 2025. The oxygen tanks have been relocated away from resident rooms. Resident (61) was provided with hand towels and washcloths. Identification of Others: All residents have the potential to be affected. Systematic Changes: All staff will be educated on the importance of resident hand hygiene and the availability of hand towels and washcloths in resident rooms on or before October 10, 2025. Advocate checklists will be updated to include the verbiage "ensure clean linen is in resident room, including hand towels and washcloths" on or before October 10, 2025.	October 10, 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
Charlotte Lindsey	Administrator	9/29/25

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F0584 SS = D	Continued from page 1 room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure a homelike environment for one of one sampled resident (39) due to the noise level in his room and that one of one sampled resident (61) had a hand towel available to dry himself after he had used his handwashing sink. Findings include: 1. Observation on 8/26/25 at 3:50 p.m. in resident 61's room revealed: Certified nurse aide (CNA) L assisted the resident in his bathroom after he had used the toilet. The resident used a grab bar beside the toilet to hold himself up while CNA L completed his peri-care, helped him with his clothing, and transferred him to his wheelchair with assistance from the resident's wife. There was a wall-mounted soap dispenser and paper towel dispenser near the resident's hand washing sink. It was just outside of his bathroom. CNA L had used that sink to wash and dry her hands after she exited the bathroom. She had not reminded or assisted resident 61 to wash his hands after he had exited the bathroom. There were no cloth towels on the towel rack that was mounted on the side of the countertop sink. There was a wadded-up washcloth that sat on top of the sink counter. Interview on 8/26/25 at 4:00 p.m. with resident 61 and his spouse revealed that the spouse had asked staff at different times for a clean washcloth and hand towel to be left on the towel rack for the resident to use, but that request was inconsistently accommodated. The resident confirmed he was able to independently use his handwashing sink. He was able to reach the paper towels and the soap dispenser. He preferred using cloth towels	F0584	Monitoring: Administrator/DON/designee will audit 4 resident rooms weekly for 1 month beginning on or before October 10, 2025, for hand towels and washcloths. After 1 month, the audits will continue 2 times per month for an additional 1 month. Then monthly until the QAPI committee determines the facility is demonstrating sustained compliance. Any issues identified during these audits will be corrected immediately and re-education will be provided at the time of the audit.	

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F0584 SS = D	Continued from page 2 rather than paper towels because he had used cloth towels at home. Observations on 8/27/25 at 8:30 a.m. in resident 61's room revealed that same used washcloth observed above remained on the sink's countertop. There were no cloth towels on the towel rack. At 1:50 p.m., the used washcloth had been removed and not replaced with a clean one. There were no cloth towels on the towel rack. Interview on 8/27/25 at 2:05 p.m. with CNA L revealed it was her responsibility to ensure resident 61 had a clean washcloth and hand towel on his towel rack to use. That had not occurred. Interview on 8/27/25 at 2:15 p.m. with director of nursing (DON) B revealed she had not known that resident 61's washcloths and hand towels were not consistently placed on the resident's towel rack for him to use as he preferred. His preference for using cloth towels to wash and dry his hands was not accommodated, but it should have been. Review of the provider's revised 6/10/25 Safe and Homelike Environment policy revealed "4. The facility will provide and maintain bed and bath linens that are clean and in good condition." Based on observation, interview, record review, and policy review, the facility failed to provide a homelike environment for one of one resident (39) due to a very loud pressure valve release noise from bulk oxygen tanks placed directly outside the wall of the resident's room. 2. Observation and interview with resident 39 in his room on 8/26/25 at 5:03 p.m. revealed: *He was the only occupant of the room. *He preferred to lie flat in his bed for much of the day due to chronic thoracic (middle section of the spine) pain. *He liked to listen to books on tape but would also watch television sometimes. *His bed was placed with the long side against the exterior wall of the room. *Approximately 11 large bulk oxygen tanks were grouped along the exterior wall of the room.	F0584		

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F0584 SS = D	Continued from page 3 *The tanks intermittently released pressure with a loud, aggressive hissing noise. -Each tank release noise lasted from 5 to 15 seconds. -The noise level interrupted the ability to converse or hear the television. *He wore headphones a lot to help block the noise. *He said the tanks' release noises interrupted his thoughts, activities, and disturbed his sleep. *He felt the tanks' release noise increased his anxiety and caused him to be startled frequently. *He stated he hated the noise and it was often louder than the one experienced at that time. *The noise had been present since he admitted to the facility last year. *He had not asked for a different room as he was grateful to be there. *He felt that the noise aggravated his anxiety and negatively affected his mental health. Observation on 8/27/25 from 9:30 a.m. to 9:45 a.m. outside of resident 39's room revealed: *There was no pattern to how often the tanks' release noise would occur. *The tanks' release noise occurred three times during approximately 15 minutes of observation. -The tanks' release noise level varied but could be heard and clearly identified in the hall 30 feet from resident's room with the room door closed. Review of the resident 39's electronic medical record (EMR) revealed: *Resident 39 was admitted on 10/29/24. *His admitting diagnoses included: *Generalized Anxiety Disorder (a chronic mental health condition characterized by excessive and persistent worry and anxiety that is difficult to control.)	F0584		

