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
	10719SD	A. BUILDING: _____ B. WING _____	09/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SD HUMAN SERVICES CENTER - GERIATRIC PROGR	3515 BROADWAY AVE POST OFFICE BOX 7600 YANKTON, SD 57078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 9/1/26 through 9/3/26. SD Human Services Center-Geriatric Program was found not in compliance with the following requirement: S210.	S 000		
S 210	44:73:04:06 Personnel Health Program The facility shall have a personnel health program for the protection of the residents. Before assignment to duties or within fourteen days after employment, a licensed health professional must evaluate all personnel to ensure no personnel is infected with any reportable communicable disease that poses a threat to others. The evaluation must include an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease that may endanger the health of residents, and fellow personnel may not return to duty until the personnel is determined by a physician, physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee record review and interview, the provider failed to ensure an employee health evaluation was completed and reviewed by a licensed healthcare professional to ensure the employee was not infected with any communicable diseases that would pose a threat	S 210	Travel staff F completed a communicable disease screen on September 2, 2026 that was reviewed by the Director of Nursing. Files for travel staff currently employed were reviewed by the Nursing Home Administrator on September 24, 2026. All temp staff have a completed health evaluation that was reviewed by a licensed healthcare professional as of September 24, 2026. The policy "Employee Health Policy" will be amended on September 25, 2026 by adding that all temporary employees will complete a communicable disease screen that will be reviewed by the Infection Control Nurse or designee. The policy update will be reviewed by the Infection Control Nurse, with a required completion date of September 25, 2026. Nursing Home Administrator or designee will complete audits of new temporary employee files to ensure a communicable disease screening has been completed and reviewed by a licensed healthcare professional. All new hire temporary employee files will be audited until 5 consecutive audits have passed at 100%. Following 5 consecutive audits at 100%, 2 new hire temporary emloyee files will be audited each quarter. When 2 quarters of 100% compliance is achieved, the auditing frequency will be determined by the QAPI Committee. Reports of all audits will be submitted to the QAPI Nurse or designee monthlly and reported to the QAPI Committee monthly.	09/25/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amelia Henderson, NHA — TITLE: Program Director — (X6) DATE: 09/25/2026

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S 210	Continued From page 1 to others within fourteen days of hire for one of one contracted travel staff member reviewed (F). Findings include: 1. Review of contracted travel staff F's employee record revealed she was hired on 7/27/26 as a certified nursing assistant (CNA). There was no documentation in her record that indicated she had a heath evaluation completed and reviewed by a health professional to ensure she was free from communicable disease. 2. Interview on 9/3/26 at 8:08 a.m. with director of nursing (DON) B revealed that the facility did not complete health evaluations for contracted travel staff, including CNA F. 3. Interview on 9/3/26 at 10:17 a.m. with program director A revealed that she expected the contracted travel staff to have health evaluations completed, and stated that not completing those evaluations could put all residents at risk for contracting a communicable disease.	S 210		

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SD HUMAN SERVICES CENTER - GERIATRIC PROGRAM	**3515 BROADWAY AVE POST OFFICE BOX 7600, YANKTON, South Dakota, 57078**

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F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/1/26 through 9/3/26. SD Human Services Center-Geriatric Program was found not in compliance with the following requirements: F655 and F657. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/1/26 through 9/3/26. Areas surveyed included potential resident abuse and resident safety. SD Human Services Center-Geriatric Program was found in compliance.	F0000		
F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services.	F0655	Resident 11's representative was contacted and offered a copy of the resident's baseline care plan on September 23, 2026. Resident 11's baseline care plan was released to the representative on September 25, 2026. Resident 2's baseline care plan was released to the representative on November 6, 2025. All new admissions to the Geriatric Program within the last 21 days were reviewed by the Nursing Home Administrator to ensure a copy of the baseline care plan was provided. The policy "Care Planning for Geriatric Units" was amended on September 26, 2026 to indicate that upon completion of the baseline care plan, the unit nurse or designee will provide a copy to the resident and/or prompt Medical Records to release a copy to the resident representative. After hours, the nurse will review the baseline care plan with the resident representative, if applicable, over the phone and a copy shall be sent the next business day. On September 28, 2026, required reading will be assigned to all nurses with the updated policy and assessment via the facility's policy management system, Policy Tech, with a required completion date of October 5, 2026. Supervisors will ensure staff have completed by October 5, or prior to their next working shift after October 5. Staff who are on leave will complete the required reading and assessment prior to first shift working. QAPI Nurse or designee will complete audits of baseline care plans being shared with the resident/representative upon completion of the baseline care plan. All admission records will be audited until 5 consecutive audits have passed at 100%. Following 5 consecutive audits at 100%, 2 new admission records will be audited each quarter. When 2 quarters of 100% compliance is achieved,	

