| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435062 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 08/28/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **Alcester Care And Rehab Center, Inc** | **101 CHURCH STREET , ALCESTER, South Dakota, 57001** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0000 | INITIAL COMMENTS<br><br>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/26/25 through 8/28/25. Alcester Care and Rehab Center, Inc. was found in compliance. | F0000 | | |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Tiffany Miller | Administrator | 9/15/2025 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435062 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 08/26/2025 |
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| E0000 | Initial Comments<br><br>A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 8/26/25. Alcester Care And Rehab Center, Inc was found in compliance. | E0000 | | |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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|---|---|---|
| Tiffany Miller | Administrator | 9/15/2025 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435062 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING | (X3) DATE SURVEY COMPLETED 08/26/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Alcester Care And Rehab Center, Inc | 101 CHURCH STREET , ALCESTER, South Dakota, 57001 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT C (EACH DEFICIENCY MUST BE REGULATORY OR LSC IDENTI | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K0000 | INITIAL COMMENTS<br><br>A recertification survey was conducted on 8/26/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Alcester Care And Rehab Center, Inc was found not in compliance.<br><br>The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K222 in conjunction with the provider's commitment to continued compliance with the fire safety standards. | K0000 | | |
| K0222<br>SS = D<br><br>Bldg. 01 | Egress Doors<br><br>CFR(s): NFPA 101<br><br>Egress Doors<br><br>Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:<br><br>CLINICAL NEEDS OR SECURITY THREAT LOCKING<br><br>Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.<br><br>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6<br><br>SPECIAL NEEDS LOCKING ARRANGEMENTS<br><br>Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is | K0222 | Maintenance supervisor has adjusted door to ensure the door latches properly when released. The latch on the door was also removed and reattached to be put on the correct wayto ensure proper mechanicsof the latching of the door.<br><br>All residents had potential to be affected by this deficient practice by not easily being able to open the door.<br><br>Administrator and interdisciplinary team will review and revise the policy and procedure on all egress doors on 9/15/2025.<br><br>Administrator, or designee, will educate maintenance supervisor on requirements of egress doors and all staff will be educated on proper functioning of doors on 09/26/2025 and 10/03/2025.<br><br>Maintenance supervisor, or designee, will complete audits on all doors to ensure proper latching and proper opening two times a week for four weeks and monthly for two more months.<br><br>Maintenance supervisor will present findings at monthly QAPI meetings for three months or until the QAPI committee advises to discontinue monitoring. | 10/10/2025 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Tiffany Miller | Administrator | 9/15/2025 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435062 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING | (X3) DATE SURVEY COMPLETED 08/26/2025 |
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| Alcester Care And Rehab Center, Inc | 101 CHURCH STREET , ALCESTER, South Dakota, 57001 |

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| K0222 SS = D Bldg. 01 | Continued from page 1<br>constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.<br><br>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4<br><br>DELAYED-EGRESS LOCKING ARRANGEMENTS<br><br>Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.<br><br>18.2.2.2.4, 19.2.2.2.4<br><br>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS<br><br>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.<br><br>18.2.2.2.4, 19.2.2.2.4<br><br>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS<br><br>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.<br><br>18.2.2.2.4, 19.2.2.2.4<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on observation, testing, and interview, the provider failed to provide operable egress doors as required at one randomly observed exit door locations (east fire doors). Findings include:<br><br>1. Observation and testing on 8/26/25 at 12:07 p.m. revealed the south leaf of the east cross-corridor fire exit doors was unable to be easily opened. Testing of the door revealed it would not open without applying greater than fifty pounds of force in the direction of the path of egress to the doors push bar. Further testing at that same time revealed the panic bar was not operating the rod to release the latch at the top of the door.<br><br>Interview with the maintenance director at the time of | K0222 | | |

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| K0222 SS = D Bldg. 01 | Continued from page 2 the observation confirmed those conditions. He stated he was unaware that door was not able to be opened and stated it had worked when last tested. | K0222 | | |

South Dakota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 10591 | A. BUILDING: _____ B. WING _____ | 08/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALCESTER CARE AND REHAB CENTER, INC | 101 CHURCH ST ALCESTER, SD 57001 |

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| S 000 | Compliance/noncompliance Statement<br><br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/26/25 through 8/28/25. Alcester Care and Rehab Center, Inc. was found not in compliance with the following requirement: S236. | S 000 | | |
| S 236 | 44:73:04:12(1) Tuberculin Screening Requirements<br><br>Tuberculin screening requirements for healthcare personnel or residents are as follows:<br>(1) Each new healthcare personnel or resident shall receive an initial individual TB risk assessment and the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within twenty-one days of employment or admission to a facility. The qualified personnel must record the assessment and the test in the employee's record or the resident's medical record. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of admission or employment is considered a two-step test. A TB blood assay test completed within a twelve-month period prior to the date of admission or employment is an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare personnel or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin testing having been completed within the prior twelve months. Skin testing or a TB blood assay test is not necessary if documentation is provided by the transferring healthcare facility, healthcare personnel, or resident, of a previous | S 236 | Unable to correct past noncompliance for resident 1 and resident 7 due to time requirementof completionwithin twenty-onedays of admission. All other residents have the potential to be affected by this deficient practice.<br><br>Administrator, or designee, and interdisciplinary team will review and revise as necessary the poicy and procedure for tuberculin screening for new residents on 9/15/2025.<br><br>DON or designee will provide education to all staff responsible for ensuring TB tests are completed in the required timeframe on 9/26/2025 and 10/03/2025.<br><br>DON or designee will perform audits on all new admissions to the facility to ensure there is a TB test completed timely once a week for four weeks and once per month for two more months.<br><br>DON or designee will present findings from these audits monthly for three months at the QAPI meetings for review until the QAPI committee advises to discontinue monitoring. | 10/10/2025 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tiffany Miller | TITLE: Administrator | (X6) DATE: 9/15/2025

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 10591 | A. BUILDING: _____ B. WING _____ | 08/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| S 236 | Continued From page 1<br>positive reaction to either test. Any new healthcare personnel or resident who has a newly recognized positive reaction to the skin test or TB blood assay test must have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Based on record review, interview, and policy review, the provider failed to ensure that one of one sampled resident (7) received his two-step tuberculosis (TB) skin test (a test used to detect the respiratory disease tuberculosis) within 14 days of admission to the facility, according to the provider's policy.<br>Findings include:<br><br>1. Review of resident 7's medical record on 8/28/25 revealed:<br>*He was admitted on 11/18/24.<br>*The first step of the resident's TB skin test was administered on 12/3/24. The results read on 12/5/24 were negative. That was 18 days after his admission.<br>*The second step of the resident's TB skin test was administered on 12/10/24. That was 23 days after his admission.<br><br>2. Interview on 8/27/25 at 3:10 p.m. with administrator A revealed:<br>*Resident 1's two-step TB skin test was not completed within 14 days of his admission to the facility.<br><br>3. Review of the provider's 5/18/25 tuberculosis policy revealed:<br>*"Each new healthcare worker or resident should receive a two-step, TST [Tuberculin Skin Test] within 14 days of employment or admission to the | S 236 | | |

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| | 10591 | A. BUILDING: _____ B. WING _____ | 08/28/2025 |

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| S 236 | Continued From page 2<br>facility." | S 236 | | |