STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435097	A. BUILDING _____ B. WING _____	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST LAKE ANDES, SD 57356

(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
F 000	INITIAL COMMENTS An extended recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/27/24 through 8/29/24 and from 9/3/24 through 9/5/24. Lake Andes Senior Living was found not in compliance with the following requirements: F550, F578, F582, F583, F584, F656, F657, F658, F684, F727, F758, F812, F835, F842, F867, F880, and F944. On 8/27/24: *At 11:30 a.m., immediate jeopardy was identified related to the prevention and control of resident COVID-19 infections at F880. *At 1:25 p.m., notice of immediate jeopardy was provided verbally and in writing to executive director (ED) A, director of nursing (DON) B, and regional nurse consultant (RNC) S. An immediate jeopardy removal plan was requested at that time. The survey team exited the building at 2:00 p.m. *At 7:45 p.m. ED A provided their final plan for the removal of the immediate jeopardy through an email submission. *At 8:33 p.m. the provider's removal plan was reviewed and accepted by the survey team. On 8/28/24: *At 8:00 a.m. the survey team entered the facility to observe and review the provider's documentation related to their removal plan of the immediate jeopardy. Based on observations and documentation review the survey team could not remove the immediacy as the removal plan had not been fully implemented. *At 10:30 a.m. a meeting was held by the survey team with ED A, DON B, and RNC S regarding	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Clay Brouwer, LNHA
TITLE: Executive Director
(X6) DATE: 9/27/2024

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F 000	Continued From page 1 the removal plan had not been fully implemented and the immediacy had not been removed. The survey team exited the building at 10:45 a.m. On 8/29/24: *At 8:30 a.m. the survey team entered the facility to observe and review the provider's documentation related to their removal plan of the immediate jeopardy. *At 10:10 a.m. the survey team's observations and review of the provider's documentation for the removal of the immediate jeopardy determined the immediacy was removed. The resident census was 39. On 9/5/24: *At 9:08 a.m., immediate jeopardy was identified related to the quality of care regarding hypoglycemic (lower than standard blood sugar level range) and hyperglycemic (higher than standard blood sugar level range) risks for diabetic residents at F684. *At 11:55 a.m. notice of immediate jeopardy was provided verbally and in writing to ED A and DON B. An immediate jeopardy removal plan was requested at that time. *At 5:16 p.m. ED A provided their final plan for the removal of the immediate jeopardy. *At 5:45 p.m. the provider's removal plan was accepted by the survey team. *At 6:15 p.m. the survey team reviewed the provider's documentation for the removal of the immediate jeopardy and determined the immediacy was removed. The resident census was 39.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights	F 550	F550	10/3/2024

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F 550	Continued From page 2 CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her	F 550	F550 1. In continuing compliance with F 550, Resident Rights/Exercise of Rights, Lake Andes Senior Living corrected the deficiency by ensuring R19, R34, and all like residents have dignity covers on their catheter bags on 09/11/2024. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated by the Director of Nursing on 09/27/2024 or prior to the start of their next shift on ensuring residents with catheters have dignity covers always placed over the catheter bags. The Director of Nursing and/or designee will audit all residents with catheters for dignity covers 3 times per week for one week, weekly for 3 weeks, monthly for 2 months and then randomly to ensure continued compliance. 3. As part of Lake Andes Senior Living's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process.	

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F 550	Continued From page 3 rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure dignity was maintained for two of three sampled residents (19 and 34) who had urinary catheter drainage bags that were not covered. Findings include: 1. Observation on 8/27/24 at 11:51 a.m. with resident 34 revealed: *He was in his wheelchair in the dining room with his urinary catheter drainage bag hanging under the wheelchair. *The urinary catheter drainage bag was not covered and contained visible urine. Observation on 8/29/24 at 8:43 a.m. with resident 34 revealed: *He was in the living room near the television with his urinary catheter drainage bag hanging under his wheelchair. *The urinary catheter drainage bag was not covered and contained visible urine. 2. Observation on 9/3/24 at 2:55 p.m. with resident 19 revealed: *He was in bed with a urinary catheter drainage bag hanging from the bed bar on the left side of his bed. *The urinary catheter drainage bag was not covered and half-filled with visible urine. *The urinary catheter drainage bag was visible from the hallway. 3. Interview on 9/03/24 at 3:00 p.m. with director	F 550		

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F 550	Continued From page 4 of nursing (DON) B revealed: *She expected urinary catheter drainage bags to have been covered when under the resident's wheelchair or when hanging from the edge of the resident's bed. *Staff had been educated about covering urinary catheter bags. *Dignity covers were available for all catheters. 4. Review of the provider's revised 2023 Promoting/Maintaining Resident Dignity policy revealed: *"It is the practice of this facility to protect and promote the resident's rights and treat each resident with respect and dignity ..." *"All staff members are involved in promoting care to residents to promote and maintain resident dignity and respect resident rights." Review of the provider's October 19, 2022, Catheter Care Policy revealed the policy did not address covering the urinary catheter drainage bag.	F 550		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the	F 578	F 578 1. In continuing compliance with F 578, Request/Refuse/Dscntnue Trmnt; Formlte Adv Dir, Lake Andes Senior Living corrected the deficiency by initiating POA paperwork for R11 and all like residents by 10/03/2024. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated on ensuring that emergency contacts, who are not POAs or family members, only receive information and are not given power to make health care or financial decisions by the Director of Nursing on 09/27/2024 or prior to the start of their next shift. The Director of Nursing and/or	10/3/2024

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F 578	Continued From page 5 requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, and interview, the provider failed to ensure one of one sampled resident (11) had documentation of a power of attorney for healthcare that would have allowed information to be released to the resident's friend. Findings include: 1. Review of resident 11's electronic medical record (EMR) revealed: *He had a brief interview for mental status (BIMS)	F 578	F 578 designee will audit 24hr report for correct emergency contact/POA notification 3 times per week for 4 weeks, 2 times per week for 4 weeks, weekly for 4 weeks and then randomly to ensure continued compliance. 3. As part of Lake Andes Senior Living's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process.	

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F 578	Continued From page 6	F 578		

score of 7 which indicated he had severe cognitive impairment.
*He had a friend listed as a contact for care conferences and his emergency contact.
*On 9/13/23 resident 11's friend had given verbal consent for him to receive an Influenza and a Respiratory syncytial virus (RSV) vaccination.
*On 4/30/24 verbal education had been given to resident 11's friend regarding the increase in his Mirtazapine (an antidepressant) from 7.5 milligrams (mg) to 15 mg once daily at bedtime.
-Resident 11's friend had verbalized understanding and had been "ok" with the increase.
*On 5/14/24 at a care conference, resident 11's code status had been reviewed. Resident 11's friend was "on board" if hospice services had been required.

Interview on 9/3/24 at 3:24 p.m. with social services director (SSD) E regarding power of attorney for healthcare/advanced directives revealed:
*She would help residents with their advanced directive.
*She had been unsure if there had been any written release of information for resident 11's emergency contact.
*She agreed that his emergency contact had not been his POA and her agreement to care would not be necessary.

Interview on 9/3/24 at 3:48 p.m. with SSD E regarding notification of resident 11's emergency contact revealed she had produced a document that allowed his emergency contact notification of his care conferences only.

Interview on 9/3/24 at 3:58 p.m. with regional

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F 578	Continued From page 7 nurse consultant S and director of nursing B regarding releasing information to resident 11's emergency contact revealed: *They agreed they did not have the emergency contact listed as power of attorney for healthcare and that the emergency contact could not make medical treatment decisions for resident 11. *They had not been aware releasing his information without the proper documentation in place may have been a HIPAA (health insurance portability and accountability act). Resident 11 was ill and was not interviewed regarding his friend as his emergency contact. Review of the provider's 2014 advanced directives policy revealed advanced directives included: *"Advance Directives - such as a Durable Power of Attorney for Health Care document, Living Will, and POLST and other similar directives." *"Plans for care when a sudden, life-threatening condition is diagnosed - such as a stroke, heart attack, pneumonia, or cancer." *"Plans for care when a resident's health is gradually deteriorating - such as progression of Alzheimer's disease or other dementia; weight loss without an obvious medical cause; and worsening of congestive heart failure, kidney failure, or chronic lung disease." *"Considering a palliative or comfort care plan or enrolling in a hospice program."	F 578		
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing	F 582	F 582 1. In continuing compliance with F 582, Medicaid/Medicare Coverage/Liability Notice, Lake Andes Senior Living corrected the deficiency by updating NONMC/SNFABN issuance process related	10/3/2024

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F 582	Continued From page 8 facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or	F 582	F 582 to R12, R38, R39 and all like residents on 09/17/2024. The process for issuing notices will now be completed by the Business Office Manager. The Executive Director or MDSC will issue notices in Business Office Mangers absence. 2. To correct the deficiency and to ensure the problem does not recur the Executive Director, MDSC, and Business Office Manager on the NONMC/SNFABN requirements and issuing process by Accura Regional Nurse Consultant on 09/17/2024. The Executive Director and/or designee will audit NOMNC/SNFABN weekly for 12 weeks and then randomly to ensure continued compliance. 3. As part of Lake Andes Senior Living's ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	

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F 582	Continued From page 9 discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to ensure the proper Medicare notices were completed and provided timely for three of three sampled residents (12, 38, and 39) prior to their discharge from Medicare Part A skilled services. Findings include: 1. Review of the Entrance Conference Worksheet completed by the provider on 8/27/24 revealed six residents were listed who had been discharged from Medicare Part A skilled services: *Five of those residents remained in the facility following their discharge from Medicare Part A. *One of those residents (39) was identified on the worksheet above as being discharged to home following his discharge from Medicare Part A. 2. Review of resident 39's CMS (Centers for Medicare and Medicaid Services) SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review form completed by business office manager (BOM) U on 8/29/24 revealed: *Resident 39's Medicare Part A Skilled Services Episode start date was 3/18/24. *His last covered day on Medicare Part A Service was 4/16/24. *The form's first question: Was a SNF ABN	F 582		

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F 582	Continued From page 10 [Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage], Form CMS-10055 provided to the resident? was answered No with a handwritten explanation, "Unknown. Was not in my job position at the time." *The form's second question: Was a NOMNC [Notice of Medicare Non-Coverage], Form CMS-10123 provided to the resident? Was answered Yes and and a copy of the form that was signed by resident 39 was provided. A request for resident 39's SNF ABN form was made on 9/4/24 at 5:54 p.m. from regional nurse consultant S and was not received by the end of the survey on 9/5/24 at 6:30 p.m. Review of the NOMNC form signed by resident 39 on 4/7/24 revealed: *The provider's name was above the title of the form. -The provider's address was not listed as required. -The provider's phone number was not listed as required. *The Effective Date Coverage of Your Current [left blank] Will End was completed with the date "4-10-24". -The type of services ending was left blank and should have been identified as skilled nursing. -The date of 4/10/24 was six days earlier than 4/16/24, his last covered day on Medicare Part A Service. Review of resident 39's electronic medical record (EMR) revealed: *He was admitted on 3/18/24 with Medicare Part A covering his stay. *On 4/17/24, after his Medicare Part A stay ended, he remained in the facility until 5/24/24.	F 582		

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F 582	Continued From page 11 *He had skilled covered days remaining, continued to reside in the facility, and had not been discharged home on 4/16/24 as indicated on the Entrance Conference Worksheet. 3. Review of resident 12's CMS SNF Beneficiary Protection Notification Review form completed by BOM U on 8/29/24 revealed: *His Medicare Part A Skilled Services Episode start date was 4/8/24. *His last covered day on Medicare Part A Service was 5/9/24. *The form's first question Was a SNF ABN, Form CMS-10055 provided to the resident? was answered No with a written explanation, "Unknown. Was not in my job position at the time." *The form's second question Was a NOMNC, Form CMS-10123 provided to the resident? Was answered Yes and and a copy of the unsigned form with the provider's notes was provided. A request for resident 12's SNF ABN form was made on 9/4/24 at 5:54 p.m. from regional nurse consultant S and was not received by the end of the survey on 9/5/24 at 6:30 p.m. Review of the NOMNC form for resident 12 revealed: *The provider's name was above the title of the form, but the provider's address or phone number was not listed as required. *The Effective Date Coverage of Your Current [left blank] Will End was completed with the date "5-6-24". -The type of services ending was left blank and should have been identified as skilled nursing. -The date of 5/6/24 was three days earlier than 5/9/24, his last covered day on Medicare Part A	F 582		

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F 582	Continued From page 12	F 582		

Service.
*The form was not signed or dated to indicate when the notice was received.
-The form contained the following handwritten notes:
--"mailed 5/1/24 [with his daughter's first and last name]".
--"called 5/10/24, mailed again".
--"called, no response 5/22".

Review of resident 12's EMR revealed:
*He was admitted on 4/8/24 with Medicare Part A covering his stay.
*His 4/15/24 Minimum Data Set (MDS) assessment recorded his brief interview for mental status (BIMS) score was nine, which meant he was moderately cognitively impaired.
*On 5/10/24, after his Medicare Part A stay had ended, he remained in the facility.

4. Review of resident 38's CMS SNF Beneficiary Protection Notification Review form completed by BOM U on 8/29/24 revealed:
*Her Medicare Part A Skilled Services Episode start date was 7/17/24.
*Her last covered day on Medicare Part A Service was 7/31/24.
*The form's first question: Was a SNF ABN, Form CMS-10055 provided to the resident? was answered Yes and a copy of the form that was signed by resident 38 was provided.
*The form's second question: Was a NOMNC, Form CMS-10123 provided to the resident? Was answered Yes and a copy of the form that was signed by resident 38 was provided.

