STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435134	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST MARTIN VILLAGE	4825 JERICHO WAY RAPID CITY, SD 57702

(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 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/24/25 through 3/27/25. Good Samaritan Society - St Martin Village was found not in compliance with the following requirements: F561, F657, F658, F700, F725, F745, F755, F759, F761, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/24/25 through 3/27/25. Areas surveyed included quality of care and quality of treatment related to a resident's fall. Good Samaritan Society - St Martin Village was found in compliance.	F 000		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.	F 561	Unable to correct prior deficient practice. Resident 20, 13, 28, 18, 15, 42, and 306 have all had their sit-stand- walk data collection tool user defined assessment updated. All information gathered from the assessment has been updated on their care plan with their choices of bathing. All residents have the potential to be at risk when their bathing choices aren't being followed. Education will be provided by the Director of Nursing or designee to all nursing staff on resident's rights and ensuring that resident's requests are being followed. All residents had the sit-stand-walk data collection tool user defined assessment updated. Bathing preference will be addressed at time of admission and follow up during initial care conference for compliance. Director of Nursing or designee will audit completion of bathing preferences on up to 5 residents weekly x3, every other week x3, and monthly x3. Director of Nursing or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Director of Nursing or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	5.9.25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jana McCroden	Senior Director	4.18.25

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 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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§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.

§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and policy review, the provider failed to support residents' right to choose and receive the frequency and type of shower or bath consistent with their preferences for 7 of 17 sampled residents (20, 13, 38, 18, 15, 42, and 306).
Findings include:

1. Interview on 3/24/25 at 3:30 p.m. with resident 20's daughter/power of attorney (POA) revealed:
*Resident 20 was scheduled for a bath weekly.
*She previously was bathed twice weekly but resident 20's daughter/POA was told she no longer received twice weekly baths because there was not enough staff to accommodate that.

Review of resident 20's electronic medical record (EMR) revealed:
*She was admitted on 7/22/20.
*Her 2/17/25 Brief Interview of Mental Status (BIMS) assessment score was 6, which indicated she had severe cognitive impairment.
*She was documented to have been bathed weekly.
*Her Sit-Stand-Walk Data Collection Tool assessment indicated she preferred two or more baths per week.

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F 561	Continued From page 2 *Resident 20's 3/26/25 care plan did not address her preference to receive two or more baths per week. 2. Interview on 3/24/25 at 5:04 p.m. with resident 13 revealed: *She was bathed once weekly. *She had notified facility management that she would like to bathe more than once weekly but was told she could not because there was not enough staff. Review of resident 13's EMR revealed: *She was admitted on 2/21/20. *Her 2/4/25 BIMS assessment score was 15, which indicated she was cognitively intact. *She was documented to have been bathed weekly. *Her Sit-Stand-Walk Data Collection Tool assessment indicated she preferred two or more baths per week. *Resident 13's 3/26/25 care plan did not address her preference to receive two or more baths per week. 3. Interview on 3/25/25 at 11:32 a.m. with resident 38 revealed: *She usually received her bath weekly. *She had not received a bath in the past week. *She had not refused her bath for a "long time". Review of resident 38's EMR revealed: *She was admitted on 5/3/23. *Her 2/20/25 BIMS assessment score was 15, which indicated she was cognitively intact. *Her Sit-Stand-Walk Data Collection Tool assessment indicated she preferred one bath per week. *There was no documentation that indicated she	F 561		

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had been bathed since 3/15/25.
-She had not received a bath within the last 10 days.

4. Interview on 3/24/24 at 2:28 p.m. with resident 306 and his daughter in his room revealed:
*Resident 306 stated he always had to ask for a bath.
*He was told by staff, "I'll be right back to give you a shower" and three hours later he still hadn't had one.
*He stated, "They always say we're short-staffed."
*He stated he wanted a shower but "they talked me into a bath."
*His daughter stated she would like for him to "get on a bath schedule."

Review of resident 306's EMR revealed:
*He was admitted on 2/11/25.
*His 2/12/25 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated he was cognitively intact.
*His 2/11/25 Sit-Stand-Walk Data Collection Tool assessment indicated he preferred two or more baths per week.
*His 2/11/25 care plan did not address his preferences for type or frequency of bathing.
*From 2/23/25 to 3/25/25 he had documented bathing on 3/3/25, 3/5/25, 3/10/25, and 3/20/25.

A follow-up interview on 3/26/25 at 4:13 p.m. with resident 306 and his wife in his room revealed:
*His wife stated, "One bath a week is not enough."
*He stated he had previously shared his concerns about not getting a shower with the social worker.

5. Interview on 3/24/25 at 3:02 p.m. with resident 15 in her room revealed:

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*She stated, "I didn't get a bath last week, and they're working on getting one for this week."
*She stated, "It does not feel like there's enough help here."

