STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435136	A. BUILDING B. WING	08/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUSTER CARE AND REHAB CENTER	1065 MONTGOMERY ST , CUSTER, South Dakota, 57730

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/4/26 through 8/6/26. Custer Care and Rehab Center was found not in compliance with the following requirements: F578 and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/4/26 through 8/6/26. Areas surveyed included a resident's right to visitation, an elopement, and quality of care related to a resident's fall. Custer Care and Rehab Center was found in compliance.	F0000		
F0578 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 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	F0578	Immediate Action Taken: The code status for resident 16 was verified and entered correctly and consistently into all relevant locations within the electronic medical record. Scope and Impact: Determining the code status of, presence/absence of advanced directives is required for all residents. Therefore, all residents have the potential to be affected. Education and Prevention Measures: The administrator educated the DON, SSD, and all licensed nursing staff beginning August 11, 2026 regarding the regulatory requirements and documentation procedures for Advanced Directives/Code Status. A chart audit of all residents was completed August 11, 2026. Discrepent findings were adressed immediately, and all needed actions were completed by August 17, 2026. Facility policy was created for Communication of Code Status. Upon admission or request for change in Code Status, the DON will collect the required signatures, note in the Medical Record and scan the original directly into the Medical Record at that time. For the purpose of timeliness, 24 hours is allowed from the time of admission or change to have the document signed by the physician. In the absence of an Advance Directive or further direction from the physician, the default will be full code. Ongoing Monitoring: For a period of three months, the SSD will perform weekly audits of new admissions and those residents on the quarterly MDS schedule for consistent documentation of the residents advanced directives/code status and report to the QAA committee monthly. After three months, these audits will be performed monthly and continue to be reported to the QAA committee monthly until such time it is determined that substantial compliance is maintained.	08/23/26

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
Madison L Barta	Administrator	08/21/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUSTER CARE AND REHAB CENTER	1065 MONTGOMERY ST , CUSTER, South Dakota, 57730

(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
F0578 SS = D	Continued from page 1 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 interview, record review, and policy review, the provider failed to ensure that a resident's advance directive (a legal document that expresses a person's health care wishes if they become unable to speak for themselves) and code status (specifies the type of emergent treatment a person wishes to receive if their heart or breathing would stop) were accurately documented to reflect the resident's chosen wishes for one of one sampled resident (16) with documented code status discrepancies. Findings include: 1. Interview on 8/4/26 at 10:42 a.m. with resident 16 in her room revealed she resided at the facility since July 2026. She was "rehabbing" after a hospitalization and hoped to regain strength and return to living at home with her husband. 2. Review of resident 16's electronic medical record (EMR) revealed that she admitted to the facility on 7/2/26. Her 7/2/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. There was a banner displayed in her EMR, which indicated she did not want CPR (cardiopulmonary resuscitation, an emergency procedure to provide chest compressions and often rescue breathing to preserve brain function and maintain blood circulation). Her 7/2/26 baseline care plan (a short-term, personalized plan to address care needs, developed within 48 hours of a resident's admission) indicated her code status was DNR (do not resuscitate). She had a 7/8/26 physician's order for DNR. There was no advance	F0578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0578 SS = D	Continued from page 2 directive form in her EMR. A copy of her advance directive was requested. 3. Review of resident 16's signed 7/2/26 advance directive revealed that she wanted CPR and full resuscitative measures. 4. Interview on 8/5/26 at 3:19 p.m. with administrator A and director of nursing (DON) B revealed that the facility did not use paper charts for the residents. Their process for advance directives was that the scheduled nurse was responsible for having the advance directive form signed by the resident or the resident's representative. That form was then to be placed in a folder for the resident's physician to sign. After the physician signed the form, the nursing staff were to enter the order into the resident's EMR. The business office manager was then responsible for scanning the advance directive into the resident's EMR. 5. Interview on 8/6/26 at 9:17 a.m. with registered medication aide (RMA) H revealed that she confirmed no paper charts were used and that all resident care information and orders were documented in the resident's EMR. 6. Interview and EMR and documentation review on 8/6/26 with DON B revealed that she acknowledged resident 16's code status in her EMR did not match her wishes on her signed advance directive form. She acknowledged that without the advance directive form being scanned into the EMR, the staff would not be able to verify that the code status matched the resident's advance directive, and stated, "I think we have an opportunity to tighten up that process." She acknowledged that the facility's policy that addressed advance directives was not specific about the process for obtaining and documenting residents' advance directives. 7. Review of the provider's 12/7/23 Admission, Transfer, and Discharge Policy and Procedure revealed, "At the time of admission, the facility will have the physician's orders for the resident's immediate care, consistent with the resident's present physical and mental status. Minimal content of these orders will include a list of diagnosis, medication, advanced directives, diet order, therapy order, and routine care to maintain or improve functional capabilities; until the comprehensive	F0578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUSTER CARE AND REHAB CENTER	1065 MONTGOMERY ST , CUSTER, South Dakota, 57730