Review of the SNF ABN form for resident 38 revealed:
*The provider's name, address and phone

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F 582	Continued From page 13 number were not listed as required. *The resident had signed and dated the form on 7/30/24, which was a one-day notice, not the two-day notice required by 42 CFR [Code of Federal Regulations] 405.1200 (b)(1). Review of the NOMNC form for resident 38 revealed: *The provider's name was above the title of the form, but the provider's address and phone number were not listed as required. *The Effective Date Coverage of Your Current [left blank] Will End was completed with the date "7-31-24". -The type of services ending was left blank and should have been identified as skilled nursing. -The date of 7/31/24 was her last covered day on Medicare Part A Service. *The form was signed and dated by the resident on 7/30/24, which was a one-day notice, not the two-day notice required. Review of resident 38's EMR revealed: *She was admitted on 7/17/24 with Medicare Part A covering her stay. *On 7/31/24, after her Medicare Part A stay had ended, she remained in the facility. 5. Interview on 9/4/24 at 10:11 a.m. with executive director (ED) A, in-person, and business office consultant (BOC) V, by phone, revealed: *BOM U had started her position on 4/28/24 but was currently out of the facility on leave. *BOM U was responsible for issuing the Medicare notices since July 2024, after BOC V had provided training on the Medicare notices which included the required two-day notice for the Medicare notices.	F 582		

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F 582	Continued From page 14 *Both ED A and BOC V agreed the Medicare notices should have included the provider's name, address, and phone number above the title of the forms. *In reviewing resident 39's Medicare Part A stay and his NOMNC notice BOC V agreed: -He remained in the facility following his Medicare Part A's last covered day, 4/16/24. -He should have been given a SNF ABN notice. -The 4/10/24 date written on his NOMNC form was wrong and should have been 4/16/24. -She was not sure why resident 39's NOMNC form had the wrong date. *In reviewing resident 12's Medicare Part A stay and his NOMNC notice BOC V agreed: -He should have been given an SNF ABN notice. -The 5/6/24 date written on his NOMNC form was wrong and should have been 5/9/24. -She was not sure why resident 12's NOMNC form had the wrong date. *In reviewing resident 38's Medicare Part A stay and her Medicare notices BOC V agreed that her last covered day on Medicare Part A Service was 7/31/24. *Both ED A and BOC V agreed that resident 38 had not been given her Medicare notices at least two days before the end of her skilled services as required. On 9/4/24 at 11:36 a.m. a request for the provider's policy regarding the Medicare notices, including both the SNF ABN and NOMNC notices was made to ED A and he revealed that they had no policy regarding the required Medicare notices. 6. Review of the "Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) Form CMS-10055	F 582		

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F 582	Continued From page 15 (2018)" and "Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123" provided to ED A on 9/4/24 at 11:36 a.m. revealed: *"Completing the SNF ABN ... The SNF must include the SNF's name, address, and phone number, at a minimum." *"When to Deliver the NOMNC ...The NOMNC must be delivered at least two calendar days before Medicare-covered services end..." *"Heading" -"The name, address and telephone number of the provider that delivers the notice must appear above the title of the form." -"Fill in the type of services ending, {home health, skilled nursing, comprehensive outpatient rehabilitation services, or hospice} and the actual date the service will end."	F 582		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened	F 583	F 583 1. In continuing compliance with F 583, Personal Privacy/Confidentiality of Records, Lake Andes Senior Living corrected the deficiency by ordering and installing bathroom doors for residents 35, 36, 38, and 139 who reside in rooms 9, 10, 11, and 12. Additionally, all other residents were interviewed to see if they preferred bathroom curtains or a door for their bathrooms. Each resident's preference was documented in their care plan. Residents who wanted doors will have them installed by the maintenance director upon arrival. 2. To correct the deficiency and to ensure the deficiency does not recur all staff were educated by the executive director on 9/27/2024 on ensuring residents have their privacy maintained when using the bathroom by ensuring the curtain or door is	10/3/2024

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F 583	Continued From page 16 mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review the provider failed to ensure privacy had been maintained for four of four sampled residents (35, 36, 38, and 139) who had adjoining rooms with a shared bathroom. Findings include: 1. Observation and interview on 8/27/24 at 12:28 p.m. with resident 35 revealed: *Resident 35 resided in room 12 which shared a bathroom with room 10. *Both of those rooms' bathroom doors had been removed. *A shower curtain was hung in place of the door on resident 35's side of the room. *There was no curtain on the side of the bathroom shared with room 10. *Room 10 was being used to store resident equipment including a recliner, a bed, cardboard boxes, and linens. -Staff entered room 10 to access these items.	F 583	F 583 closed. Additionally, each new resident will have their choice of a curtain or door for their bathroom in their care plan. The director of nursing and/or designee will audit resident bathrooms for privacy weekly for 8 weeks, and then randomly to ensure continued compliance. 3. As part of Lake Andes Senior Livings' ongoing commitment to quality assurance, the director of nursing services and/or designee will report identified concerns through the community's QA process.	

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F 583	Continued From page 17 *Resident 35 stated that she could not close the door because there was no door to close. 2. Observation on 8/27/24 at 1:34 p.m. and throughout that day with resident 36 in room 11 revealed: *The bathroom doors of the shared bathroom between resident rooms 9 and 11 had been removed and a shower curtain had been hung in those doorways on both sides. *Room 9 was being used as a conference room for the surveyors. *Resident 36 opened the curtain while seated on the toilet in that shared bathroom and asked the surveyors who they were and if she knew them. *When staff entered room 11 the surveyors could hear their conversations with resident 36 even with both curtains drawn. 3. Observation and interview on 9/3/24 at 10:17 a.m. with resident 36 in room 11 revealed: *Resident 35 opened the bathroom curtains between rooms 9 and 11 and entered room 11 from room 9 during the surveyor's interview with resident 36. *Resident 36 stated, "I don't like an audience." *Resident 35 then stood in the bathroom, where the surveyor could see her in the bathroom mirror, and listened to the surveyor's interview with resident 36. *The interview with resident 36 was ended and conducted at a later time. 4. Observation and interview on 9/3/24 at 4:09 p.m. with resident 38 revealed. *Resident 38 was now in room 12 which shared a bathroom with room 10. -Room 10 was being used to store resident equipment including a recliner, a bed, cardboard	F 583		

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F 583	Continued From page 18 boxes, and linens. *There was a shower curtain hanging in the doorways on each side of the adjoining bathroom. -The curtain on room 10's side of the bathroom contained netting on the upper third of the curtain that allowed a direct line of sight into the bathroom and room 12. *Staff entered room 10 four times during the surveyor's interview with resident 38 which was conducted in room 12. -The surveyor had to stop the interview each time to allow for resident 38's privacy. 5. Observation and interview on 9/4/24 at 8:24 a.m. with resident 38 revealed: *The same curtain remained on the side between the bathroom and room 10. *Resident 38 stated she was uncomfortable when she was in the bathroom because "they come and go from room 10 and I never know when they are going to walk in there." *She stated, "I am afraid someone is going to walk in on me when I am in the bathroom." 6. Observation and interview on 9/4/24 at 8:29 a.m. with director of nursing B revealed she: *Confirmed that the curtain between room 10 and the bathroom did not provide privacy for the resident in room 12 who used that bathroom. *She stated that the curtain needed to be changed. 7. Interview on 9/4/24 at 10:40 a.m. with executive director A regarding the use of shower curtains as doors on shared bathrooms revealed he: *Agreed the curtains did not provide complete privacy. *Stated the shared bathrooms were only shared	F 583		

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F 583	Continued From page 19 female to female or male to male. *Confirmed that before the shower curtains, an accordion-style door was used that reached from the floor of the doorway to the top of the doorway. *Agreed that the curtain with the netting on top, did not provide adequate privacy as a person could see through the netting *Stated that bathroom doors were expensive. 8. Review of resident 36's electronic medical record revealed: *An 8/18/24 progress note (PN) that indicated, "Resident very upset and scared. Resident from the other room [resident 139] that shares the bathroom came into her room and climb into her bed and would leave. Staff went down and finally assisted the resident and got her to go back into her room." 9. Review of resident 139's electronic medical record revealed: *An 8/18/24 PN indicated, "Resident went from her bathroom that she shares into the other resident room and climb into the bed. Staff was informed and removed her back to her room. Other resident was frighten." *An 8/20/24 PN indicated "Room change due to resident's behavior disrupting neighbor. She will have own room and bathroom. Resident kept going into other room next door... Resident moved due to behaviors of her going into her neighbors room and disturbing neighbor when she was using the bathroom. Resident neighbor was really upset by this and had found her laying in her bed." 10. Interview on 9/4/24 at 2:03 p.m. with DON B regarding the incident on 8/18/24 with resident 36 revealed she:	F 583		

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F 583	Continued From page 20 *Confirmed that resident 139 had entered resident 36's room through the shared bathroom. -Resident 139 was moved to a private room. *Confirmed that the shared bathrooms were only between resident rooms 9 and 11 and rooms 10 and 12. *Did not know when they began using the shower curtain instead of a retractable door. -The retractable doors have not been replaced since they broke. *Stated that they would not put males and females on opposite sides of the bathroom. *Confirmed that they did not have a policy regarding the use of the shower curtain or the shared bathrooms. *Confirmed she was aware of the resident's concerns regarding privacy. 11. Review of the provider's revised 2023 Promoting/Maintaining Resident Dignity policy revealed: *"It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances residence quality of life..." *"Maintain resident privacy." Review of the provider's undated "A Resident Bill of Rights" handbook revealed: *"You have the right to privacy and confidentiality in the facility. This includes your accommodations..."	F 583		
F 584 SS=F	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,	F 584	F 584 1. In continuing compliance with F 584, Safe/Clean/Comfortable/Homelike Environment, Lake Andes Senior Living corrected the deficiency by ensuring a	10/3/2024

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F 584	Continued From page 21 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 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:	F 584	F 584 homelike environment is maintained for all 39 residents. Lake Andes Senior Living corrected the following to ensure a clean and safe environment: -heat register outside of room 15 painted. -storage room outside of room 30 cleared of all items. -cloth chair stain cleaned. -dining room air conditioning units and vents inspected, cleaned, replaced, and painted as needed. -stained ceiling tiles replaced with new tiles. -air conditioning units in rooms 1, 2, 6, 8, 9, 11, 12, dusted and cleaned. All other air conditioning units air return grates dusted and cleaned as needed. -air return vents in the dining room painted and replaced as needed. -weather stripping removed from outside of room 30. -door paneling and wood chips fixed on rooms 23, 25, and 29. All other doors were inspected and fixed as needed. -toilet plumbing and caulk replaced in room 29. All other toilets were inspected, and parts were replaced as needed. -holes in bathroom 29 were fixed and painted. All other bathrooms were inspected for holes and fixed as needed. -new threshold installed for room 29. All other rooms were inspected for missing thresholds. - door and door frames for resident rooms 20, 21, 22, 25, 26, 27, and 28 were painted. All other door and door frames painted as needed. -bathroom sink faucet in resident room 24	

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F 584	Continued From page 22 Based on observation, interview, and record review, the provider failed to ensure a clean and homelike environment was maintained for all 39 residents who resided at the facility. Findings include: 1. Observation on 8/27/24 at 12:10 p.m. revealed: *The heat register outside of resident room 15 was rusted and not cleanable. *The storage cove outside room 30 contained: -An oxygen concentrator. -An "locked out" Volaro lift. -A rolling desk chair. -A shelf contained: --Eight individual incontinent undergarments. --An open package of bathroom hygiene wipes. --An open package of incontinent undergarments. --A sheepskin blanket/bed pad. --A sign that indicated enhanced barrier precautions. Observation on 9/3/24 at 9:00 a.m. of the east hallway revealed there was a cloth chair that had a stain on the seat. Observation on 9/3/24 at 9:47 a.m. of the dining room revealed: *The west side Fujitsu air conditioning unit had 21 brown drip stains on it. *The east side Fujitsu air conditioning unit had four brown drip stains on it. *The vent next to that Fujitsu air conditioning unit had rust and a black substance on it. *There were 17 water-stained tiles on the ceiling of the dining room. Observations made on 9/4/24 throughout the day from 8:00 a.m. through 6:00 p.m. revealed the individual room air conditioners in rooms 1, 2, 6,	F 584	F 584 replaced. All other bathroom faucets inspected and replaced as needed. -hallway ceiling light outside of room 21 cleaned and free of debris. All ceiling lights inspected and cleaned as needed. -bathroom door outside of the director of nursing office painted. All other door inspected and painted as necessary. -bathroom outside of the director of nursing office had mirror reflectors replaced as necessary. -disposable menstrual products machine removed from the bathroom. -sink faucet and toilet plumbing cleaned and replaced as needed. -new paper towel dispenser installed in the bathroom. -metal ceiling tile frames near the south door and headed to the front doors were cleaned, repainted, and replaced as needed. All other ceiling tile frames were inspected and cleaned as needed. -ceiling tiles between the nurse's station and front door were replaced with new ceiling tiles. All other ceiling tiles were inspected and replaced as needed. -baseboard molding between the living room and hallway fixed and replaced as needed. All other baseboard molding was inspected and fixed as needed. 2. To correct the deficiency and to ensure the deficiency does not recur all staff were educated by the executive director on 9/27/2024 on maintaining a safe, clean, comfortable, and homelike environment. The executive director and/or designee will audit the facility for a clean and homelike	

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F 584	Continued From page 23 8, 9, 11, and 12 had accumulated dust on the air return grates. Observation on 9/4/24 at 4:30 p.m. of the dining room revealed the air return vent on the east side of the dining room was rusty and uncleanable. Observation on 9/4/24 at 4:48 p.m. revealed: *A piece of weather stripping from the bottom of the exterior door was propped against the wall outside room 30. *Resident rooms 23, 25, and 29's doors were missing several portions of the door paneling. -There was exposed wood with sharp edges on the outside hinge side of those doors. *The toilet plumbing in room 29 had a green patina and was an uncleanable surface. -A portion of the toilet caulking was missing. *The bathroom door in room 29 had been removed and at least 20 holes remained in the wall. -There was peeling paint on the bathroom door framing. *There was no threshold between the laminate flooring in room 29 and the carpet in the hallway. -An uncleanable gap remained in that flooring transition area. *Doors and door frames to resident rooms 20, 21, 22, 25, 26, 27, and 28, had peeling paint and were uncleanable surfaces. *The linen closet door next to resident room 26 had peeling paint and was an uncleanable surface. *The bathroom sink faucet in resident room 24 was green with a patina and was not a cleanable surface. *The hallway ceiling light outside room 21 contained unidentifiable debris. *The bathroom outside of the director of nursing office contained the following uncleanable	F 584	F 584 environment weekly for 8 weeks, and then randomly to ensure continued compliance. 3. As a part of Lake Andes Senior Livings' ongoing commitment to quality assurance, the executive director and/or designee will report identified concerns though the community's QA process.	