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
Amelia Henderson, NHA	Program Director	09/26/2026

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F0655 SS = D	Continued from page 1 (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure the baseline care plan (personalized plan that addresses a resident’s care needs, goals, and interventions) was reviewed with, and a copy was offered to, the resident or the resident’s representative within 48 hours of admission to the facility for two of two newly admitted sampled residents (2 and 11). Findings include: 1. Review of resident 11’s electronic medical record (EMR) revealed he admitted to the facility on 12/16/25. There was no documentation that indicated resident 11’s baseline care plan was reviewed with him or his representative, and that a copy of the resident’s baseline care plan was offered to him or his representative within 48 hours	F0655	the auditing frequency will be determined by the QAPI Committee. Reports of all audits will be submitted to the QAPI Nurse or designee monthly and reported to the QAPI Committee monthly.	10/05/2026

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F0655 SS = D	Continued from page 2 of his admission to the facility. 2. Review of resident 2's EMR revealed he admitted to the facility on 11/3/25. There was no documentation that indicated resident 2's baseline care plan was reviewed with him or his representative, and that a copy of the resident's baseline care plan was offered to him or his representative within 48 hours of his admission to the facility. 3. Interview on 9/2/26 at 3:37 p.m. with registered nurse (RN) C revealed that the nurse who admitted a resident was to complete that resident's baseline care plan. The baseline care plan was then to be placed in the resident's paper chart or scanned into the resident's EMR. The nurse who admitted the resident did not review the baseline care plan with the resident or the resident's representative or offer the resident or the resident's representative a copy of the resident's baseline care plan. 4. Interview on 9/3/26 at 9:36 a.m. with director of nursing (DON) B revealed the nurse working in the unit that a new resident admitted to was to complete the resident's baseline care plan. Secretary I was to send a copy of the resident's baseline care plan to the resident's representative and document that in the resident's EMR. 5. Interview and record review on 9/3/26 at 10:23 a.m. with program director A revealed that as of 9/3/26, no baseline care plan had been sent to Resident 11's representative. She verified that a copy of resident 2's baseline care plan was mailed to his state guardian on 11/6/25, not within the 48-hour required time frame. 6. Interviews with RN C and DON B revealed inconsistent understanding of which staff role was responsible for offering and documenting delivery of the baseline care plan. 7. Secretary I was out of the facility and not available for an interview on 9/3/26. 8. Review of the provider's undated Care Plan policy revealed, "A baseline care plan will be developed by the charge nurse or designee within 48 hours." "A	F0655		

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F0655 SS = D	Continued from page 3 copy of the baseline care plan will be provided to the resident and representative." "It will be documented in the EHR [electronic health record] who was provided a copy, how the copy was provided, and if the copy was provided in a language other than English by the person providing the copy."	F0655		
F0657 SS = D	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 record review, interview, and policy review, the provider failed to ensure residents' care plans (a personalized plan addressing a resident's care needs, goals, and interventions) were reviewed and revised to reflect the current care needs for one of one sampled resident (4) who received an anticoagulant (blood thinner) medication, and one of one sampled resident (5) whose care plan did not	F0657	Resident 4's care plan was updated on September 24, 2026 to include a goal and interventions related to the use of an anticoagulant medication. Resident 5's care plan was updated to reflect current code status on September 1, 2026. Care plans will be reviewed and updated, if needed, for all residents receiving anticoagulant medication and for all residents with a DNR code status. The policy "Care Planning for Geriatric Units" was amended on September 26, 2026 to include the unit nurse, or designee will update the care plan with all new orders. Each night, the night nurse will check for new orders from the day and see that the care plan has been updated as needed. If a new order necessitates an update to the care plan and the care plan was not updated, the night nurse will make the update. On September 28, 2026, required reading will be assigned to all nurses with the updated policy and assessment via the facility's policy management system, Policy Tech, with a required completion date of October 5, 2026. On September 28, 2026 all nurses will be re-trained by their assigned charge nurse, or designee, on how to make updates to the care plan in the Electronic Health Record with a required completion date of October 5, 2026. Supervisors will ensure staff have completed the required reading and re-training by October 5, or prior to their next working shift after October 5. Staff who are on leave will complete the required reading and assessment prior to first shift working. QAPI Nurse or designee will complete audits of comprehensive care plans to ensure they accurately reflect the resident's current orders and care needs. One comprehensive care plan will be audited each week until 8 weeks of 100% compliance is achieved. Following 100% compliance for 8 weeks, 2 audits will be conducted each month. When 3 months of 100% compliance is achieved, the auditing frequency will be determined by the QAPI Committee. Reports of all audits will be submitted by the QAPI Nurse or designee monthly and reported to the QAPI Committee monthly.	10/05/2026