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F0584 SS = D	Continued from page 4 *Post-traumatic stress disorder (PTSD) (a mental health condition that's develops after experiencing or witnessing a traumatic event.) *Schizotypal disorder (a mental disorder characterized by thought disorder, paranoia, and social anxiety.) *Other schizoaffective disorder (a mental health condition marked by a mix of symptoms such as hallucinations and delusions, and mood disorder symptoms such as depression.) *He had a Basic Interview for Mental Status (BIMS) assessment score of 14, which indicated his cognition was intact. Review of resident 39's care plan revealed: *Resident 39 had screened positive for PTSD related to prior Vietnam war service. *Resident had triggers identified to a history of trauma that included excessive or prolonged television (TV) viewing, especially TV programming with action scenes. *Resident 39 experienced stressful or startled responses when others walked quickly or stomped behind him. Interview on 8/27/25 at 9:30 a.m. with Social Services Designee H regarding oxygen tank release noise levels in resident 39's room revealed: *She was not aware of the noise made by the bulk oxygen tanks releasing pressure. *She agreed that his PTSD and anxiety could be aggravated by that noise Interview on 8/28/25 at 8:40 a.m. with maintenance technician E revealed: *He was aware of the noises from the oxygen tanks releasing pressure. *He had not heard it from inside the resident 39's room. *He had not thought about if the noise was disturbing resident 39.	F0584		

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F0584 SS = D	Continued from page 5 *He thought residents would "probably get used to it." Interview on 8/28/25 at 8:48 a.m. with certified medication aide (CMA) F revealed: *She was not aware of the oxygen tanks' release noise in resident 39's room. *She stated she "was probably used to it." *She wouldn't want a resident to be constantly disturbed. Interview on 8/28/25 at 9:30 a.m. with registered nurse (RN) G revealed she was not aware of the tanks' release noises in resident 39's room. Interview on 8/28/25 at 9:50 a.m. with resident 39 revealed: *The social worker had come to visit him about the tank noise on 8/26/25. *He had told her that the noise was extremely startling, increased his stress and anxiety, and interrupted his activities and thoughts. *The tank released while he was talking, startling both resident and this surveyor. *He was grateful to have a roof over his head, but was very happy to be moving to a new room away from the noise. Interview on 8/28/25 at 12:20 p.m. with administrator A revealed: *The bulk oxygen tanks had been placed in that location prior to her return to the facility approximately two years ago. *Now aware of the noise, they intended to move the tanks away from resident rooms. *They would not have a resident reside in that room until the tanks were moved. Review of the providers safe and homelike environment policy revealed:	F0584		

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F0584 SS = D	Continued from page 6 *"In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible." *"Comfortable sound levels" was defined to mean "levels that do not interfere with resident's hearing, levels that enhance privacy when privacy is desired, and levels that encourage interaction when social participation is desired."	F0584		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to implement a process that ensured an accurate accounting of daily fluid intake for one of one sampled resident (4) on dialysis with a physician-ordered fluid restriction. Findings include: 1. Observation and interview on 8/27/25 at 8:15 a.m. with resident 4 revealed she was returning to her room from the dining room after breakfast. She was not available for an interview on 8/26/25 because she had been at dialysis for most of that day. She dialyzed on Tuesdays, Thursdays, and Saturdays. There were 13 bottled waters, a six-pack of soda, and a lidded cup with water inside it in her room. She had opened one of those bottled waters and drank from it during the interview. She stated her medical provider had told her she should be "trying to get rid of fluid," and avoid drinking a lot of fluids. Review of resident 4's electronic medical record (EMR) revealed a 4/17/22 physician's order for: "Fluid Restriction: 1500 cc [cubic centimeters] per day. Dietary: 320 cc 3 X [times]/day [per day]. Nursing: 120 cc 3x/day med [during medication] pass: 60 cc 3x/day. Interview on 8/27/25 at 3:20 p.m. with licensed practical nurse (LPN) R regarding resident fluid restrictions revealed	F0684	Corrective Action: An immediate audit was completed with all residents who are on fluid restrictions to ensure resident charts matched the orders. Resident 4 was educated on the number of drinks in her room. She verbalized she does not drink all the fluid in her room. DON provided education via huddle book to nursing staff to dispose of water bottles left over from dialysis sack lunches. Identification of Others: All residents have the potential to be affected. Systematic Changes: All staff were educated on who the residents were who had fluid restrictions and to let nursing know if there was an overage in the allotted fluid restriction at the monthly All Staff meeting September 4, 2025. DON provided an updated fluid restriction list to dietary and ensured nursing's list is present in huddle book. All staff will be educated further on the fluid restriction policy and bedside fluids on or before October 10, 2025.	October 10, 2025