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F 584	Continued From page 24 surfaces: -The bathroom door was peeling. -The mirror had several areas of reflective surface missing. -The disposable menstrual products machine was rusted. -The sink faucet and toilet plumbing were white and green with water stain residue. -The paper towel dispenser was cracked in the front and there was an unidentified tan substance in the crack. *The metal ceiling tile frames starting near the south doors headed towards the front door were stained or rusted a dark orange color. *There were at least 15 ceiling tiles between the nurse's station and front door that were stained with a dark orange substance. *The baseboard molding between the living room and hallway was torn and the drywall was exposed. 2. On 9/5/24 at 6:15 p.m. the survey team met with executive director (ED) A and director of nursing (DON) B for an exit conference and reviewed the environmental observations. ED A and DON B provided no disagreement or comment. 3. Review of the provider's undated "A Resident Bill of Rights" handbook revealed, "You are entitled to a quality of life. A facility must provide care and an environment that contributes to your quality of life including: A safe, clean, comfortable and homelike environment."	F 584		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans	F 656	F 656 1. In continuing compliance with F 656, Develop/Implement Comprehensive Care Plan, Lake Andes Senior Living	10/3/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435097	A. BUILDING _____ B. WING _____	09/05/2024

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F 656	Continued From page 25 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656	F 656 corrected the deficiency by updating R139 care plan with fall and elopement interventions, updating R19 care plan for enhanced barrier precautions, and reviewing/updating all other resident care plans for current needs by MDSC by 10/03/2024. 2. To correct the deficiency and to ensure the problem does not recur the Director of Nursing, Assistant Director of Nursing, MDSC, Social Services Designee, and Certified Dietary Manager were educated on person centered care plan guideline by Accura's Regional Nurse Consultant on 09/17/2024. All licensed and non-licensed staff were educated by the Director of Nursing on 09/27/2024 or prior to the start of their next shift about their roles and responsibilities to ensure resident care plans accurately and effectively depict individual needs and choices. The Director of Nursing and/or designee will audit 3 resident care plans for accuracy weekly for 4 weeks, 2 resident care plans weekly for 8 weeks, and then randomly to ensure continued compliance. 3. As part of Lake Andes Senior Living's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process.	

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F 656	Continued From page 26 section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review the provider failed to ensure the care plans for two of two sampled residents (19 and 139) reflected their current needs: *Resident 139's care plan did not include fall and elopement interventions. *Resident 19's care plan did not include enhanced barrier precautions (EBP) (use of gown and gloves while providing contact care) due to his open wounds and his indwelling catheter. Findings include: 1. Observation on 8/27/24 at 8:52 a.m. of resident 139 while she was lying in her bed revealed: *Her bed had been in a lowered position. *A fall mat was on the floor next to the bed. Review of resident 139's electronic medical record (EMR) revealed: *She had been admitted on 8/15/24. *On 8/29/24 she had been identified as a fall risk. *On 8/29/24 she had been identified as an elopement risk. -An order had been obtained for a Wanderguard (a door alarming bracelet). Review of resident 139's current care plan revealed: *There had not been any indication for the use of the fall mat to have been used next to her bed. *There had not been any indication that she had been using a Wanderguard due to her elopement	F 656		

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F 656	Continued From page 27 risk. 2. Observation on 9/3/24 at 9:55 am of resident 19 in his room revealed: *He had a urinary catheter drainage bag hanging from the left side of his bed. *There was no sign to indicate EBP was to be used when providing care to resident 19. *There were gloves, but no gowns or eye protection were in the room or outside the door. Observation and interview on 9/3/24 at 10:32 a.m. with certified medication aide (CMA) I revealed she: *Was taking resident 19's vitals. *Was not wearing a gown or gloves. *Stated that she provided medication to resident 19, took his vitals, and applied a cream to his legs. *Confirmed that resident 19 was "off all precautions as of today." *Stated, "I only wear gloves when applying a cream, but I don't need a gown." Observation and interview on 9/3/24 at 11:26 a.m. with certified nursing assistant (CNA) M and CNA N revealed. *They transferred resident 19 with a mechanical stand aid. *CNA M and CNA N were not wearing gowns or gloves. *CNA N stated they did not need to wear a gown when providing care to resident 19. Review of resident 19's electronic medical record (EMR) revealed: *He was admitted on 7/25/24. *Admission documentation indicated five open wounds being treated.	F 656		

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F 656	Continued From page 28 *On admission there was a physician's order for an indwelling urinary catheter. *There had not been any indication in resident 19's current care plan that EBP was required or when it was required. Observation and interview on 9/3/24 at 3:28 p.m. with director of nursing B revealed: *She confirmed that the sign for EBP was not inside the door above the light switch in resident 19's room where she had expected it to be. *She confirmed there were no gowns or eye protection present in resident 19's room or outside the door. *It was her expectation that gowns, gloves, and eye protection be worn when providing care for residents with wounds and indwelling urinary catheters. On 9/5/24 at 6:15 p.m. the survey team met with executive director (ED) A and DON B for an exit conference and reviewed the "area of the citation proposed". ED A and DON B provided no disagreement or comment. Review of the provider's October 2017 Person Centered Care Plan policy revealed: *It did not include the provider's letterhead or facility name. *"COMPREHENSIVE PERSON-CENTERED CARE PLANS: 1. Developed within 7 days after completion of the comprehensive MDS [Minimum Data Set] Assessment. 2. Contains measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs ..." *" The overall person-centered care plan should be oriented towards: ... managing risk factors."	F 656		

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F 657	Continued From page 29	F 657		
F 657 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. (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 ensure care plans were revised to reflect the current care needs of two of two sampled residents (22 and 38) related to: *Resident 22 who had a central venous catheter (CVC) he used for dialysis treatments.	F 657	F 657 1. In continuing compliance with F 657, Care Plan Timing and Revision, Lake Andes Senior Living corrected the deficiency by updating R22 care plan with correct Dialysis information, updating R38 care plan for correct Diabetes Management information, and reviewing/updating all other resident care plans for current needs by MDSC by 10/03/2024. 2. To correct the deficiency and to ensure the problem does not recur the Director of Nursing, Assistant Director of Nursing, MDSC, Social Services Designee, and Certified Dietary Manager were educated on person centered care plan guideline by Accura's Regional Nurse Consultant on 09/17/2024. All licensed and non-licensed staff were educated by the Director of Nursing on 09/27/2024 or prior to the start of their next shift about their roles and responsibilities to ensure resident care plans accurately and effectively depict individual needs and choices. The Director of Nursing and/or designee will audit 3 resident care plans for accuracy weekly for 4 weeks, 2 resident care plans weekly for 8 weeks, and then randomly to ensure continued compliance. 3. As part of Lake Andes Senior Living's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process.	10/3/2024

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F 657	Continued From page 30 *Resident 38 who checked her blood sugars and self-administered insulin. Findings include: 1. Observation on 8/29/24 at 12:46 p.m. of resident 22 while seated in his wheelchair revealed he had a central venous catheter (CVC) he used for dialysis treatments. Review of resident 22's care plan revealed: *"I have End Stage Renal disease and require dialysis." *"I go to dialysis on Monday, Wednesday & Friday @ 1000, make sure I have had my meal and medications before I go, I take a sack lunch to dialysis." *"Monitor Bruit and thrill, redness or swelling at site every shift. Nursing." *"Notify my MD of any shunt problems: no bruit, bleeding, port problems, symptoms of infection, abnormal labs, persistent symptoms of fluid retention (peripheral edema, weight gain, neck vein distention, orthopnea, elevated B/P, tachycardia or tachypnea)." Interview on 9/5/24 10:30 a.m. with Minimum Data Set (MDS) coordinator D regarding resident 22's care plan revealed: *She had not revised his care plan to remove the checking for a bruit and thrill of his fistula. *She agreed that resident 22 had CVC to receive his dialysis treatment and would not have required the checking for a bruit and thrill of his fistula. 2. Interview on 8/29/24 at 10:49 a.m. with resident 38 revealed: *She stated that she resided there because of complications with her diabetes. *She tested her blood glucose (sugar) levels four	F 657		

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F 657	Continued From page 31 times a day, and gave herself injections of insulin. *She stated her "blood sugars are all over the place." -She clarified that she had some blood glucose levels that were low and some blood glucose levels that were high when she checked them. *It was her goal to return to a community living environment. Review of resident 38's electronic medical record (EMR) revealed: *She was admitted on 7/11/24. *She had a Brief Interview for Mental Status (BIMS) score of 15 which indicated she was cognitively intact. *Her diagnosis included type 1 diabetes mellitus, anxiety disorder, celiac disease, mild intellectual disabilities, oppositional defiant disorder, and adverse effect of insulin and oral hypoglycemics [antidiabetic] drugs, subsequent encounter. *A 7/11/24 physician order for blood glucose monitoring before meals and at bedtime. *A 7/11/24 physician order for Novolog Injection Solution 100 unit/ML [milliliter] per sliding scale. *A 7/15/24 medication self-administration safety screen that had been initiated but not completed. *An 8/17/24 progress note stated, "Resident checked her blood sugar independently and gave herself her insulin appropriately." *An 8/27/24 progress note that stated, "resident did own testing and giving of insulin." *There was no physician order for medication self-administration. *The resident care plan did not indicate that resident 38 checked her blood sugars or self-administered her insulin. On 9/5/24 at 6:15 p.m. the survey team met with executive director (ED) A and director of nursing	F 657		

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F 657	Continued From page 32 (DON) B for an exit conference and reviewed the accuracy of care plans. ED A and DON B provided no disagreement or comment. Review of the provider's October 2017 Person Centered Care Plan policy revealed: *It did not include the provider's letterhead or facility name. *"Person centered care planning is an on-going process which actively encourages the resident and/or the resident's representative to be an active participant in the care planning process and addresses the development and implementation of individualized person care." *Reviewed and revised annually, quarterly, with significant change in status and as needed." *" The overall person-centered care plan should be oriented towards: ... managing risk factors."	F 657		
F 658 SS=D	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 record review, interview, observation and policy review, the provider failed to ensure: *One of one sampled resident (11) had been re-weighed after a nine-pound weight loss within 13 days. *One of one sampled resident (38) had been accurately assessed for self-administration of medication. Findings include:	F 658	F 658 1. In continuing compliance with F 658, Services Provided Meet Professional Standards, Lake Andes Senior Living corrected the deficiency by reviewing R11 and all other residents' weights for accuracy. Any residents with a gain or loss of 3 or more pounds were re-weighed with nurse supervision and if weight change verified to be accurate, physician was notified by 10/03/2024. R38 and all like residents were assessed for self-administration of medications by 10/03/2024. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated on the Weight and Height Management guideline by the Director of Nursing on 09/17/2024 and or prior to the start of their next shift. The Director of Nursing and MDSC were educated on ensuring the Self-Administration of	10/3/2024

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F 658	Continued From page 33 1. Review of resident 11's electronic medical record (EMR) revealed: *On 8/8/24 a weight of 165 pounds had been documented. *On 8/21/24 a weight of 156 pounds had been documented. *There was no documentation found that resident 11 had been reweighed due to that 5.45% weight loss in 13 days. Interview on 9/3/24 at 3:19 p.m. with certified nursing assistant (CNA) N regarding a change in a resident's weight revealed: *She would have informed her charge nurse of the weight change and then she would reweigh the resident. Interview on 9/4/24 at 3:26 p.m. with regional nurse consultant S, director of nursing B, and assistant director of nursing C regarding re-weighing residents revealed: *They had some issues with their scales. *All residents would have been weighed weekly on their bath days. *They agreed that there had been no documentation of resident 11 refusing to be weighed. *They agreed that resident 11 had not been reweighed once a 9-pound weight loss had been identified from his last recorded weight. Review of the provider's October 2021 Weight and Height Measurement policy reveled: *"If resident has gained or loss three or more pounds resident needs to be reweighed with nurse supervision. If nurse has verified weight change nurse must notify physician and nursing leadership."	F 658	F 658 Medications Guideline by Accura's Regional Nurse Consultant on 09/27/2024. The Director of Nursing and/or designee will audit resident weights weekly for 12 weeks and then randomly to ensure continued compliance. The Director of Nursing and/or designee will audit all residents who self-administer medications for assessment completion and physician order weekly for 4 weeks, monthly for two months and then randomly to ensure continued compliance. 3. As part of Lake Andes Senior Living's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process.	