Review of resident 15's EMR revealed:
*She was admitted on 1/20/25.
*Her 1/21/25 BIMS assessment score was 15, which indicated she was cognitively intact.
*Her 1/20/25 Sit-Stand-Walk Data Collection Tool assessment indicated she preferred one bath per week.
*From 2/23/25 to 3/25/25 she had a bed bath documented on 2/27/25, 3/6/25, and 3/13/25.
*It was documented that she refused a bath on 3/20/25.
*There was no documentation that indicated she had been bathed since 3/13/25, 12 days prior.

A follow-up interview on 3/26/25 at 4:36 p.m. with resident 15 in her room revealed:
*She did not refuse a bath last week.
*She would prefer two or three baths per week.

6. Interview on 3/24/25 at 3:26 p.m. with resident 18 in her room revealed:
*She was supposed to get a bath that day but did not.
*She was told by staff that they would "try to get her a bath tonight."

Review of resident 18's EMR revealed:
*She was admitted on 8/21/24.
*Her 9/13/24 BIMS assessment score was 12, which indicated she was moderately cognitively impaired.
*Her 2/27/25 Sit-Stand-Walk Data Collection Tool assessment indicated she preferred one bath per week.

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*She had documented baths on 3/3/25, 3/10/25, 3/19/25, and 3/24/25, all at 2:14 p.m.
-The bath that was documented on 3/24/25 at 2:14 p.m. was the same day she said that she was supposed to get a bath but did not and was told by staff that they would try to get her a bath that night.

A follow-up interview on 3/26/25 at 4:42 p.m. with resident 18 regarding her preferences revealed she would like to have a bath every day if possible.

7. Interview on 3/24/25 at 4:14 p.m. with resident 42 in her room revealed:
*She stated, "We only get a bath once a week because they're short on help."
*She would prefer more frequent baths.

Review of resident 42's EMR revealed:
*She was admitted on 2/17/25.
*Her 2/18/25 BIMS assessment score was 12, which indicated she was moderately cognitively impaired.
*Her 2/17/25 Sit-Stand-Walk Data Collection Tool assessment indicated she would like two or more baths per week.
*She had a 2/24/25 physician order for two baths per week.
*From 2/23/25 to 3/25/25 she had baths documented on 3/4/25, 3/10/25, and 3/17/25.

8. Review of the provider's grievances from 1/16/24 through 2/26/25 revealed:
*There were five grievances filed on behalf of four separate residents related to not receiving baths consistent with their preferences.
*Documented resolutions to those grievances included the provider:

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-Indicated what days baths were scheduled.
-Educated staff on following the bath schedule.
-Followed up with the resident in writing that they would try to accommodate a preference for two baths per week but did not schedule the resident for two baths.
-Followed up with family and indicated the resident is getting baths.
-Followed up with family and indicated the resident remains on a bathing schedule.

9. Interview on 3/26/25 at 1:45 p.m. with Clinical care leader (CCL)/infection preventionist (IP) D regarding resident bathing revealed if no bath aide was available the certified nursing assistant (CNA) that was working on the floor providing resident cares would be responsible to provide the resident's bathing according to the bath schedule.

10. Interview on 3/26/25 at 2:25 p.m. with Minimum Data Set (MDS) nurse C revealed:
*The resident preferences related to bathing was documented in the Sit-Stand-Walk Data Collection Tool assessment in the EMR.
-MDS nurse C completed this assessment quarterly.
*CCL/IP D maintained the resident bath schedule and MDS nurse C believed she went by the preferences documented on the Sit-Stand-Walk Data Collection Tool assessment to make the bath schedule.
*It was her expectation that the preferences documented in the Sit-Stand-Walk Data Collection Tool assessment be followed when scheduling the resident's bathing.

11. Interview on 3/27/25 at 8:01 a.m. with CNA M revealed:

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F 561	Continued From page 7 *She was usually scheduled as a bath aide when she worked. *If a resident refused a bath, the bath aide was to ask again later that day. If the resident refused again, the bath aide was to ask another staff member to approach the resident for a bath or the evening staff was to attempt to give that resident a bath. *She rarely had a resident refuse their scheduled bathing. *Residents usually received one bath per week. *There were times the bath aide was reassigned to work as a CNA on the floor to provide resident cares. *If the bath aide was reassigned to the floor each CNA would be responsible to complete the resident's bathing according to the bathing schedule. *She thought the bath aide was reassigned to work the floor at least one day per week. *If a resident requested more than one bath per week, staff were to attempt to accommodate the request, and the bathing schedule and the resident's care plan were to be updated to reflect the request. 12. Interview on 3/27/25 at 8:22 a.m. with CNA P regarding resident bathing revealed: *There was a resident bathing schedule located in the nurses' station. *The residents' baths were to be completed by the CNA assigned to provide resident bathing for that shift. *There were times when a bath aide was not scheduled to work. *There were times the bath aide was reassigned to work on the floor to provide resident care. *If there was no bath aide scheduled the "float" CNA would usually complete the resident baths.	F 561		

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*If there was no float or a bath aide the CNAs assigned to work on the floor were to complete the baths scheduled for that day.
*In the last three weeks, on the days he had worked, there had been three or four times when no bath aide was available to complete the assigned residents' baths and the CNA that was providing direct care was responsible to provide the resident on their assignment with their bath.