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F0684 SS = D	Continued from page 7 that a "Huddle Book" was kept at the nurses' station. The huddle book was referred to by caregivers for resident-specific information, including which residents had fluid restrictions. Resident 4's name was on that fluid restriction list. Regarding the excessive number of fluids available to the resident in her room, LPN R stated a bottled water and a lunch were sent with the resident on her dialysis days. The resident often had not consumed the bottled water at dialysis and brought it back with her to her room. LPN R stated that those unused bottled waters should have been removed from the resident's room when the nurse had completed the resident's post-dialysis assessment. On 8/27/25 at 4:20 p.m., a copy of resident 4's fluid intake documentation for one week was requested from director of nursing (DON) B. Interview on 8/27/25 at 5:20 p.m. with DON B revealed that when a resident had a physician-ordered fluid restriction, that restriction was to be added to the resident's treatment administration record (TAR). Daily fluid intakes were to be documented, calculated, and monitored on that TAR to ensure compliance with the physician's order. Resident 4's fluid restriction order information had not been added to her TAR. Her daily fluid intake had not been calculated or monitored to determine if her fluid restriction was being followed as ordered. Review at that same time with DON B of the communication tool used between the provider and the dialysis unit revealed no noted concerns by either entity regarding the resident having potentially not followed her fluid restriction. DON B agreed that failing to follow the provider's processes for accounting for resident 4's fluid restrictions and not removing unnecessary fluids from the resident's room had placed that resident at risk for potential harm. Review of the provider's revised 5/2/25 Fluid Restriction policy revealed:1. The breakdown of a resident's fluid intake "will be recorded on the medication record or other format as per facility protocol.""4. Water will not be provided at the bedside unless calculated into the daily total fluid restriction or unless specifically ordered by the physician."	F0684	Monitoring: Administrator/DON/designee will audit 2 resident charts weekly for 1 month beginning on or before October 10, 2025, to review fluid restriction intakes and to ensure there are no fluids at bedside for all residents who are on fluid restrictions. After 1 month, the audits will continue 2 times per month for an additional 1 month. Then monthly until the QAPI committee determines the facility is demonstrating sustained compliance. Any issues identified during these audits will be corrected immediately and re-education will be provided at the time of the audit.	
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F0689		

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F0689 SS = D	Continued from page 8 §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, interview, record review, and policy review, the provider failed to ensure: The whiteboard communication board in one of one sampled residents' rooms (61) was updated to reflect the amount and type of caregiver assistance required for him to safely transfer from his toilet to his wheelchair. The safety of one of one sampled resident (61) who was not transferred by one of one certified nurse aide (CNA) L as directed in the resident's care plan and the provider's huddle book (a communication tool that informs caregivers of residents' care needs), which may have increased his risk for falling and/or injury. Findings include: 1 Observation on 8/26/25 at 3:50 p.m. in resident 61's room revealed a wall-mounted whiteboard with the following information written on it: "7/17[/25]: SPT [stand pivot transfer-a staff person assists the resident to a standing position, and the resident then turns their body to move to another surface] w/FWW [front wheeled walker] assist X1 [assisted by one staff person]." There was a folded mat propped against the wall at the foot of the resident's bed. Continued observation revealed CNA L was with resident 61 inside his bathroom, assisting him off the toilet. Without first putting a gait belt around the resident's waist (a waist strap gripped by the caregiver and used as support for safe mobility and transfer), she lifted up on the resident's pants and verbally cued him to use the wall-mounted grab bar next to the toilet to help pull himself up off the toilet to stand. The resident had repeatedly stated he was "too weak" to pull himself up to stand. He called out for his wife to help. After hearing the resident call for her help, the resident's spouse entered the bathroom with a gait belt and handed it to CNA L. CNA L then placed the gait belt around the resident's waist. The gait belt enabled CNA L to provide the support resident 61 needed to come to a standing position, pivot, and lower himself onto his wheelchair seat safely. Interview on 8/26/25 at 4:20 p.m. with CNA L regarding	F0689	Corrective Action: CNA L was provided education on transfer techniques, specifically using a gait belt on date of occurrence. The whiteboard in resident (61) room was updated to match the care plan. Whiteboard markers were removed out of all resident rooms. Identification of Others: All residents have the potential to be affected. Systematic Changes: All therapists were provided with education September 9, 2025, to update the whiteboard in resident rooms and to have timely communication with nursing staff regarding any changes. Monitoring: Administrator/DON/designee will audit 4 resident room whiteboards weekly for 1 month beginning on or before October 10, 2025. After 1 month, the audits will continue 2 times per month for an additional 1 month. Then monthly until the QAPI committee determines the facility is demonstrating sustained compliance. Any issues identified during these audits will be corrected immediately and re-education will be provided at the time of the audit. Administrator/DON/designee will continue audits on 4 resident transfers to ensure the use of a gait belt weekly for 1 month beginning on or before October 10, 2025. After 1 month, the audits will continue 2 times per month for an additional 1 month. Then monthly until the QAPI committee determines the facility is demonstrating sustained compliance. Any issues identified during these audits will be corrected immediately and re-education will be provided at the time of the audit.	October 10, 2025