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F 658	Continued From page 34 2. Interview on 8/29/24 at 10:49 a.m. with resident 38 revealed: *She stated that she resided there because of complications with her diabetes. *She tested her blood glucose levels four times a day and gave herself injections of insulin. *She stated her "blood sugars are all over the place." -She clarified that she had some blood glucose levels that were low and some blood glucose levels that were high when she checked them. *It was her goal to return to a community living environment. Review of resident 38's electronic medical record (EMR) revealed: *She was admitted on 7/11/24. *She had a Brief Interview for Mental Status (BIMS) score of 15 which indicated she was cognitively intact. *Her diagnosis included type 1 diabetes mellitus, anxiety disorder, celiac disease, mild intellectual disabilities, oppositional defiant disorder, and adverse effect of insulin and oral hypoglycemics [antidiabetic] drugs, subsequent encounter. *A 7/11/24 physician order for blood glucose monitoring before meals and at bedtime. *A 7/11/24 physician order for Novolog Injection Solution 100 unit/ML [milliliter] per sliding scale. *A 7/15/24 medication self-administration safety screen that had been initiated but not completed. *An 8/17/24 progress note stated, "Resident checked her blood sugar independently and gave herself her insulin appropriately." *An 8/27/24 progress note that stated, "resident did own testing and giving of insulin." *There was no physician order for medication self-administration.	F 658		

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F 658	Continued From page 35 On 9/5/24 at 6:15 p.m. the survey team met with executive director (ED) A and director of nursing (DON) B for an exit conference and reviewed the accuracy of assessment for self-administration of medication. ED A and DON B provided no disagreement or comment. Review of the providers revised 2023 Medication Self Administration Safety Screen and/or Self Administration of Nebulizer Evaluation policy revealed: *"Evaluation and approval for self administration of medication will be based on The Medication Self Administration Safety Screen and/or Self Administration of Nebulizer Evaluation." *"The Medication Self Administration Safety Screen will be completed prior to the resident initiating self administration of medications ..." *"A physician's order will be obtained indicating which medications the resident may self administer and with or without supervision."	F 658		
F 684 SS=K	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 interview and record review the provider failed to ensure care and services according to accepted standards of clinical	F 684	F 684 1. In continuing compliance with F 684, Quality of Care, Lake Andes Senior Living corrected the deficiency by implementing new Glycemic Management Protocol from medical director on 09/05/2024 for R3, R20, R22, R38 and all like residents. 2. To correct the deficiency and to ensure the problem does not recur all licensed nurses and medication aides were educated by the Director of Nursing on 09/05/2024 or prior to the start of their next shift on the signs/symptoms of hypo/hyperglycemia, the new Glycemic Management Protocol, and the importance of documenting all interventions and physician notifications related to glycemic management in the electronic health record. All licensed and	10/3/2024

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F 684	Continued From page 36 practice regarding blood sugar monitoring, interventions, and notification to the resident's physician for four of seven diabetic residents (3, 20, 22, and 38) that experienced blood sugar levels outside of the normal range. Interventions and timely follow-up to those blood sugars was not consistently identified in their records. Finding include: Notice: Notice of immediate jeopardy was given verbally and in writing on 9/5/24 at 11:55 a.m. to executive director (ED) A and director of nursing (DON) B of the immediate jeopardy related to F684 when the provider failed to ensure quality of care regarding hypoglycemic (lower than standard blood sugar level range) and hyperglycemic (higher than standard blood sugar level range) risks for diabetic residents. On 9/5/24 at 11:55 a.m. ED A and DON B were asked for an immediate removal plan. Plan: "On 9/5/2024, diabetic residents #3, #20, #22, and #38 who receive insulin will be managed with the glycemic management protocol given by the medical directors' guidelines. Nurses (RN and LPN) as well as medication aides have been educated on hypoglycemia and hyperglycemia protocols. Nurses are to contact each individual residents' provider in event of a low or high blood sugar reading. Nurses were educated to document interventions for low or high blood sugar within the resident's EMR. Nurses have been educated on the importance of following each individual resident's guidelines given by the resident's medical provider to properly manage diabetes."	F 684	F 684 non-licensed staff were educated by the Director of Nursing on 09/27/2024 or prior to the start of their next shift about their role and responsibilities in caring for and responding to those residents' experiencing hyperglycemia or hypoglycemia. The Director of Nursing and/or designee will audit resident blood sugars for glycemic management protocol compliance 3 times per week for 4 weeks, 2 times per week for 4 weeks, weekly for 4 weeks and then randomly to ensure continued compliance. 3. As part of Lake Andes Senior Living's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process.	

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	435097	A. BUILDING _____ B. WING _____	09/05/2024

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F 684	Continued From page 37 "On 9/5/2024, nursing staff education was completed by the DON and ADON to ensure those who are currently working are providing appropriate glycemic care and the steps to follow in the event of a low or high blood sugar reading. Glycemic management protocol instructs that the nurse on duty will contact the residents' provider during clinical hours or their hospital on-call provider after business hours. All nurses and medication aides not on shift will be educated prior to them coming on shift." "On 9/5/2024, all nurses and medications aides were educated on glycemic management protocols. All those not on shift will be educated prior to them coming on shift." "Any concerns will be reported to the charge nurse, director of nursing, infection preventionist, and/or administrator immediately and addressed in facility QAPI." On 9/5/24 at 5:16 p.m. ED A provided their final plan for the removal of the immediate jeopardy. On 9/5/24 at 5:45 p.m. the provider's removal plan was accepted by the survey team. On 9/5/24 at 6:15 p.m. the survey team reviewed the provider's documentation for the removal of the immediate jeopardy and determined the immediacy was removed. After the removal of the immediate jeopardy, the scope and severity of the citation level was "H". 1. Interview on 8/29/24 at 10:49 a.m. with resident 38 revealed: *She stated that she resided there because of complications with her diabetes. *She tested her blood glucose (sugar) levels four times a day and gave herself injections of insulin.	F 684		

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F 684	Continued From page 38 *She stated her "blood sugars are all over the place." -She clarified that she had some blood glucose levels that were low and some blood glucose levels that were high when she checked them. *It was her goal to return to a community living environment. Interview on 9/3/24 4:09 p.m. with resident 38 about her blood sugar levels on 9/2/24 revealed she: *Stated, "I wasn't feeling the best, I was really sleepy." *Could not recall if she ate her breakfast that day, however, she stated," I slept through lunch and when they finally woke me up my blood sugar was 46." *Stated it was close to supper time so they "brought me supper to my room and I ate it even though I didn't want it." *Did not know her blood sugar was low but recalled feeling "shaky." *Recalled, "They checked it [her blood sugar] about 3 hours later." *Stated, "They said they tried to wake me overnight but I didn't budge." -There was no overnight blood sugar or attempts to wake her documented. *Stated she got really bad migraines and had one around 11 o'clock that night after her blood sugar was low. Review of resident 38's EMR revealed: *She was admitted on 7/11/24. *She had a Brief Interview for Mental Status (BIMS) score of 15 which indicated she was cognitively intact. *Her diagnosis included type 1 diabetes mellitus, anxiety disorder, celiac disease, mild intellectual	F 684		

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F 684	Continued From page 39 disabilities, oppositional defiant disorder, and adverse effect of insulin and oral hypoglycemics [antidiabetic] drugs, subsequent encounter. *A 7/11/24 progress note indicated, "Events leading up to admission: resident's blood sugar dropped to an extremely low level, leading her to end up in the emergency room" *A physician order for "Novolog Injection Solution 100 UNIT/ML [milliliter] (Insulin Aspart) Inject as per sliding scale:" -"71 - 150 = 0;" -"151- 200 = 3;" -"201 - 250 = 5;" -"251 - 300 = 7;" -"301 - 350 = 9;" -"351 - 400 = 11." -"Greater than 400 Call MD [medical doctor]." -"subcutaneously three times a day." -There was no guidance or order for what to do when the glucose level was lower than 71. *A physician order for "Glucose Oral Tablet Chewable 4 GM [grams] (Dextrose (Diabetic Use)) Give 4 tablet by mouth as needed for Hypoglycemia." *On 7/16/24 at 6:58 a.m. a blood sugar of 57 mg/dL had been recorded. -Glucose Oral Tablets were not administered. *On 7/16/24 at 11:19 a.m. a recheck blood sugar of 414mg/dL had been recorded. -This was 4 hours and 21 minutes later. -There was no documentation the physician was notified. *On 8/14/24 at 10:00 a.m. a blood sugar of 51 mg/dL had been recorded. -Glucose Oral Tablets were not administered. -There was no documentation of interventions related to the low blood sugar level or that the physician was notified. *On 8/14/24 at 11:11 a.m. a recheck blood sugar	F 684		

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F 684	Continued From page 40 of 123 mg/dL had been recorded. -This was 1 hour and 11 minutes later. *On 8/18/24 at 8:05 p.m. a blood sugar of 410 mg/dL had been recorded. -There was no documentation the physician was notified. *On 8/20/24 at 4:47 p.m. a blood sugar of 407 mg/dL had been recorded. -There was no documentation the physician was notified. *On 8/30/24 at 11:29 a.m. a blood sugar of 49 mg/dL had been recorded. -Glucose Oral Tablets were not administered. *On 8/30/24 at 4:11 p.m. a recheck blood sugar of 415 mg/dL had been recorded. -This was 3 hours 42 minutes later. -There was no documentation the physician was notified. *On 9/2/24 at 5:10 p.m. a blood sugar of 46 mg/dL had been recorded by registered nurse (RN) Z. -Glucose Oral Tablets were not administered. *On 9/2/24 at 8:28 p.m. a recheck blood sugar of 216 mg/dL had been recorded. -This was 3 hours and 18 minutes later. On 9/4/24 at 6:21 p.m. a blood sugar of 38 mg/dL had been recorded. -Glucose Oral Tablets were not administered. -There was no documentation of interventions related to the low blood sugar level or that the physician was notified. *On 9/5/24 at 5:00 a.m. a blood sugar of 402 mg/dL had been recorded. -There was no documentation the physician was notified. 2. Review of resident 22's EMR revealed: *He was admitted on 5/25/23. *His Brief Interview for Mental Status (BIMS)	F 684		

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F 684	Continued From page 41 score was 15 which indicated he was cognitively intact. *His diagnosis included type 2 diabetes mellitus, end-stage renal disease, dependence on renal dialysis, and chronic vascular disease. *"Insulin aspart solution inject as per sliding scale:" -"If 0-70 milligrams (mg) per deciliter (dL) = follow hypoglycemia protocol;" -"71-150= 0." -"151-200= 2;" -"201-250= 4;" -"251-300= 6; -"301-350= 8;" -"351+= 10 call MD," -"Subcutaneously four times a day related to Diabetes Mellitus." *On 7/27/24 at 8:00 p.m. a blood sugar of 351 mg/dL had been recorded. *On 7/28/24 at 8:00 p.m. a blood sugar of 374 mg/dL had been recorded. *On 7/29/24 at 8:00 p.m. a blood sugar of 359 mg/dL had been recorded. *On 7/30/24 at 5:00 p.m. a blood sugar of 355 mg/dL had been recorded. *On 8/28/24 at 8:00 p.m. a blood sugar of 354 mg/dL had been recorded. *There was no documentation the physician was notified on 7/27/24, 7/28/24, 7/29/24, 7/30/24, nor 8/28/24. 3. Review of resident 3's electronic medical record (EMR) revealed: *She was admitted on 2/26/19. *Her Brief Interview for Mental Status (BIMS) score was 15 which indicated she was cognitively intact. *Her diagnosis included type 2 diabetes mellitus, hepatic failure, and chronic kidney disease.	F 684		

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F 684	Continued From page 42 *A physician order for "Humalog Injection Solution (Insulin Lispro) Inject as per sliding scale:" -"0 - 200 = 0;" -"201 - 250 = 3 units;" -"251 - 300 = 6 units;" -301+ = 9 units," -subcutaneously three times a day." *There were no parameters for when the physician was to have been notified. *On 5/21/24 at 9:07 p.m. a blood sugar of 414 mg/dL had been recorded. *On 5/23/24 at 4:34 p.m. a blood sugar of 439 mg/dL had been recorded. *There was no documentation the physician was notified on 5/21/24 nor 5/23/24. 4. Review of resident 20's EMR revealed: *She was admitted on 12/7/21. *Her Brief Interview for Mental Status (BIMS) score was 7 which indicated she was severely cognitively impaired. *Her diagnosis included type 2 diabetes mellitus, metabolic encephalopathy, cerebral infarction due to embolism and dementia. *A physician order for "Humalog Injection Solution (Insulin Lispro) Inject as per sliding scale:" -"151 - 200 = 2 units;" -"201 - 250 = 4 units;" ; 251 - 300 = 6 units;" -"301 - 350 = 8 units;" -"351 -400 = 10 Units;" -"401 - 500 = Call MD." -"subcutaneously with meals." *On 8/5/24 at 4:18 p.m. a blood sugar of 402 mg/dL had been recorded. -There was no documentation the physician was notified.	F 684		