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F0657 SS = D	Continued from page 4 reflect his current code status wishes. Findings include: 1. Review of resident 4's electronic medical record (EMR) revealed he admitted to the facility on 7/17/24. His diagnoses included coronary artery disease (a heart condition where waxy plaque builds up inside the coronary arteries, reducing blood and oxygen flow to the heart), left ventricular mural thrombus (a blood clot that forms inside the main pumping chamber of the heart), and current use of long-term anticoagulants. He had a 8/22/24 physician's order for Xarelto (blood thinning medication) 20 milligrams (mg) oral tablet to be administered once daily at bedtime. His 8/7/26 care plan did not indicate he was on an anticoagulant medication. It did not identify goals and interventions regarding the resident's anticoagulant medication use. 2. Review of resident 5's EMR revealed he admitted to the facility on 6/16/25. He had a diagnosis of chronic systolic heart failure (a long-term condition where the heart muscle becomes weak and cannot squeeze hard enough to pump blood forward). He had a 8/4/26 physician's orders for life-sustaining treatment that indicated he had a DNR (do not resuscitate) code status. His 8/28/26 care plan had an intervention and focus area initiated on 7/30/25 that indicated resident 5's code status was a full code (the medical team will use all available life-saving measures to revive a patient if their heart stops or they stop breathing). 3. Interview and EMR review on 9/2/26 with registered nurse (RN) C revealed the nurse's were able to update resident care plans. She expected something to be in the resident's care plan regarding having a risk for bleeding and bruising if a resident was on an anticoagulant medication. The resident's care plans were reviewed by the interdisciplinary (IDT) team which included RN/nurse manager (NM) D, director of nursing (DON) B, and Minimum Data Set (MDS) nurse H. RN/NM D would have been involved in reviewing resident 4 and 5's care plans. She agreed that resident 4's care plan did not include that he used an anticoagulant or interventions that the staff were to monitor him for bleeding risks and symptoms or actions they were to take if those symptoms were observed. 4. Interview and EMR review on 9/2/26 at 4:01 p.m. and 4:06 p.m. with RN/NM D revealed that the	F0657		

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F0657 SS = D	Continued from page 5 facility did not want all the nurses to update the residents' care plans and that the care plans were expected to be updated only by the few nurses who were trained to update them. Resident 4's care plan did not indicate that he received an anticoagulant, risks of anticoagulant use, or interventions related to use of anticoagulant medication use. She agreed that a resident's anticoagulants use should be addressed in the residents' care plan. Care plans were to be reviewed on a quarterly schedule, anytime a resident's medication changed, or when changes occurred, she would go in and update the care plan at that time. When a resident's code status wishes changed, the resident's care plan was to be updated to reflect the resident's current code status. She acknowledged resident 5's care plan was not updated to reflect his current code status. The direct care staff referred to the resident care plan and the DNR list (a list of the resident with their code status identified) to know how to care for the resident's and the resident's code status. 5. Interview on 9/3/26 at 10:08 a.m. with DON B revealed that MDS nurse H was to complete the residents' comprehensive (complete and including all or nearly all necessary details, elements, or aspects of resident care) care plan for residents. RN/NM D was responsible for revising and updating care plans for residents who resided in her assigned unit, which included resident 4 and 5. Care plans were to be updated by RN/NM D with changes and reviewed at least quarterly at the IDT team meetings. She expected changes to be made to the resident's care plan as they occurred. 6. Review of the provider's undated Care Planning policy revealed "It is the policy of SDHSC-Geriatric program that each resident has a person-centered care plan that meets professional standards of quality care. Care plans will be initiated, developed, implemented, and reviewed in accordance with federal regulations. To provide timely instructions for the provision of effective and person-centered care to each resident that meet professional standards of quality and the resident's preferences and goals, and addresses the resident's medical, physical, mental, and psychosocial needs. To promote continuity of care and communication among staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission. To ensure the resident and representative, if applicable, are informed of the plan for delivery of care and services."	F0657		