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F0689 SS = D	Continued from page 9 the above transfer revealed she was expected to have used a gait belt whenever she had assisted a resident with a transfer. It was a standard safety and fall prevention intervention. She stated she referred to the information on the whiteboards in residents' rooms to know how to properly transfer the residents. She had not known who was responsible for updating the information on the residents' whiteboards. Interview on 8/26/25 at 4:30 p.m. with resident 61 and his spouse revealed that he had been awake early and had been busy throughout that day with therapy and outpatient appointments. His physical stamina was diminished. He had fallen since he was admitted to the facility. His bed was lowered at night, and the fall mat observed above was to be placed along the side of his bed at night, related to his risk for falling. Review of resident 61's electronic medical record (EMR) revealed his admission date was 4/17/25. His diagnoses included a right femur (upper leg/thigh) fracture and chronic obstructive pulmonary disease (a chronic breathing disorder). An 8/18/25 event note indicated: "CNA stated she was attempting to transfer resident [61] from his bed to his wheelchair for toileting, his right leg slid forward causing [the] resident to be lowered to the floor onto his buttocks." There was no injury to the resident as a result of that fall. An 8/19/25 Fall Assessment-Post Incident score was "18." That indicated the resident was at high risk for falling. Review of resident 61's current care plan initiated on 4/18/25 revealed a focus area of "Transfers/Bed Mobility/Ambulation." A revised 6/19/25 intervention for that focus area indicated resident 61 required "extensive assistance of 1 staff person with bed mobility, transfers and ambulation." That intervention was revised again on 7/21/25 by director of rehabilitation C and indicated "Assist X 2 [by two staff persons] stand pivot transfer [a staff member assists the resident to a standing position, and the resident then turns their body to move to another surface] with FWW [a front-wheeled walker] and [the use of a] gait belt." Interview on 8/27/25 at 9:30 a.m. with director of nursing (DON) B revealed the whiteboards in residents' rooms were to be maintained and updated by the therapy department. If the whiteboard was updated, those changes were documented on a Therapy to Care Plan-Communication Tool. Copies of that tool were distributed to the provider's Minimum Data Set (MDS)	F0689		

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F0689 SS = D	Continued from page 10 Coordinator, the DON, and the nurses' station. Nursing staff were to communicate those resident-specific changes to caregivers during shift changes. Copies of those tools were placed in a Huddle Book that contained resident-specific care information and was kept at the nurses' station for the caregivers to reference. Review of the above Huddle Book revealed a 7/17/25 Therapy to Care Plan-Communication Tool, signed by physical therapist Q, had indicated resident 61 required a "2 person stand pivot transfer with FWW and gait belt." Interview on 8/28/25 at 10:25 a.m. with physical therapy assistant (PTA) P regarding the 7/17/25 expectations for transferring resident 61, and the transfer information documented on his whiteboard revealed that the information on his whiteboard was outdated and not accurate. She confirmed resident 61 had required the assistance of two staff persons and the use of a gait belt when he was transferred. Physical therapist Q was not available to interview. Interview on 8/28/25 at 11:30 a.m. with director of rehabilitation C regarding resident 61 revealed that the process used to ensure caregivers were informed of and educated on changes in resident 61's transfer needs failed. Caregivers referred to the transfer information on a resident's whiteboard to know how they were expected to transfer that resident. That failure placed resident 61 at a higher risk for having been injured and/or falling when he was transferred. PT Q was should have updated resident 61's whiteboard at the same time she completed her 7/17/25 Therapy to Care Plan-Communication Tool that included the resident's updated transfer recommendations. Review of the provider's revised 5/15/25 Resident Handling/Transfers policy revealed "13. Staff members are expected to maintain compliance with safe handling/transfer practices." "14. Resident lifting and transferring will be performed according to the resident's individual plan of care."	F0689		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435043	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET , SPEARFISH, South Dakota, 57783

(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
F0755 SS = D	Continued from page 11 permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure two of two observed medication refrigerators had not contained expired vaccines that were available for administration to the residents. Findings include: 1. Observation on 8/28/25 at 1:45 p.m. of the medication room refrigerator in the Clarkson Hall revealed: *Ten influenza vaccines had expired on 6/30/25. *One pneumococcal 13-valent vaccine had expired on 4/2025. Interview immediately after having identified the above expired vaccines with registered nurse (RN) G revealed: *She had thought that the night nursing staff had been	F0755	Corrective Action: The expired vaccine medications have been removed from the two refrigerators. Identification of Others: All residents have the potential to be affected. Systematic Changes: Administrator/DON/designee will provide education to all nurses and med aides on medication expiration dates and whose responsibility it is to remove those medications once expired on or before October 10, 2025. Monitoring: Administrator/DON/designee will audit nurses' station refrigerators weekly for 1 month beginning on or before October 10, 2025, for expired medications. After 1 month, the audits will continue 2 times per month for an additional 1 month. Then monthly until the QAPI committee determines the facility is demonstrating sustained compliance. Any issues identified during these audits will be corrected immediately and re-education will be provided at the time of the audit.	October 10, 2025