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F 684	Continued From page 43 5. Interview on 9/4/24 at 10:06 a.m. with director of nursing (DON) B and regional nurse consultant (RNC) S revealed: *There was no written facility policy on "hypoglycemia management" or "diabetic care." *There were "[Providers Name] Standing Orders." -A copy of the standing orders was provided to the survey team. *A written request was provided for an interview with RN Z -RN Z was not available before the end of the survey. 6. Review of the "[Providers Name] Standing Orders" revealed: *There were 4 documents provided each with a different illegible physician's signature. *They had not been reviewed by the current DON. -They had been reviewed by the previous DON on 3/22/23. *"These standing orders may be used at the discretion of the licensed Nurse. They are to be used only for the length of time specified, and then be replaced by a routine physician's order if additional use is indicated." *"Glucose Gel 15, 40%Gel Tube, PRN [as needed] low Blood Sugar/per nurse assessment, Hypoglycemia." *"Glucagon, 1mg [milligram] IM [intramuscularly], PRN Low Blood sugar, Unresponsive, Hypoglycemia." *"May perform a one touch blood glucose on any resident to R/O [rule out] hypo or hyperglycemia." Interview on 9/5/24 at 8:25 a.m. with assistant director of nursing (ADON) C on the process for following up on low or high blood sugars	F 684		

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F 684	Continued From page 44 revealed: *She confirmed that the doctor was to be notified when a resident had a low or high blood sugar reading. -The process depended on if the event occurred on the day shift or the night shift and who the doctor was. --During the day, if it was urgent the physician assistant at the clinic should have been called by phone. --If it was a less serious issue a fax should have been sent. *Any time a physician was contacted "we would document it. When we contact the medical doctor we will put in a progress note." *She did not know the facility policy on low blood sugars. -She stated, "as a nurse, if it [a blood sugar reading] was in the 30's or 40's or something we would need to do something right away and contact the medical doctor. If in the 70's I would assess the resident and see if she was having breakfast soon." *When asked specifically about a blood sugar of 46 she stated, "I would get them some carbs like peanut butter, a sandwich, or juice and check it [the blood sugar] again in 15 minutes." *She confirmed that the medical doctor should have been notified." *She stated, "If it [a blood sugar of 47] was on the night shift we would wait til morning to contact the medical doctor." *She confirmed that the blood sugar, interventions, and notification to the physician by call or a fax sent, and a recheck of the blood sugar should have been documented in the resident's record. Interview on 9/5/24 at 9:45 a.m. with ADON C	F 684		

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F 684	Continued From page 45 revealed she defined "hypoglycemia" as a range between 60-70 but that she would assess the symptoms because "a person could feel hypoglycemic at 100 if they are used to their blood sugars being in the 600's." Interview on 9/5/24 at 1:48 p.m. with ED A and Chief Operating Officer AA regarding the diabetic care of insulin-dependent residents revealed they both agreed that notifications had not been made to residents' physicians according to their physician's orders and that interventions were missing from resident's electronic medical record. Interview on 9/5/24 at 5:29 p.m. with executive director A and DON B revealed the only time a physician was notified of a high or low blood sugar was on the documents provided. Review of the documents provided by ED A and DON B revealed: *Resident 20's physician had been notified of high blood sugars on 7/21/24 at 7:20 a.m. and again at 11:40 a.m. *There was no documentation that residents 3, 22, or 38's physicians had been notified of the 18 blood sugar levels outside of the normal range.	F 684		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility	F 727	F 727 1. In continuing compliance with F 727, RN 8 Hrs/7 days/Wk, Full Time DON, Lake Andes Senior Living corrected the deficiency by reviewing current staff schedule to ensure 8 hours of continuous RN coverage daily. 2. To correct the deficiency and to ensure the problem does not recur the Executive Director, Director of Nursing, and Assistance Director of Nursing were educated by Accura's Regional Nurse Consultant on	10/3/2024

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F 727	Continued From page 46 must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview, staff schedule review, and payroll record review, the provider failed to ensure a registered nurse (RN) was scheduled for eight consecutive hours for two of four weekends in May 2023. Findings include: 1. Interview on 9/4/24 at 3:03 p.m. with executive director A regarding the required eight hours of RN coverage on a daily basis revealed he: *Was responsible for filing the payroll-based journal (PBJ) reports. -He began submitting the facility's payroll-based journal information starting with Quarter 3 of 2024. *Had been aware they did not have an RN working in the facility on 5/7/24, 5/27/24, and 5/28/24. *Stated they always had a nurse in the building, but not always an RN on weekends. 2. Review of the provider's staff schedule and payroll record for May 2023 revealed they did not have RN coverage on the following dates: *Sunday 5/7/24. *Saturday 5/27/24. *Sunday 5/28/24.	F 727	F 727 09/17/2024 on ensuring facility has 8 hours of continuous RN coverage daily. The Director of Nursing and/or designee will audit schedule for 8 hours of continuous RN coverage daily weekly for 12 weeks and then randomly to ensure continued compliance. 3. As part of Lake Andes Senior Living's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs.	F 758	F 758 1. In continuing compliance with F 758, Free from Unnec Psychotropic Meds/PRN Use, Lake Andes Senior Living	10/3/2024

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F 758	Continued From page 47 §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and	F 758	F 758 corrected the deficiency by ensuring R139 and all like residents with PRN psychotropic medications were reviewed to ensure rationale and duration were received from physician if medication to continue beyond 14 days by 10/03/2024. 2. To correct the deficiency and to ensure the problem does not recur All licensed nurses were educated by the Director of Nursing on 09/17/2024 or prior to the start of their next shift on the PRN Psychotropic Medication Process. The Director of Nursing and/or designee will audit all PRN psychotropic medications weekly for 12 weeks and then randomly for continued compliance. 3. As part of Lake Andes Senior Living's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process.	

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F 758	Continued From page 48 indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review the provider had failed to ensure one of one sampled resident (139) had as needed (PRN) lorazepam (antianxiety medication) order renewed for use beyond 14 days. Findings include: 1. Review of resident 139's electronic medical record (EMR) revealed: *On 8/15/24 an order for lorazepam 0.5 milligrams (mg) orally to be given every six hours as needed for anxiety. *On 8/18/24 an order for lorazepam 2 mg per milliliter (ml) to be given 0.5 mg every six hours as needed for anxiety. *On 8/20/24 an order for lorazepam 0.5 mg to be given 0.25 mg every 12 hours as need for anxiety. *All orders had been active until 9/4/24. 2. Interview on 9/4/24 at 3:34 p.m. with regional nurse consultant S, director of nursing B, and assistant director of nursing C regarding resident 139's prn lorazepam revealed: *They had not been aware that all three lorazepam orders had not been renewed. *They all had agreed that the three as needed orders for lorazepam were not current. *"They obtained a new order on 9/4/24 for resident 139 for lorazepam 2 mg/ml give 0.25 mg	F 758		

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	435097	A. BUILDING _____ B. WING _____	09/05/2024

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F 758	Continued From page 49 orally every six hours as needed for anxiety." 3. Review of the provider's January 2022 PRN Psychotropic Medication Process revealed: *"To ensure that the resident's medication regimen is managed to promote or maintain the resident's highest practicable mental, [physician] and psychosocial well-being." *"To ensure the utilization of PRN psychotropic medication(s) only when needed to treat specific diagnosed condition(s) and monitor the resident's use of PRN psychotropic medications in an effort to assist with stabilizing or improving the resident's outcome, quality of life and functional capacity." *"All PRN Anti-Psychotic medications will be limited to 14-days and will not be renewed unless the prescriber directly examines the resident for appropriateness of the medication and documents the rational in the medical record prior to the nurse accepting and processing the order."	F 758		
F 812 SS=F	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	F 812	F 812 1. In continuing compliance with F 812, Food Procurement, Store/Prepare/Serve-Sanitary, Lake Andes Senior Living corrected the deficiency by labeling/dating all food items stored in freezers, labeling/dating all food items in resident refrigerator, and discarding all expired food items from resident refrigerator on 09/27/2024. The Certified Dietary Manager implemented new labeling and storage of food process on 09/27/2024. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated on the new labeling and storage of food process by the Certified Dietary Manager on 09/27/2024 or prior to the start of their next shift. The Certified Dietary Manager and/or designee will audit all	10/3/2024

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F 812	Continued From page 50 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, interview, and policy review, the provider failed to ensure food items for resident consumption were appropriately labeled and stored in a safe and sanitary manner for the following: *Three of five freezers that contained food items that were not labeled or dated. *One of one resident refrigerator that contained food items that were not labeled, dated, or discarded by the use-by date. 1. Observation on 8/27/24 at 8:15 a.m. of the lower-level food storage area revealed: *A freezer labeled "Freezer 1" contained two bags of fruit that were opened and not labeled or dated. *A freezer labeled "Freezer 2" contained: -One bag of waffles that was open and not dated. -One bag of French Toast that was opened and not dated. -Three bags of frozen omelets that were not labeled or dated. -Garlic bread that was open and not dated. *An unlabeled freezer contained two bags of frozen vegetables that were open and not labeled or dated. 2. Observation on 8/27/24 at 10:49 a.m. of the resident refrigerator located in the therapy room revealed: *What appeared to be fruit in a plastic container dated 8/16/24.	F 812	F 812 refrigerators and freezers for compliance with new labeling and storage of food process weekly for 4 weeks, monthly for 2 months and then randomly to ensure continued compliance. 3. As part of Lake Andes Senior Living's ongoing commitment to quality assurance, the Certified Dietary Manager and/or designee will report identified concerns through the community's QA Process.	

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F 812	Continued From page 51 -The date indicated the food had been in that refrigerator for 11 days. *Yogurt labeled "CIN 8/16/24". -The date indicated the food had been in that refrigerator for 11 days. *An open container of coffee creamer dated 7/30/24. -The date indicated the food had been in that refrigerator for 28 days. *A plastic bag with breaded meat labeled with resident 38's name that was not dated. 3. Interview on 9/4//24 at 10:18 a.m. with dining services manager F revealed: *She confirmed that there were unlabeled food items in the freezers and resident refrigerator. *Food items were to have been labeled with a black marker or a piece of tape that indicated a date received and an opened date. -The black markers smudge and wipe off and the tape falls off. *They have food labels that do not stick to the packages. *She was in the process of implementing a "re-bagging system." *Prepared or leftover food was to have been labeled with a sticker that identified the food, the date it was placed in the refrigerator, and the date it should have been discarded. *She would have expected items in the freezer to be labeled and dated. *She would have expected items in the resident refrigerator to have been labeled, dated, and to have been thrown away after 7 days. -The kitchen and activities staff are responsible for monitoring the resident refrigerator. 4. Review of the provider's undated Food Storage Policy revealed:	F 812		

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F 812	Continued From page 52 *It did not have an approval date by the medical director or governing body. *Date marking should be visible on all high-risk foods." *"Leftover food must be used within7 days or discarded ..." *"Frozen Foods: All foods should be covered, labeled and dated." Review of the provider's November 16, 2018, Outside Food and Food Storage policy revealed: *"Foods or beverages brought in from the outside will be labeled with the resident's name, room number and dated by nursing with the current date the item(s) was brought to the facility for storage." *" ...will be dated when accepted for storage and discarded after 48 hours."	F 812		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, policy review, and job description review the provider failed to ensure the facility was operated and administered by executive director (ED) A and director of nursing (DON) B, in a manner that ensured the safety and overall well-being of all 39 residents in the facility. Those areas included: *Maintaining an effective infection control program that included following appropriate	F 835	F 835 1. In continuing compliance with F 835, Administration, Lake Andes Senior Living corrected the deficiency by having Accura's Regional Nurse Consultant review regulation F583, F584, F684, F727, F867, F880 and all other deficient regulations with the Executive Director and Director of Nursing to ensure understanding of deficient areas by 09/27/2024. 2. To correct the deficiency and to ensure the problem does not recur the Executive Director and Director of Nursing collaborated with Accura's Regional Nurse Consultant to correct regulation F583, F584, F684, F727, F867, F880 and all other deficient regulations by 10/03/2024. Accura's Regional Nurse Consultant will provide oversight weekly for 12 weeks to ensure compliance with corrected regulations is maintained. 3. As part of Lake Andes Senior Living's	10/3/2024

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F 835	Continued From page 53 infection control procedures for the prevention and management of COVID-19 infections which included: -The implementation of appropriate precautions, including enhanced barrier precautions. -Ensuring staff demonstrated the proper use of personal protective equipment. -Hand hygiene after caring for infected residents. *Ensuring quality of care regarding hypoglycemic and hyperglycemic risks for four of seven insulin-dependent diabetic residents (3, 20, 22, and 38) which included interventions and physician notification according to blood glucose parameters set by the resident's physician. *Ensuring the facility was safe, clean, comfortable, and had a homelike environment. Resident rooms and other common use areas maintained in a manner to ensure the homelike environment. *Maintaining a resident's personal privacy with toileting for three residents (35, 36, and 38) who had adjoining rooms with a shared bathroom. *Ensuring a registered nurse worked for at least eight consecutive hours a day on three dates (5/7/24, 5/27/24, and 5/28/24). *Implementing an effective performance improvement plan (PIP) and quality assurance program. Findings include: 1. Observations, interviews, record reviews, and policy reviews throughout the course of the survey, conducted from 8/27/24 through 8/29/24 and from 9/3/24 through 9/5/24, revealed ED A and DON B had not ensured the safe management and overall well-being of all the residents who lived in the facility. This was evidenced by there was a widespread system breakdown to ensure the facility had	F 835	F 835 ongoing commitment to quality assurance, Accura's Regional Nurse Consultant and/or designee will report identified concerns through the community's QA Process.	