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F0578 SS = D	Continued from page 3 assessment is conducted and the interdisciplinary care plan is developed."	F0578		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F0880	Immediate Action Taken: On August 5, 2026 the maintenance manager removed the ice and water dispenser from the facility to address the concerns identified during the survey. The action was verified by the administrator through visual inspection. Maintenance was informed of his resposibilities by the adminsitrator and completed the removal of the machine in its entirelty, including all lines leading to the machine, with the correspond ng shut off valves closed. Scope and Impact: The facility has determined that all residents have potential to be affected. Education and Prevention Measures: On August 13, 2026 the DON implemented education for all facility staff regarding the removal of the ice and water dispenser, emphasizing that all ice must now be obtained from the kitchen per facility policy. Additionally, on August 13, 2026 the DON will update its infection control plan to include the newly established Ice Machines and Portable Ice Carts policy, which outlines the procesure for obtaining ice and upkeep of ice machines. Ongoing Monitoring: For a period of three months, the Certified Dietary Manager will report to the QAA committee on cleaning and maintenance of the ice machine. After the period of three months, the QAA committee will request random audits until such time it is determined that substantial compliance is maintained.	08/23/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = D	Continued from page 4 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure standard infection control practices were followed for the cleaning of one of one water and ice dispenser located in a passthrough room between the 200 and 400 hallway. Findings included: 1.Observation on 8/5/26 at 2:30 p.m. revealed the water and ice dispenser had visible residue and buildup. The wire rack had white buildup on top, around the sides, and underneath. A brown-colored substance was observed underneath the wire rack, floating in the water. One of the pipes leading from the water into the interior of the dispenser had approximately one inch of white-tan crusted film wrapped around it. Inside the ice dispenser, there was one half of an inch of white film up the inside of the dispenser with streaks running the full length of the interior surface. Additionally, inside the water and ice dispenser, a piece of white-tan crusted film approximately two inches in length was observed lying on a metal component.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0880 SS = D	Continued from page 5 2. Interview on 8/5/26 at 2:40 p.m. with certified nursing assistant (CNA) F revealed she was employed at the facility since 4/29/25 and had never observed the water and ice dispenser being cleaned. She stated the staff use the dispenser to provide water and ice for the residents. 3. Interview on 8/5/26 at 2:52 p.m. with maintenance manager C regarding the water and ice dispenser revealed he was unaware that cleaning the water and ice dispenser was his responsibilities and he had never cleaned it. 4. Interview on 8/5/26 at 3:05 p.m. with director of nursing (DON) B revealed she was unsure who was responsible for cleaning the water and ice dispenser. She had observed the direct care using the dispenser to provide ice and water to the residents. She was aware of the above observed condition of the water and ice dispenser. 5. Interview on 8/5/26 at 4:33 p.m. with registered medication aide (RMA) E revealed she had informed maintenance manager C multiple times about how dirty the water and ice dispenser was. 6. Interview on 8/6/26 at 11:00 a.m. with administrator A regarding the water and ice dispenser revealed maintenance manger C was responsible for cleaning the water and ice dispenser. She provided him with a daily task list that remained unchanged, with different tasks from what needed to be done, and it does not get changed unless she updated it, and if the water and ice dispenser was not included on that list, he would not have known it needed to be cleaned. She agreed the dispenser should have been cleaned. 7. Review of the provider's December 2023 Infection Control Plan policy revealed it did not include education or procedures regarding cleaning the water or ice dispenser as part of infection control practices.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUSTER CARE AND REHAB CENTER	1065 MONTGOMERY ST , CUSTER, South Dakota, 57730

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 8/4/26. Custer Care and Rehab Center was found in compliance.	E0000		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Madison L Barta	Administrator	08/13/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435136	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 08/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUSTER CARE AND REHAB CENTER	1065 MONTGOMERY ST , CUSTER, South Dakota, 57730

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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 8/4/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Custer Care and Rehab Center was found in compliance.	K0000		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Madison L Barta	Administrator	08/13/26

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
	80076	A. BUILDING: _____ B. WING _____	08/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUSTER CARE AND REHAB CENTER	1065 MONTGOMERY ST CUSTER, SD 57730

(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 8/4/26 through 8/6/26. Custer Care and Rehab Center was found not in compliance with the following requirement: S301.	S 000		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for all dietary or food-handling personnel. The training must include the following subjects: (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee record review, interview, and policy review, the provider failed to ensure one of one newly hired dietary employee (cook G) completed the required dietary orientation training within 30 days of her hire date. Findings include: 1. Review of cook G's employee record revealed	S 301	Immediate Action Taken: Training requirements reviewed with Cook G by the Certified Dietary Manager. Scope and Impact: All residents have the potential to be impacted by proper training of dietary and food handling services. Education and Prevention Measures: The CDM was educated by the administrator on August 13 regarding the facilities expectations for new hire and annual training in accordance with state and federal regulations. An orientation checklist that aligns with these requirements was created for future use. Ongoing Monitoring: For a period of three months, the CDM will perform monthly audits of new hire and annual trainings completed. These audits will be reported to the QAA committee monthly. After the period of three months, these audits will be completed quarterly by the CDM and reported to the QAA committee once per quarter until such time it is determined that substantial compliance is maintained.	08/23/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Madison L Barta	Administrator	08/13/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80076	A. BUILDING: _____ B. WING _____	08/06/2026

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S 301	Continued From page 1 she was hired on 4/13/26. She completed the required handwashing training on 4/18/26 and the required nutrition and hydration training on 4/21/26. There was no documentation that she completed the required training related to food safety, food handling and preparation, foodborne illnesses, serving and distribution, leftovers, time and temperature controls, and sanitation within 30 days of her hire date. 2. Interview on 8/6/26 at 9:36 a.m. with food and nutrition services manager D revealed that she was aware newly hired employees were to complete the required orientation training topics within 30 days of their hire date. She stated that those topics were reviewed during her one-on-one training session with the new hires, but the training was not documented. 3. Interview on 8/6/26 at 1:25 p.m. with administrator A regarding the dietary training revealed she expected the dietary department to follow the standards and procedures of the facility which included completing the required orientation training within 30 days of a new employee's hire date. 4. Review of the provider's revised July 2024 Required Education policy revealed, "Required education and training includes, but is not limited to New Employee Orientation, Annual Safety and Compliance, all state and federal regulatory agency requirements." "d. System-wide due dates for required education will be determined by the Required Education Advisory Committee, unless determined by a regulatory agency."	S 301		