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F0755 SS = D	Continued from page 12 checking for expired vaccines and medications. *She was unsure if there had been any other staff who were responsible for checking for expired vaccines and medications. 2. Observation on 8/28/25 at 2:15 p.m. of the medication room refrigerator in the green hall revealed: *Three influenza vaccines had expired on 6/30/25. *One pneumococcal 13-valent vaccine had expired on 4/2025. Interview immediately after having identified the above expired vaccines with licensed practical nurse (LPN) I revealed: *She thought the pharmacist checked for outdated medication once a month. *She was not aware that those expired vaccines had been in the refrigerator. *She was unsure if the night nursing staff had been checking for expired medication. Interview on 8/28/25 at 2:30 p.m. with director of nursing (DON) B regarding the expired vaccines in the two medication room refrigerators revealed: *She was not aware there was expired vaccines in the two refrigerators. *She stated the consultant pharmacist was to check for expired medications and vaccines once a month. *All staff that administered vaccines should have checked the expirations dates. *The expired vaccines should have been removed and sent back to the pharmacy for drug destruction. Review of the provider's June 2025 Hazardous Waste Pharmaceuticals revealed: *"Facility staff with approved access to pharmaceuticals will store, administer, and discard pharmaceuticals in accordance with relevant facility procedures."	F0755		

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F0755 SS = D	Continued from page 13 *"Expired medications sent for drug destruction."	F0755		
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. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to ensure follow standard food safety practices to ensure: *One of one low-temperature dishwasher's temperature was consistently monitored and documented to ensure it met the required minimum wash temperature for sanitation of items used to prepare and serve food to the residents. Findings included: 1. Observations on 8/26/25 at 10:32 a.m. and 10:37 a.m. in the kitchen revealed: *The logs for the dishwasher temperatures for August 2025 were hanging on the wall and included: -Columns to record "Temp (temperature) for "B"	F0812	Corrective Action: Maintenance assessed dishwasher water to ensure water was heating appropriately at time of surveyor acknowledgement. Maintenance stated that the water takes time to heat up because of facility boiler system. Dish machine must be processed three times to heat up to correct temperature of 120 degrees. Verbal education was given to dietary staff at time of observation of temperature variances. Ecolab was called and presented at the facility on September 2, 2025, to inspect dish machine health for optimal water and energy consumption. The dish machine is operating appropriately by Ecolab representative. Identification of Others: All residents have the potential to be affected. Systematic Changes: All dietary staff will be provided with written education on processing the dish machine 3 times before adding dishes to be washed on or before October 10, 2025. Verbiage will be added to temp log monitoring to state the proper procedure of running the dish machine 3 times before adding dishes to be washed and to notify supervisor, or maintenance, if water does not reach 120 degrees on or before October 10, 2025. All staff will be educated on importance of dishwater temps on or before October 10, 2025.	October 10, 2025

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F0812 SS = E	Continued from page 14 (Breakfast), "L" (Lunch), and "D" (Dinner), Sanitizer Concentration (PPM) (parts per million), and Initials. -Those temperature columns had documented temperatures that ranged from 110 to 126 degrees F (Fahrenheit) --Thirty-six of those documented temperatures were not at the minimum required temperature of 120 degrees F. -For July 2025: -The dishwasher temperatures documented in the columns titled "Temp (temperature) for "B" (Breakfast), "L" (Lunch), and "D" (Dinner). -ranged from 110 to 130 degrees F. --Five of those temperatures were not at the minimum required wash temperature of 120 degrees F. -There were had 41 out of 93 opportunities in July 2025 that did not have documented dishwasher temperatures. 2. Interview on 8/26/25 at 10:45 a.m. with dietary supervisor (DS) J revealed she: *Had been employed with the facility as the DS for only a short time. *Was unaware of the dishwasher's low wash temperature readings. *Stated she would call the service department that they lease the dishwasher from to schedule maintenance. -She was unsure of the last time the leased dishwasher had been serviced. 3. Interview on 8/27/25 at 1:55 p.m. with dietary aide K revealed she ran the dishwasher three times after breakfast before the water temperature reached 120 degrees F. 4. Further interview on 8/27/25 at 2:10 p.m. with DS J revealed she: *Had been employed with the facility as the DS since 6/25/25. *Called the service department that they lease the dishwasher from, and they informed her that they would	F0812	Monitoring: Administrator/dietary supervisor/designee will audit dish machine water temps 4 times weekly for 1 month beginning on or before October 10, 2025. After 1 month, the audits will continue 2 times per month for an additional 1 month. Then monthly until the QAPI committee determines the facility is demonstrating sustained compliance. Any issues identified during these audits will be corrected immediately and re-education will be provided at the time of the audit.	