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F 835	Continued From page 54 implemented: *An effective infection control program that included staff education, monitoring, and communication to prevent facility-acquired COVID-19 infections. *A diabetic care program regarding hypoglycemic and hyperglycemic risks with appropriate interventions and physician notifications. *An effective environmental program to ensure the facility was safe, clean, comfortable, and had a homelike environment. *An effective Quality Assurance and Performance Improvement (QAPI) program. Interview on 8/27/24 at 1:25 p.m. with ED A and DON B regarding their COVID-19 Outbreak policy revealed they had not followed their policy by not addressing resident room assignment for shared rooms based on a case-by-case analysis of the presence of risk factors for increased likelihood of transmission of COVID-19 infection. Interview on 9/4/24 at 10:11 a.m. with ED A revealed he started his position at the facility on 7/1/24, and was transitioning from another ED position within the same corporation ' s network. Interview on 9/5/24 at 1:48 p.m. with ED A and Chief Operating Officer AA regarding the diabetic care of insulin-dependent residents revealed they both agreed that notifications had not been made to residents' physicians according to their physician's orders and that interventions were missing from resident's electronic medical record. Review of the provider's 11/15/23 Executive Director - LNHA [Licensed Nursing Home Administrator] job description signed by ED A on 5/29/24 revealed:	F 835		

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F 835	Continued From page 55 *Job Summary identified: -Directs the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations. -Follow all established policies and procedures ... to assure that quality resident care and an effective operation can be maintained. *Essential Job Functions included: -Lead facility QA [Quality Assurance] committee and ensure compliance with regulations for state of operation. -Oversee and conduct regular rounds to monitor delivery of nursing care, operation of support departments, cleanliness and appearance of the facility, ... and ensure resident and tenant needs are being addressed. -Ensure ... all staff is appropriately trained, and a high level of interdepartmental teamwork is maintained. -Ensure the building and grounds are appropriately maintained and that equipment and work areas are clean, safe, and orderly, and any hazardous conditions are timely addressed. Review of the provider's 11/15/23 Director of Nursing (DON) job description signed by DON B on 3/11/24 revealed: *Job Summary stated "The primary purpose of your job position is to plan, organize, develop, and direct the overall operation of our nursing service department in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility ... *Essential Job Functions included: -Plan, develop, organize, implement, evaluate, and direct the nursing service department, as well as its programs and activities, in accordance with current rules, regulations, and guidelines that govern the skilled nursing and long-term care	F 835		

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F 835	Continued From page 56 facility. -Develop, maintain, and periodically update written policies and procedures that govern the day-to-day functions of the nursing service department. -Develop methods for coordination of nursing services with other resident services to ensure the continuity of the residents' total regimen of care. -Audit documentation for errors or inconsistencies and make necessary changes to prevent further errors. Refer to F583, F584, F684, F727, F867, and F880.	F 835		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842	F 842 1. In continuing compliance with F 842, Resident Records - Identifiable Information, Lake Andes Senior Living corrected the deficiency by ensuring R20, R22, R34, R38 and all like residents had complete and accurate medical records by 10/03/2024. New Medical Records Guideline was implemented on 09/27/2024. 2. To correct the deficiency and to ensure the problem does not recur all licensed nursing staff, leadership staff, and medical records staff were educated on 09/27/2024 or prior to the start of their next shift on the new medical records guideline. All licensed nursing staff were educated by the Director of Nursing on 09/27/2024 or prior to the start of their next shift on ensuring all charting, assessments, medications, and treatments are accurately completed. The Executive Director and/or designee will audit 3 resident medical records for accuracy and completeness weekly for 12 weeks and then randomly to ensure continued compliance. The Director of Nursing and/or designee will	10/3/2024

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F 842	Continued From page 57 §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and	F 842	F 842 audit 3 resident medical records for accuracy and completeness weekly for 12 weeks and then randomly to ensure continued compliance. The Director of Nursing and/or designee will audit MARS/TAR and 24-hour report for accuracy and completeness of medical record 3 times per week for 12 weeks and then randomly to ensure continued compliance. 3. As part of Lake Andes Senior Living's ongoing commitment to quality assurance, the Executive Director and/or designee will report identified concerns through the community's QA Process.	

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F 842	Continued From page 58 determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review the provider failed to ensure complete and accurate documentation had been entered in the resident records for four of twenty (20, 22, 34, and 38) sampled residents. Findings include: 1. Review of resident 20's electronic medical record (EMR) revealed: *The physician was to be notified for blood sugars greater than 401. *A blood sugar reading above 401 was documented 8/5/24. -There was no documentation to indicate that the physician had not been notified. 2. Review of resident 22's EMR revealed: *The physician was to be notified for blood sugars greater than 351. *Five blood sugar readings above 351 were documented between 7/27/24 and 8/28/24. -There was no documentation to indicate that the physician had not been notified. 3. Review of resident 34's EMR revealed: *A 9/5/24 progress note stated "Held care conference for [resident 20's name] today but no answer from poa [power of attorney]. Resident will remain a DNR/DNI [do not resuscitate/do not intubate] Code status and be here for long term care." -Resident 34's EMR contained information referring to the wrong resident.	F 842		

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F 842	Continued From page 59 4. Review of resident 38's EMR revealed: *An 8/1/24 physician fax communication regarding resident 4's nitroglycerin order. *Her care plan states "Ensure [resident 8's name] is aware/compliant with the facilities smoking policy.". -Resident 38's EMR contained information referring to the wrong resident. *The physician was to be notified for blood sugars greater than 400. *Five blood sugar readings above 400 were documented between 7/16/24 and 9/5/24. -There was no documentation to indicate that the physician had been notified. *Five blood sugar readings below 60 were documented between 7/16/24 and 9/5/24. -There was no documentation to indicate interventions were provided or that the physician had been notified. Refer to F684. 5. Interview on 8/29/24 at 4:00 p.m. with executive director (ED) A revealed that the only policy the facility had related to the accuracy and privacy of electronic medical records was the Resident's Access to Protected Health Information (PHI)/Medical Record policy provided. Interview on 9/4/24 at 10:06 a.m. with director of nursing (DON) B and regional nurse consultant (RNC) S revealed: *There was no written facility policy on "hypoglycemia management" or "diabetic care." *There were "[Name of provider] Standing Orders." -A copy of the standing orders was provided to the survey team.	F 842		

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F 842	Continued From page 60 Review of the "[Name of provider] Standing Orders" did not indicate when a physician was to be notified of a high or low blood sugar. Interview on 9/4/24 at 2:46 p.m. interview with director of nursing (DON) B revealed: *She confirmed that resident 4's fax communication was in resident 38's EMR *She stated, "Oh that is not okay." *Confirmed that this might be considered a violation however stated that "only staff and surveyors would be able to see that." Interview on 9/5/24 at 8:25 a.m. and again at 9:45 a.m. with assistant director of nursing (ADON) C on the process for following up on low or high blood sugars revealed: *She confirmed that the doctor was notified when a resident had a low or high blood sugar reading. *Any time a physician is contacted "we would document it. When we contact the medical doctor we will put in a progress note." *She defined "hypoglycemia" [a low blood sugar] as a range between 60-70. Interview on 9/5/24 at 5:29 p.m. with ED A and DON B revealed the only time a physician was notified of a high or low blood sugar was on the documents provided. Review of the documents provided by ED A and DON B revealed resident 20's physician had been notified of high blood sugars on 7/21/24. 6. Review of the provider's April 14, 2003, Resident's Access to Protected Health Information (PHI)/Medical Record policy revealed: *It included the letterhead of another corporation. -It did not include the provider's letterhead or	F 842		

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F 842	Continued From page 61 facility name. *The policy did not address the accuracy of the resident record. On 9/5/24 at 6:15 p.m. the survey team met with ED A and DON B for an exit conference and reviewed the accuracy of documentation. ED A and DON B provided no disagreement or comment.	F 842		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring,	F 867	F 867 1. In continuing compliance with F 867, QAPI/QAA Improvement Activities, Lake Andes Senior Living corrected the deficiency by implementing an effective quality assurance program (QAPI) that focuses on identifying and improving systemic problems. 2. To correct the deficiency and to ensure the deficiency does not recur all staff were educated on 9/27/2024 by the executive director on the facility's quality assurance and performance improvement process, the facility's Covid-19 Outbreak policy, and the diabetic care program. All employees were encouraged to attend the facility's monthly QAPI meetings, and to report any concerns immediately to their supervisor. Monthly QAPI meeting minutes will be posted in the employee breakroom for all employees to review. Employees not in attendance will be educated prior to the start of their next shift. The executive director and/or designee will audit all employee files for completed training weekly for 4 weeks and monthly for 3 months to ensure continued compliance. 3. As part of Lake Andes Senior Livings's ongoing commitment to quality assurance,	10/3/2024

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F 867	Continued From page 62 and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on	F 867	F 867 the executive director and/or designee will report identified concerns through the community's QA process.	

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F 867	Continued From page 63 high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of	F 867		

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F 867	Continued From page 64	F 867		

action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on interview and policy review, the provider failed to implement an effective quality assurance process improvement (QAPI) program that focused on identifying and improving systemic problems.
Findings include:

1. Interview on 9/5/24 at 4:44 p.m. with executive director (ED) A revealed:
*Regarding their QAPI Program:
-The committee met monthly with the medical director in attendance.
-They had developed a performance improvement plan (PIP) for falls which included reviewing interventions that were put in place.
*Regarding their infection prevention & control program and their 5/6/24 COVID-19 Outbreak policy:
-He agreed that they were currently experiencing a COVID-19 outbreak in the facility.
-He was aware that they had allowed residents with confirmed COVID-19 infection to share a room with residents that did not have that respiratory pathogen, increasing the likelihood of the transmission of COVID-19 infections.
-He thought they were doing what was best for the residents by allowing the residents who were not infected to remain in the room with a resident with confirmed COVID-19 infection as they had been exposed to that respiratory pathogen.
-He agreed that they had not followed their COVID-19 Outbreak policy and stated it was "our

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F 867	Continued From page 65 mistake." *Regarding their diabetic care program for insulin-dependent diabetic residents: -He was not aware of the lack of physician notification according the blood glucose parameters ordered by the resident's physician. -He was not aware of the lack of interventions documented in the resident's electronic medical record. 2. Review of the provider's 5/23/23 Quality Assurance and Performance Improvement Plan (QAPI)/Quality Assessment and Assurance (QAA) policy revealed: *The Purpose of QAPI was "a systematic approach for improving quality of life, quality of care, and services we provide to our residents. We take a proactive approach to continually improve the way engage and care for our residents, caregivers, ... so that we may realize our vision to provide a homelike environment to our residents ... To do this, all employees will participate in ongoing QAPI efforts which support our mission ..." *"The scope of the QAPI program encompasses all segments of care and services, including customer service, care management, clinical quality, quality of life, resident choice and effective care transitions." *"The facility Executive Director and Director of Nursing are designated as the governing body of the nursing home QAPI program. They are responsible for:" *"Developing a culture that involves input from facility staff, residents, families, and other care partners." *"To develop leadership and facility wide training on QAPI, ensuring staff have time, equipment, and training as needed."	F 867		

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F 867	Continued From page 66 Refer to F582, F584, F658, F684, F758, F812, F880 and F944.	F 867		
F 880 SS=K	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	F 880	F 880 1. In continuing compliance with F 880, Infection Prevention & Control, Lake Andes Senior Living corrected the deficiency by cohorting COVID positive residents 5, 6, 8, 10, 19, 20, 29, 31, 32, 33, 38, 89 together and cohorting presumptive positive residents 6, 38, and 8 together on 08/27/2024. The Executive Director, Director of Nursing, Assistant Director of Nursing/Infection Preventionist were educated by Accura's Regional Nurse Consultant on 08/27/2024 on the COVID-19 requirements. R34, R19 and all like residents were reviewed to ensure those that met enhanced barrier precaution criteria had signage posted and PPE placed in their room for staff to utilize by 09/27/2024. 2. To correct the deficiency and to ensure the problem does not recur all staff were educated by the Director of Nursing on 08/27/2024 or prior to the start of their next shift on donning/doffing PPE, wearing N95 masks, hand hygiene, ensuring residents in isolation remain in isolation, and staff interventions for isolated residents who exit their room. All licensed and non-licensed staff were educated by the Director of Nursing on 09/27/2024 or prior to the start of their next shift on the Enhanced Barrier Precaution guideline, roles and responsibilities in caring for and responding to those residents with COVID-19 or requiring isolation, use of PPE by staff, and necessary hand hygiene and glove use to receive cares. The Director of Nursing and/or designee will audit donning/doffing PPE of 3 employees	10/3/2024

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F 880	Continued From page 67 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 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 ensure the management COVID-19 cases with 12 of 12 sampled residents (5, 6, 8, 10, 19, 20, 29, 31, 32, 33, 38, and 89) implement appropriate precautions, and prevent further transmission of	F 880	F 880 weekly for 12 weeks and then randomly to ensure continued compliance. The Director of Nursing and/or designee will audit wearing N95 mask correctly of 3 employees weekly for 12 weeks and then randomly to ensure continued compliance. The Director of Nursing and/or designee will audit hand hygiene of 3 employees weekly for 12 weeks and then randomly to ensure continued compliance. The Director of Nursing and/or designee will audit employees for redirection and interventions for residents in isolation 3 times per week for 12 weeks and then randomly to ensure continued compliance. The Director of Nursing and/or designee will audit staff for enhanced barrier precaution compliance 3 times per week for 4 weeks, 2 times per week for 4 weeks, weekly for 4 weeks and then randomly to ensure continued compliance. 3. As part of Lake Andes Senior Living's ongoing commitment to quality assurance, the Director of Nursing and/or designee will report identified concerns through the community's QA Process.	