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F0812 SS = E	Continued from page 15 only service the dishwasher if they had problems with the chemicals, not the water temperature. *Had the maintenance technicians inspect the dishwasher that day, and they advised her that the kitchen staff would need to run the dishwasher multiple times to get the water temperature to 120 degrees F. *Agreed there were several unrecorded temperatures on the dishwasher temperature logs. *Had been training new staff, and had forgotten to check the dishwasher logs. 5. Interview on 8/28/25 at 8:32 a.m. with maintenance technician E revealed he: *Informed the DS that the kitchen staff would need to run the dishwasher multiple times to reach the required temperature of 120 degrees F. *Was unaware of the dishwasher's low wash temperature readings before the DS informed him. *Had not been asked to perform maintenance on the dishwasher in the past few months. 6. Interview on 8/28/25 at 8:40 a.m. with administrator A revealed: *She was unaware of the dishwasher's low wash temperature readings. *She expected the kitchen staff to have notified the DS of the dishwasher's low wash temperature readings. *There had been no gastrointestinal outbreak in the facility. 8. Review of the provider's 6/15/25 Dishwasher Temperature policy revealed: "It is the policy of this facility to ensure dishes and utensils are cleaned under sanitary conditions through adequate dishwasher temperatures." "4. For low temperature dishwashers (chemical sanitization): a. The wash temperature shall be 120 degrees F.	F0812		

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F0812 SS = E	Continued from page 16 b. The sanitizing solution shall be 50ppm (parts per million) hypochlorite (chlorine) on dish surface in final rinse."	F0812		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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	F0880	Corrective Action: Verbal education was provided to Med Aide (M) on cleaning inhalers at time of occurrence. Verbal education was provided to CNA (N) on hand hygiene during a transition in cleaning urine on the floor and handling a catheter urine bag valve at time of occurrence. Identification of Others: All residents have the potential to be affected. Systematic Changes: All Med Aides and nurses will be provided with education on cleansing inhalers on or before October 10, 2025. All staff will be trained on the importance of hand hygiene and glove use on or before October 10, 2025.	October 10, 2025

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F0880 SS = D	Continued from page 17 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure infection prevention and control practices were followed by: One of one observed certified medication aide (CMA) (M) who did not clean one of one sampled resident's (76) inhaler after it was used for medication administration. One of one observed certified nurse aide (CNA) (N) who did not complete hand hygiene (handwashing) during a transition in cleaning urine from the floor and handling one of one sampled resident's (63) catheter urine collection bag valve. One of one observed CNA (L) who had not reminded or assisted one of one sampled resident (61) to perform hand hygiene after he had used the bathroom. Findings include:	F0880	Monitoring: Administrator/DON/designee will audit Med Aides dispensing inhalers to 2 residents weekly for 1 month beginning on or before October 10, 2025, for cleansing of the inhaler. After 1 month, the audits will continue 2 times per month for an additional 1 month. Then monthly until the QAPI committee determines the facility is demonstrating sustained compliance. Any issues identified during these audits will be corrected immediately and re-education will be provided at the time of the audit. Administrator/DON/designee will audit hand hygiene and glove use of 4 staff weekly for 1 month beginning on or before October 10, 2025. After 1 month, the audits will continue 2 times per month for an additional 1 month. Then monthly until the QAPI committee determines the facility is demonstrating sustained compliance. Any issues identified during these audits will be corrected immediately and re-education will be provided at the time of the audit.	

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F0880 SS = D	Continued from page 18 1. Observation and interview on 8/26/25 at 11:37 a.m. with CMA M after she had administered resident 76's medication through an inhaler revealed: Without first cleaning the mouthpiece of the inhaler, CMA M placed the uncleaned inhaler back into its box inside the medication cart. The box top was opened and stored with other residents' medications. She stated that she should have used an alcohol pad to clean the mouthpiece after it was used to mitigate the resident's risk of infection or cross-contamination, but she had not done that. 2. Observation and interview on 8/26/25 at 12:21 p.m. with CNA N in resident 63's room revealed: Resident 63 was seated in his recliner. There was a large amount of urine on the floor in front of and to the side of his recliner. After CNA N lifted the resident's pant leg, CNA N stated the valve of the resident's urinary catheter bag was not properly tightened and that caused the urine inside the catheter bag to leak out and onto the floor. CNA N performed hand hygiene, then put on a gown and a pair of gloves. He used cloth towels to absorb the urine from the floor. With those same gloved hands, CNA N adjusted the resident's urinary catheter bag valve and resumed cleaning the floor. CNA N stated he was not sure at what point in the above observation that he should have removed his gloves, performed hand hygiene, and put on a clean pair of gloves. He agreed that using unclean gloves while handling the catheter bag valve had increased resident 63's risk for infection. 3. Observation and interview on 8/26/25 at 3:50 p.m. with resident 61, after CNA L had assisted him to use the bathroom, revealed: CNA L exited the bathroom, removed and discarded her gown and gloves. Outside of the bathroom, there were wall-mounted paper towel and soap dispensers near the handwashing sink that she used to perform hand hygiene. She had not reminded or assisted the resident to perform hand hygiene after he had exited the bathroom.	F0880		

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F0880 SS = D	Continued from page 19 Resident 61 confirmed he was able to independently use the handwashing sink to wash and dry his hands. He had not always remembered to perform hand hygiene after he used the bathroom without staff reminding him. Interview on 8/27/25 at 2:05 p.m. with CNA L regarding the above resident observation revealed she had not reminded or assisted resident 61 to wash his hands after he had used the bathroom, but she should have. She agreed that resident hand washing after bathroom use was an important infection prevention intervention. Interview on 8/28/25 at 2:07 p.m. with Infection Preventionist O regarding the above observations revealed that she confirmed the above observed staff missed opportunities to mitigate the risk of infection. Review of the provider's revised 5/20/25 Administration of Metered-Dose Inhaler (MDI) policy revealed: "18. When all the ordered inhalations have been administered, remove the spacer (if used) from the MDI, and wash the spacer and mouthpiece according to the manufacturer's instructions." Review of the provider's revised 4/10/25 Hand Hygiene policy revealed: "2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table." That hand hygiene table included the following condition: "When, during resident care, moving from a contaminated body site to a clean body site." A Glove Use policy was requested from administrator A on 8/28/25 at 3:10 p.m. At 3:45 p.m. on 8/28/25, administrator A stated the facility had no Glove Use policy. A Resident Hand Hygiene policy was requested from administrator A on 8/26/25 at 12:05 p.m. At 2:50 p.m. on 8/28/25, administrator A stated the facility had no Resident Hand Hygiene policy.	F0880		

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	435043	A. BUILDING B. WING	08/26/2025

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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 8/26/25. Spearfish Canyon Healthcare 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
Charlotte Lindhorst, LNHA	Administrator	9/17/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435043	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 01 - MAIN BUILDING 0... B. WING	08/26/2025

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K0000	INITIAL COMMENTS A recertification survey was conducted on 8/26/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Spearfish Canyon Healthcare was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K211, K293, and K321 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000	Corrective Action: The exit discharge for the basement on the east side of the facility has been redirected to the interior hallway of the facility. An illuminated Exit sign will be hung above the interior door leading into the facility on or before October 10, 2025. A sign stating "Not an Exit" will be put on the door leading to the outside vestibule on or before October 10, 2025.	October 10, 2025
K0211 SS = D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to provide a continuously maintained exit discharge to the public way. Findings included:Observation on 8/26/25 at 3:00 p.m. revealed the exit discharge for the basement on the east side of the facility was a concrete pad outside the exit door. There was a large grass-covered yard between the concrete pad and the public way (a nearby alley). Observation on 8/26/25 at 3:20 p.m. revealed the exit discharge for the main level at the northeast exit was a concrete walkway and staircase that extended to within five feet of the public way (a nearby alley).Interview with the maintenance supervisor at the time of above observations confirmed the finding.The deficiencies affected two of the nine facility emergency exits and had the potential to affect 100% of	K0211	The exit discharge for the main level at the northeast exit will have the grass replaced with a hardened surface to extend to the public way (alley) on or before October 10, 2025. Identification of Others: All residents, staff, and visitors have the potential to be affected. Systematic Changes: Maintenance staff will ensure all exit discharges and pathways are maintained and free of obstructions on or before October 10, 2025. Monitoring: Monitoring: Administrator/designee will audit all exit discharges and pathways 1 time per week for 1 month on or before October 10, 2025. After 1 month, the audits will continue 2 times per month for 1 month. Then monthly until the QAPI committee determines the facility is demonstrating sustained compliance. Any issues identified during these audits will be corrected immediately and re-education will be provided at the time of the audit.	

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
Charlotte Rahling	Administrator	9/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435043	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET , SPEARFISH, South Dakota, 57783

(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
K0211 SS = D	Continued from page 1 those who may have needed to use those exits.	K0211	Corrective Action: Light bulbs in current Exit signs in the basement have been changed to allow for continuous illumination. New luminous Exit signs have been ordered to replace all zip tied plastic Exit signs. Identification of Others: All staff, visitors, and residents have the potential to be affected. Systematic Changes: Maintenance staff will ensure Exit signs are illuminated through weekly checks as stated in Tels on or before October 10, 2025. Monitoring: Administrator/designee will audit all Exit signs for illumination 1 time per week for 1 month on or before October 10, 2025. After 1 month, the audits will continue 2 times per month for 1 month. Then monthly until the QAPI committee determines the facility is demonstrating sustained compliance. Any issues identified during these audits will be corrected immediately and re-education will be provided at the time of the audit.	October 10, 2025
K0293 SS = D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to provide continuously illuminated exit and directional signage for staff working in the facility basement. Findings included:Observation on 8/26/25 at 12:20 p.m. revealed the exit and directional signage in the basement did not have continuous illumination. The signage was generally flat plastic signs hung by improvised methods (e.g., zip ties from overhead conduit).Interview with the maintenance supervisor at the time of the above observation confirmed the finding.The deficiency affected 100% of the facility employees who worked in the basement and may have needed to use the basement emergency exits.	K0293		
K0321 SS = E Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of	K0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435043	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET , SPEARFISH, South Dakota, 57783