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F 880	Continued From page 68 the disease, including ensuring staff demonstrated the proper use of personal protective equipment (PPE) (e.g. N95 face masks and gowns), and proper hand hygiene between residents to prevent the spread of COVID-19 infection. Findings include: Notice: On 8/27/24: *At 11:30 a.m., immediate jeopardy was identified related to the prevention and control of resident COVID-19 infections at F880. *At 1:25 p.m., notice of immediate jeopardy was provided verbally and in writing to executive director (ED) A, director of nursing (DON) B, and regional nurse consultant (RNC) S. An immediate jeopardy removal plan was requested at that time. The survey team exited the building at 2:00 p.m. Plan: "On 8/27/2024, all covid positive residents were moved in with other covid positive residents. All negative residents are grouped with well residents with no signs symptoms of covid. Other negative residents with known exposure including resident #6, #38, and resident #8 in the presumptive area with other presumptive residents. Staff have been educated on the importance of keeping all positive residents on isolation for 10 days. Staff are to redirect if they want to come out of their room." "On 8/27/2024, staff education was completed by the DON and RN Nurse Specialist to ensure all staff who are currently working and are providing care to positive and presumptive residents, knew how to properly DONN and DOFF PPE. PPE is put on prior to entering positive and presumptive	F 880		

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F 880	Continued From page 69 rooms. This includes removing the gloves and gown inside the room and performing hand hygiene. The removal of the eye protection and mask happens outside the room. Masks and eye protection are discarded. Hand hygiene is performed again. All those not on shift will be educated prior to them coming on shift." "On 8/27/2024, All staff currently on shift were educated on properly wearing an N95 mask. All those not on shift will be educated prior to them coming on shift." "On 8/27/2024, All staff currently on shift were educated on proper hand hygiene after DOFFING PPE prior to assisting another resident. All those not on shift will be educated prior to them coming on shift." "Any concerns will be reported to the charge nurse, director of nursing, infection preventionist, and/or administrator immediately and addressed in facility QAPI." On 8/27/24: *At 7:45 p.m. ED A provided their final plan for the removal of the immediate jeopardy through an email submission. *At 8:33 p.m. the provider's removal plan was reviewed and accepted by the survey team. On 8/28/24: *At 8:00 a.m. the survey team entered the facility to observe and review the provider's documentation related to their removal plan of the immediate jeopardy. Based on observations and documentation review the survey team could not remove the immediacy as the removal plan had not been fully implemented. *At 10:30 a.m. a meeting was held by the survey team with ED A, DON B, and RNC S regarding the removal plan had not been fully implemented	F 880		

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F 880	Continued From page 70	F 880		

and the immediacy had not been removed. The survey team exited the building at 10:45 a.m.

On 8/29/24:
*At 8:30 a.m. the survey team entered the facility to observe and review the provider's documentation related to their removal plan of the immediate jeopardy.
*At 10:10 a.m. the survey team's observations and review of the provider's documentation for the removal of the immediate jeopardy determined the immediacy was removed. After the removal of the immediate jeopardy, the scope and severity of the citation level was "H".

1. Observation on 8/27/24 at 8:37 a.m. of resident 10 and 20's door revealed:
*The residents had been on isolation precautions, but the door is wide open.
*Resident 10 was on isolation until 9/1/24.

Observation on 8/27/24 at 8:39 a.m. of 19 and 32's door revealed:
*The residents had been on isolation precautions.
*Resident 19 was on isolation until 9/1/24.

Observation on 8/27/24 at 8:56 a.m. of assistant activities T revealed:
*She had applied gloves without performing hand hygiene.
*Her N95 had not been worn with the straps separated to ensure a tight seal.

Observation on 8/27/24 at 9:00 a.m. of unidentified staff revealed:
*They had applied gloves without performing hand hygiene prior to glove use.
*Staff had applied full personal protective equipment (PPE) with her gloved hands touched

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F 880	Continued From page 71 the garbage can and went to another room and opened the door. *Removed her PPE and did not perform hand hygiene. -She then touched her hair and walked down the hallway with her goggles on. *Activities assistant T walked out of a isolation room with her gown on and took the garbage into the soiled utility room. *All observed staff continued to wear the same N95 mask after leaving an isolation room. Observation on 8/27/24 at 9:15 a.m. of unidentified staff leaving resident 5 and 33's room revealed: *They had removed their gowns but had the same N95 on while going to a non-COVID-19 room. *No hand hygiene by staff before applying gloves *She had out her gown on and touched her hair with her gloved hands and entered another room. Observation on 8/27/24 at10:00 a.m. of housekeeping aide W wiping down tables in the dining room with his N95 mask is just below his lower lip and not under his chin. 2. Review of the facility record of residents that had been on isolation revealed: *On 8/22/24: -Resident 33 had tested positive for COVID-19. -Resident 5 was resident 33 ' s roommate and had tested negative. --On 8/24/25 resident 5 tested positive for COVID-19.	F 880		

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F 880	Continued From page 72 -Resident 10 tested positive for COVID-19. --On 8/26/24 resident 20 had tested positive for COVID -19. *On 8/22/24 resident 31 had tested positive for COVID-19 and her roommate resident 38 had tested negative but remained in the same room. *On 8/23/24 resident 89 had tested positive for COVID-19 and her roommate resident 8 had been negative and remained in the same room. *On 8/24/24 resident 29 had tested positive for COVID-19 and her roommate resident 6 had been negative and remained in the same room. *On 8/24/24 a progress note had been made regarding "Telephone call to resident 6's representative and informed her that resident is on quarantine for 10 days due to residents room mate is covid positive." 3. Review of resident 6, 8, 32, and 38's electronic medical record (EMR) revealed there had not been any documentation indicating information was provided to them or their responsible party regarding the risk of residents remaining in the same room with their positive roommates. 4. Interview on 8/27/24 at 9:23 a.m. with DON B regarding isolation of resident's revealed: *If one resident had tested positive for COVID-19	F 880		

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	435097	A. BUILDING _____ B. WING _____	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST LAKE ANDES, SD 57356

(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
F 880	Continued From page 73 they would isolate the roommate with them at the same time. *She would have informed the negative resident of the risk of staying in the room with their COVID-19 positive roommate. Interview on 8/27/24 at 10:17a.m. with DON B regarding the notification of the roommate and family of the COVID-19 positive roommate revealed that information would have been documented in a progress note. 5. Review of the provider's May 2024 COVID-19 Outbreak policy revealed: *"In the nursing home, place a resident with confirmed COVID infection in a single-person room, when possible. The door should be kept closed (if safe to do so). Ideally, the resident should have a private bathroom, if possible. If a single-person room is not available, only residents with the same respiratory pathogen should be housed in the same room." *"When a two or more resident(s)/tenant(s) who are currently in the facility tests positive, all staff must wear N95 throughout the facility until there are less than three positive residents in isolation. See guidance on one or two resident(s)/tenant(s) when less than three positive." *"N95, gown, eye protection, and gloves are required in the presumptive and positive resident's/tenant's rooms. When staff member foes from a presumptive or positive room to a well room, they must doff their PPE and change the N95 to a surgical mask. When a staff member goes from a positive to a presumptive room, they must change their PPE and N95." 6. Observation on 8/27/24 at 7:56 a.m. revealed: *A sign at the front door stating masks were	F 880		

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F 880	Continued From page 74 required. *There was no hand sanitizer at the front door. *The wall-mounted hand sanitizer outside resident room 4 did not work. 7. Interview on 8/27/24 at 8:05 a.m. with director of nursing (DON) B revealed that there were 10 COVID-19-positive residents in the facility. 8. Observation on 08/27/24 at 09:18 a.m. revealed: *The Lysol wipes container outside room 11 was open with the wipe pulled up through and draped over the edge. *An unidentified staff member pushed the medication cart down the hall from room 15 to room 7 while wearing a gown, n-95 mask, and gloves. -She parked the cart outside room 7 and went into room 7. -She then exited room 7 without the gown or gloves. -She removed her mask with her ungloved hands, discarded it in the trash can, opened the drawer of the cart that contained personal protective equipment (PPE), took a new mask, and put that mask on. Observation on 8/27/24 at 10:41 a.m. with activities assistant T revealed: *She exited room 15 wearing an N-95 mask and her glasses. -A resident in room 15 was COVID-19-positive. *She did not change her mask or sanitize her glasses with no shield. *She pushed the water cart down the hall. *She lowered her N-95 with ungloved hands, wiped her face with a tissue, placed that tissue in her pocket, raised her mask, donned a gown, and	F 880		

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F 880	Continued From page 75 entered room 11 wearing the same mask and glasses with no shield. She exited room 11, removed her gloves and gown, disposed of them in the trash can inside room 11's door, went back into the room, pushed the cloth curtain aside, washed her hands, moved the curtain again with her hands, touched her mask and then continued down the hall. 9. Observation on 8/28/24 at 8:56 a.m. with resident 5 and activities director (AD) G revealed: *Resident 5 was COVID-19-positive. *He exited his room with his walker, identified himself to the surveyor, and stated he was headed to breakfast. *He walked past the nurse's station and went to a table near the window in the dining room. *There are three other residents seated in the dining room. *He hollered "Give me some Juice," and AD G gave him juice and coffee. *AD G assisted resident 5 with his watch with ungloved hands, without completing hand hygiene left the area, returned with a maroon insulated cup, set it on the nurse's station, and continued to assist residents in the dining room. Observation on 8/28/24 at 09:05 a.m. with dining services manager F revealed: *She approached resident 5 and told him he needed to return to his room because people were sick. *She picked up his coffee cup with an ungloved hand and told AD G resident 5 could not be in the dining room. *She handed that coffee cup to an unidentified staff who left the dining room with resident 5. Interview on 8/28/24 at 9:08 a.m. with AD G	F 880		

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F 880	Continued From page 76 revealed she: *Confirmed that she assisted resident 5 with his beverages and watch in the dining room. *Last received training about COVID-19-positive residents "last week sometime," but could not recall when. -The training was a verbal briefing on the use of PPE and separating COVID-19-positive residents. *Stated that to find out who was positive she would have to look in point click care each day. -"So I just avoid going into their room." *Thought resident 5 was off precautions, "because they change so quick." Interview on 8/28/24 at 9:11 a.m. with certified nursing assistant (CNA) K revealed: *The names on the nameplate outside resident rooms 4, 8, and 30 did not accurately reflect the residents in those rooms. *Some residents had changed rooms yesterday and some had changed rooms today. Observation on 8/28/24 at 9:40 a.m. with CNA N revealed she: *Put on a gown outside of room 4, and was unable to find gloves or goggles outside of room 4. -Room 4 was marked "Isolation." *Located gloves and a face shield in a PPE cart outside of room 8, continued to put on her PPE, and entered room 4. *Exited room 4 with a stand lift, removed her gloves and mask, performed hand hygiene, put on a new N-95 mask, parked the stand lift outside room 5 without sanitizing it, and returned to the nurse's station. Observation on 8/28/24 at 9:41 a.m. outside resident room 6 revealed:	F 880		

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F 880	Continued From page 77 *A blue stand lift pad draped over the top of the PPE cart touching the box of gloves and hand sanitizer. -Room 6 was marked "Isolation." Interview on 8/28/24 at 09:48 a.m. with CNA N revealed: *Residents in room 4 are in isolation but did not have COVID-19. *She confirmed that the names on the nameplate outside room 4 did not accurately reflect the residents who were in room 4 at that time. *She last received education on COVID-19 precautions "sometime last week after we had positive residents.". -The training included "a pamphlet on how to use PPE properly." -It was a refresher and there was a sign-in sheet. 10. Observation and interview on 8/29/24 at 12:48 p.m. with dining services aide Y revealed: *She wore a surgical mask which hung by one ear. It did not cover her mouth. *She stood in the doorway between the kitchen and the dining room. *She spoke with another staff member. *She could not recall receiving education about wearing a mask. *When asked if masks were required in the kitchen during a facility COVID-19 outbreak she stated, "They say I am supposed to, but I don't think I have to if no one else is around". B. Based on observation, interview, record review, and policy review the provider failed to ensure enhanced barrier precautions (EBP) were appropriately implemented and carried out for two of two residents (34 and 19) identified as those	F 880		

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F 880	Continued From page 78 who should have EBP. Findings include: 1. Observation and interview on 8/27/24 at 12:39 p.m. with resident 34 revealed: *There was a sign inside the door above the light switch that indicated enhanced barrier precautions (EBP). *There was a urinary catheter drainage bag hanging under resident 34's wheelchair. *He stated that the staff wear gloves when assisting with his urinary catheter bag. *He confirmed that the staff do not wear a gown or eye protection when assisting with his care. *No gowns or eye protection was in the room or outside the door. Observation and interview on 9/3/24 at 3:21 p.m. with certified nursing assistant (CNA) L and CNA N regarding care provided for resident 34 revealed: *CNA L stated gowns were kept outside of resident 34's door. *CNA N stated gowns were kept on the backside of the door. *CNA N confirmed that there were no gowns outside of resident 34's room or on the backside of that door. Observation and interview on 9/3/24 at 3:24 p.m. with resident 34's daughter revealed: *There were no gowns on the back of the door. *Resident 34's daughter confirmed that staff did not wear gowns when transferring resident 34 or providing his care. Review of resident 34's electronic medical record (EMR) revealed: *He had a physician's order for an indwelling urinary catheter.	F 880		