(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
K0321 SS = E Bldg. 01	Continued from page 2 the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to maintain smoke-resisting partitions for several hazardous areas (maintenance shop supply, boiler room, recliner storage, biohazard storage, wall treatment storage, soiled linen storages, and laundry). Findings included:Observation on 8/26/25 at 11:30 a.m. revealed the maintenance shop supply room was over 50 square feet and contained a variety of combustible/flammable supplies (e.g., 5 gallons of boiled linseed oil, 1 gallon of lacquer thinner, 1 gallon of denatured alcohol, various spray cans, etc.). The supply room door was held open with a wedge. The door was equipped with a closer. However, upon removal of the wedge the door would not close into the frame. Observation on 8/26/25 at 11:40 a.m. revealed the boiler room corridor door was held open by a fire blanket container. The door was equipped with a closer. However, upon removal of the container holding the door open, the door would was unable to close, even with significant manual assistance, due to interference from the floor.Observation on 8/26/25 at 12:00 p.m. revealed	K0321	Corrective Action: A fireproof locker was ordered to move combustible/flammable supplies. The wedge has been removed from the supply room door. The closure on the door has been adjusted to allow door to operate properly. The closure on the door between the boiler and electrical rooms has been adjusted and all hinges have been sprayed to allow the door to operate properly. The nonfunctional upper flush bolt on the door between the laundry/dryer room and corridor has been repaired. The fire blanket container has been removed from the boiler room corridor door. The floor will be repaired, and the closure will be adjusted on or before October 10, 2025, to allow for proper closing. All penetrations will be filled on or before October 10, 2025. Identification of Others: All staff, visitors, and residents have the potential to be affected. Systematic Changes: Maintenance staff will ensure all doors do not have wedges or other objects to hold them open each day. They will also ensure that all closures on doors are adjusted properly; as well as the frame, hinges, hardware, and non-combustible thresholds are secured, aligned, in working order with no visible signs of damage, and the door clearances are correct each month as stated in Tels. All staff will be provided with education on not using wedges or any other object to prop open doors on or before October 10, 2025.	October 10, 2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435043	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET , SPEARFISH, South Dakota, 57783

(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
K0321 SS = E Bldg. 01	Continued from page 3 several unsealed penetrations through the boiler room wall/ceiling as follows: one approximately 3-inch penetration through wall above corridor door and three approximately 1.5-inch & one approximately 3-inch penetrations in the ceiling of the adjoining water softener room.Observation on 8/26/25 at 12:00 p.m. revealed a partially open door between the boiler and electrical rooms. The door was equipped with a closer. However, the door would not close into the frame without significant manual assistance.Observation on 8/26/25 at 1:40 p.m. revealed a basement conference room and adjoining recliner storage/computer network equipment room, which was well over 50 square feet, containing a large quantity of combustible materials (e.g., carboard and dozens of recliners). The conference and adjoining rooms had several penetrations/wall compromises into the corridor and other adjacent spaces as follows: two approximately 1.5-inch, one approximately 4-inch, and two approximately 2-inch penetrations in the wall between the conference room and the corridor and separations in the concrete block wall behind the computer network equipment.Observation on 8/26/25 at 1:50 p.m. revealed a basement biohazard waste (sharps) storage room with storage capacity exceeding 64 gallons which had one unsealed approximately 2-inch wall penetration.Observation on 8/26/25 at 2:00 p.m. revealed a basement storage room, which was well over 50 square feet, containing a large quantity of combustibles (primarily rolls of wall treatment). The storage room had two approximately 6-inch wall penetrations.Observation on 8/26/25 at 2:35 p.m. revealed a soiled linen room with storage capacity exceeding 64 gallons which had one unsealed approximately 6-inch wall penetration.Observation on 8/26/25 at 2:45 p.m. revealed an unsealed space around an approximately 2-inch conduit penetration in the main laundry.Observation on 8/26/25 at 2:50 p.m. revealed a nonfunctional upper flush bolt in the inactive door of a double smoke door assembly between the laundry dryer room and the corridor.Observation on 8/26/25 at 3:30 p.m. revealed a soiled linen storage room off the corridor of the 600 wing with capacity exceeding 64 gallons. The door was equipped with a closer. However, the door would not self-close.Interview with the maintenance supervisor at the time of the above observations confirmed the findings.The deficiency affected 100% of the facility employees who worked in the basement and 1 of 11 smoke compartments on the facility main floor (patient care areas).	K0321	Monitoring: Administrator/designee will audit 2 doors 1 time weekly for 1 month to ensure wedges are not holding doors open and doors are working properly on or before October 10, 2025. After 1 month, the audits will continue 2 times per month for 1 month. Then monthly until the QAPI committee determines the facility is demonstrating sustained compliance. Any issues identified during these audits will be corrected immediately and re-education will be provided at the time of the audit.	

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
	10686	A. BUILDING: _____ B. WING _____	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET SPEARFISH, SD 57783

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 8/26/25 through 8/28/25. Spearfish Canyon Healthcare was found in compliance.	S 000		
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 8/26/25 through 8/28/25. Spearfish Canyon Healthcare was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charlotte Lindberg, LNHA TITLE: Administrator (X6) DATE: 9/17/25