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F 880	Continued From page 79 *The resident care plan indicated that EBP was required. 2. Observation on 9/3/24 at 9:55 am with resident 19 revealed: *He had a urinary catheter drainage bag hanging from the left side of his bed. *There was no sign to indicate EBP was to be used when providing care to resident 19. *No gowns or eye protection was in the room or outside the door. Observation and interview on 9/3/24 at 10:32 a.m. with certified medication aide (CMA) I revealed she: *Was taking resident 19's vitals. *Was not wearing a gown or gloves. *Stated that she provided medication to resident 19, took his vitals, and applied a cream to his legs. *Confirmed that resident 19 was "off all precautions as of today." *Stated, "I only wear gloves when applying a cream, but I don't need a gown." Observation and interview on 9/3/24 at 11:26 a.m. with CNA M and CNA N revealed. *They transferred resident 19 with a mechanical stand aid. -CNA M and CNA N were not wearing gowns or gloves. *CNA N stated they did not need to wear a gown when providing care to resident 19. Review of resident 19's electronic medical record (EMR) revealed: *He was admitted on 7/25/24. *Admission documentation indicated five open wounds being treated.	F 880		

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F 880	Continued From page 80 *On admission there was a physician's order for an indwelling urinary catheter. Observation and interview on 9/3/24 at 3:28 p.m. with director of nursing B revealed: Observation and interview on 9/3/24 at 3:28 p.m. with director of nursing B revealed: *She confirmed that the sign for EBP was not inside the door above the light switch in resident 19's room where she had expected it to be. *She confirmed there were no gowns or eye protection present in resident 19's room or outside the door. *It was her expectation that gowns, gloves, and eye protection be worn when providing care for residents with wounds and indwelling urinary catheters. *She confirmed there were no gowns or eye protection present in resident 34's room or outside the door. *It was her expectation that gowns, gloves, and eye protection be worn when providing care for residents with wounds and indwelling urinary catheters. Review of the provider's May 6, 2024, Enhanced Barrier Precautions Policy revealed: *"It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms." *""Enhanced barrier precautions" (EBP) referred to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities." *" An order for enhanced barrier precautions will be obtained for residents with any of the following: Wounds...urinary catheters..."	F 880		

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F 944 SS=F	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is not met as evidenced by: Based on employee file review the provider failed to ensure that seven of seven sampled employees (B, C, J, P, Q, X, and Y) had been educated on the quality assurance and performance improvement process of the facility. Findings include: 1. Review of employee B, C, J, P, Q, X, and Y's files revealed there was no documentation they had not received the mandatory quality assurance and performance improvement education per the regulation for an extended survey.	F 944	F 944 1. In continuing compliance with F 944, QAPI Training, Lake Andes Senior Living corrected the deficiency by educating employees B, C, J, P, Q, X, and Y on the facility's quality assurance and performance improvement process on 9/27/2024. All other employee files were reviewed for missing training. Those identified will be educated by the director of nursing prior to the start of their next shift. 2. To correct the deficiency and to ensure the deficiency does not recur all staff were educated by the executive director and/or designee on 9/27/2024 on the facility's quality assurance and performance improvement process. The executive director and/or designee will audit all employee files for completed QAPI improvement training weekly for 4 weeks and monthly for 3 months to ensure continued compliance. 3. As part of Lake Andes Senior Livings' ongoing commitment to quality assurance, the executive director and/or designee will report identified concerns through the community's QA process.	10/3/2024

South Dakota Department of Health

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	10638	A. BUILDING: _____ B. WING _____	09/05/2024

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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 8/27/24 through 8/29/24 and from 9/3/24 through 9/5/24. Lake Andes Senior Living was found not in compliance with the following requirements: S206, S236, S296, and S301.	S 000		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and. (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section.	S 206	S 206 1. In continuing compliance with S 206, Personnel Training, Lake Andes Senior Living corrected the deficiency by ensuring employees B, C, J, Q, and R were trained on all mandatory training subjects. Any missing annual training requirements were added to all employee's orientation and annual ongoing education on 9/20/2024 by the executive director. 2. To correct the deficiency and to ensure the deficiency does not recur all employee files were reviewed for missing training, and those identified completed their training. All employees were educated by the executive director on 9/27/2024 to ensure new hire training is completed within 30 days of hire and all annual training is completed as assigned. The executive director and/or designee will audit employee new hire files and annual training for compliance monthly for 3 months and then randomly to ensure continued compliance. 3. As a part of Lake Andes Senior Livings' ongoing commitment to quality assurance, the executive director and/or designee will report identified concerns through the community's QA process.	10/3/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Clay Brouwer, LNHA

TITLE: Executive Director

(X6) DATE: 9/27/2024

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S 206	Continued From page 1 Additional personnel education shall be based on facility identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on review of employee training records, interview, and policy review, the provider failed to ensure mandatory training was provided on all of the required training subjects for five of five sampled employees (B, C, J, Q, and R) hired between 1/30/24 and 7/11/24 as follows: *Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms and proper restraint use for five of five sampled employees (B, C, J, Q, and R) *Accident prevention safety procedures for four of five sampled employees (C, J, Q, and R) *Care of residents with unique needs for three of five sampled employees (J, Q, and R) *Emergency procedures and preparedness, and fire prevention and response, dining assistance, nutritional risks, and hydration needs of patients or residents for one of five sampled employees (Q). Findings include: 1. Review of employee personnel records revealed: *Employee Q was hired on 1/30/24 and had no record of education about fire prevention and response, emergency procedures and preparedness, accident prevention safety procedures, proper use of restraints, incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms, care of residents with unique needs and dining assistance, nutritional risks and hydration needs of patients or residents. *Employee B was hired on 3/11/24 and had no record of education about the proper use of	S 206		

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S 206	Continued From page 2 restraints and incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms. *Employee J was hired on 4/24/24 and had no record of education about accident prevention safety procedures, proper use of restraints, incidents and diseases subject to mandatory reporting, and the facility's reporting mechanisms, and care of residents with unique needs *Employee R was hired on 5/6/24 and had no record of education about accident prevention safety procedures, proper use of restraints, incidents and diseases subject to mandatory reporting, and the facility's reporting mechanisms, and care of residents with unique needs *Employee C was hired on 7/11/24 and had no record of education about accident prevention safety procedures, proper use of restraints and incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms. 2. Interview on 9/4/24 at 1:03 p.m. and again at 4:30 p.m. with director of nursing B and regional nurse consultant S revealed: *They used an online training program for employees. *Regional nurse consultant S was not aware that proper restraint use and incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms were required topics. -They had not offered training on those topics during orientation nor the annual ongoing education. *There were no other training records available. *They confirmed that the employees had not completed their training. *They confirmed no current employees had received the required annual training on restraint use or incidents and diseases subject to mandatory reporting and their facility's process for	S 206		

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S 206	Continued From page 3 reporting. 3. Review of the provider's 10/23/23 Online Education policy revealed: *"Employees will be assigned online education through [provider's] learning management system upon hire and incrementally thereafter to satisfy annual training requirements. Training programs include required courses that all employees will need to complete ..." *"All new employees are assigned required training courses upon hire. The courses related to Dementia care must be completed within 7 days from the date of hire. All other courses assigned to the new hire must be completed no later than 30 days from the date of hire."	S 206		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12	S 236	S 236 1. In continuing compliance with S 236, Tuberculin Screening Requirements, Lake Andes Senior Living corrected the deficiency by receiving documentation of completed TB test from employee J on 9/26/2024. All other employee files were reviewed for missing TB screening/testing. Those identified had their TB screening/testing initiated. 2. To correct the deficient practice and to ensure the deficiency does not recur the regional nurse consultant provided education on the employee TB screening/testing requirements to the director of nursing, infection preventionist on 9/27/2024. The director of nursing and/or designee will audit new hire TB screening/testing for compliance weekly for 12 weeks and then randomly to ensure continued compliance. 3. As part of Lake Andes Senior Livings'	10/3/2024

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	10638	A. BUILDING: _____ B. WING _____	09/05/2024

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LAKE ANDES SENIOR LIVING	740 E LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

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S 236	Continued From page 4 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure one of five sampled employees (J) had completed the tuberculosis bacteria (TB) screening or a tuberculin skin test (TST) within fourteen days of being hired. Findings include: 1. Record review of certified nursing assistant (CNA) J's personnel file revealed: *She was hired on 4/24/24. *There was no documentation that CNA J had received the required tuberculin skin test. 2. Interview on 9/4/24 at 1:03 p.m. with director of nursing B and regional nurse consultant S confirmed there was no documentation of a Tuberculosis screening or a TST was completed for CNA J. 3. Review of the provider's May 6, 2024, TB Employee Screening policy revealed: *"All staff shall receive baseline TB screening upon hire. Consisting of two components: a. Completing questionnaire for current symptoms. b. Using a 2-step TST or single IGRA [Interferon Gamma Release Assay is a blood test that measures the body's immune response to	S 236	S 236 ongoing commitment to quality assurance, the director of nursing and/or designee will report identified concerns through the community's QA process.	

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S 236	Continued From page 5 tuberculosis bacteria] to test for infection with M. tuberculosis."	S 236		
S 296	44:73:07:11 Director of Dietetic Services A full time dietary manager who is responsible to the administrator shall direct the dietetic services. Any dietary manager that has not completed a Dietary Manager's course, approved by the Association of Nutrition & Foodservice Professionals, shall enroll in a course within 90 days of the hire date and complete the course within 18 months. The dietary manager and at least one cook must shall successfully complete and possess a current certificate from a ServSafe Food Protection Program offered by various retailers or the Certified Food Protection Professional's Sanitation Course offered by the Association of Nutrition & Foodservice Professionals, or successfully completed equivalent training as determined by the department. Individuals seeking ServSafe recertification are only required to take the national examination. The dietary manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each resident are met. If the dietary manager is not a dietitian, the facility shall schedule dietitian consultations onsite at least monthly. The dietitian shall approve all menus, assess the nutritional status of residents with problems identified in the assessment, and review and revise dietetic policies and procedures during scheduled visits. Adequate staff whose working hours are scheduled to meet the dietetic needs of the residents shall be on duty daily over a period of 12 or more hours in facilities. This Administrative Rule of South Dakota is not	S 296	S 296 1. In continuing compliance with S 296, Director of Dietetic Services, Lake Andes Senior Living corrected the deficiency by enrolling all cooks in the ServSafe Food Protection Program on 9/27/2024 with an expected completion of 11/302024. Following the completion of the survey and after interviews by the executive director, it was determined that two non-kitchen employees possessed the ServSafe Food Protection Program certification. 2. To correct the deficient practice and to ensure the deficiency does not recur, the state survey team informed the executive director and the dining services manager that the dining services manager and one cook must possess a current ServSafe Food Protection Program certificate. The executive director and/or designee will provide education to dietary staff on 9/27/2024 to ensure that they are educated on ServSafe certification requirements. The dining services manager and/or designee will audit the completion of ServSafe certifications and ensure all cooks hold a current certification monthly for 3 months and then randomly to ensure continued compliance. 3. As a part of Lake Andes Senior Livings' ongoing commitment to quality assurance, the dining services manager and/or designee will report identified concerns through the community's QA process.	10/3/2024

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S 296	Continued From page 6 met as evidenced by: Based on interview and certificate review, the provider failed to ensure the dining services manager and one cook possessed a current ServSafe Food Protection Program certificate. Findings include: 1. Interview on 9/4/24 at 10:18 a.m. with dining services manager (DSM) F revealed: *She was the only employee with a ServSafe Food Protection Program certificate. *None of the cooks who worked in the kitchen possessed a current ServSafe Food Protection Program certificate. *No employees were currently enrolled in a program. *The last cook who possessed a ServSafe Food Protection Program certificate ended her employment four months ago. 2. Interview on 9/4/24 at 3:03 p.m. with executive director A revealed: *He was not aware of the dietary manager and at least one cook were required to possess a ServSafe Food Protection Program certificate. *He was not aware if any staff other than DSM F possessed the required certificate. 3. Review of the ServSafe Food Protection Program certificate revealed. *DSM F's certificate was current.	S 296		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses,	S 301	S 301 1. In continuing compliance with S 301, Required Dietary Inservice Training, Lake Andes Senior Living corrected the deficiency by ensuring employee Q completed the required dietary training on food safety, food handling, and preparation	10/3/2024

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S 301	Continued From page 7 serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on review of employee training records, interview, and policy review the provider failed to ensure all the required dietary training topics had been provided for one of three sampled dietary employees (Q). Findings include: 1. Review of the employee file and training records revealed: *Dietary service aide Q was hired on 1/30/24 and had not completed the required dietary training on food safety, food handling, and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration and sanitation. 2. Interview on 9/4/24 at 1:03 p.m. with director of nursing B and nurse consultant S revealed: *They used an online training program for employees. *There were no other training records available. *They confirmed that dietary service aide Q had not completed the above required dietary training. 3. Review of the provider's 10/23/23 Online Education policy revealed: *"Employees will be assigned online education through [provider's] learning management system upon hire and incrementally thereafter to satisfy annual training requirements. Training programs include required courses that all employees will need to complete ..."	S 301	S 301 techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration and sanitation on 10/3/2024. 2. To correct the deficiency and to ensure the deficiency does not recur all dietary employee files were reviewed for missing training, and those identified completed their training. The executive director and/or designee will provide education to all employees on 9/27/2024 to ensure new hire training is completed within 30 days of hire and all annual training is completed as assigned. The executive director and/or designee will audit employee new hire files and annual training for compliance monthly for 3 months and then randomly to ensure continued compliance. 3. As a part of Lake Andes Senior Livings' ongoing commitment to quality assurance, the executive director and/or designee will report identified concerns through the community's QA process.	

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S 301	Continued From page 8 *" ... courses assigned to the new hire must be completed no later than 30 days from the date of hire."	S 301		
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 8/27/24 through 8/29/24 and from 9/3/24 through 9/5/24. Lake Andes Senior Living was found in compliance.	S 000		