13. Interview on 3/27/25 at 10:16 a.m. with CCL/IP D regarding resident bathing revealed:
*She maintained the resident bathing schedule.
*The resident baths were scheduled on the treatment administration record (TAR) and in the tasks in the EMR.
*The bathing schedule may change according to resident requests.
*She indicated the residents were interviewed regarding their bath preferences.
*She was not aware who completed the interview, when the interviews were to be completed, or where to locate the information obtained during the interview.
*Residents could discuss their concerns and preferences with staff or during care conferences.

14. Interview on 3/27/25 at 10:37 a.m. with administrator A regarding resident choices revealed it was her expectation that staff do their best to accommodate resident choices.

15. Interview on 3/27/25 at 12:18 p.m. with director of nursing (DON) B regarding resident bathing revealed she expected staff to follow the bathing schedule.

16. Review of the provider's 2016 Resident's Rights for Skilled Nursing Facilities revealed:

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F 561	Continued From page 9 *"The resident has the right to be informed of, and participate in, the development and implementation of his or her person-centered plan of care, including, but not limited to: -The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency and duration of care and any other factors related to the effectiveness of the plan of care." *"The resident has the right to be treated with dignity including: -The right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when to do so would endanger the health or safety of the resident or other residents." *"The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice. -The resident has a right to choose activities, schedules (including sleeping and waking times), healthcare and providers of healthcare services consistent with his or her interests, assessments and plans of care. -The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident." *"Services included in Medicare or Medicaid payment. -Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, ...hair and nail hygiene services, bathing assistance, ..." 17. Review of the provider's 12/02/2024 Grievances, Suggestions, or Concerns-Rehab/Skilled policy revealed: *"Purpose	F 561		

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F 561	Continued From page 10 -To document concerns, investigative findings and plans of correction. -To develop a systematic approach in resolving grievances as a tool to ensure continuous quality of care." *"Policy -A resident has the right to voice grievances orally, in writing and anonymously without discrimination or reprisal. Such grievances, complaints or concerns include those with respect to treatment that has been furnished, as well as those that have not been furnished." -"Grievances, suggestions and concerns are to be deemed high priority customer satisfaction issues. Facility staff will make prompt efforts to resolve a grievance and keep the resident/resident representative apprised of progress toward resolution."	F 561	Unable to correct prior deficient practice. Resident 1, 51 and 6 all had their care plans updated. Resident 51 has discharged from the facility. All residents have the potential to be at risk when their care plans are not updated per policy. Education will be provided by the Director of Nursing or designee to the interdisciplinary team on updating care plans and the care plan policy. Care plan updates will be addressed in morning clinical meeting. Director of Nursing or designee will audit up to 5 residents for completion of care plans weekly x3, every other week x3, and monthly x3. Director of Nursing or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Director of Nursing or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	5.9.25
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	F 657		

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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 two of eight sampled residents' (1 and 51) care plans were revised to reflect their current status and care needs. Findings include:

1. Observation and interview on 3/24/25 at 3:13 p.m. with resident 51 and his spouse revealed:
*The resident's room was without any personal items from home.
*He was admitted to the facility after back surgery. He had a complicated and extensive hospitalization.
*His goal was to return home with his spouse after his rehabilitation stay at the facility.
*His pain had improved since he was admitted to the facility.
*The resident's affect was flat.
*In early March 2025, the resident's medical provider had recommended he see a counselor for his worsening depression.
-The resident's spouse had asked that a male counselor see the resident. She was told there were no male counselors available to have met with the resident. No other counseling alternatives had been discussed with her or the resident.

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GOOD SAMARITAN SOCIETY - ST MARTIN VILLAGE	4825 JERICHO WAY RAPID CITY, SD 57702

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F 657	Continued From page 12 Interviews on 3/25/25 at 2:00 p.m. and on 3/26/25 at 4:45 p.m. with resident 51 in his room revealed: *He had a history of depression and was taking an anti-depressant medication. He had increased depressive symptoms since he was admitted to the facility. -He had lost weight because "nothing tasted good." He had feelings of "imprisonment," and a sense of "loss of control" of his body. He was a "loner" and remained in his room most of the time. *His spouse had visited him regularly and a few friends had also visited him. -It had felt good "to unload" how he was feeling with his friends. *At home, the resident had enjoyed sitting in his own recliner and using his home computer. Having personal items that surrounded him at home brought him "joy." Review of resident 51's electronic medical record (EMR) revealed: *He was admitted on 2/10/25. *His 3/26/25 Brief Interview for Mental Status assessment score was 13 which indicated he had little or no cognitive impairment. *His 2/11/25 PHQ-9 (Patient Health Questionnaire - a self-report tool used to assess depression symptom severity) assessment score was 8 which indicated he had mild depression. *His anti-depressant medication was increased on 2/19/25. Review of resident 51's care plan revealed: *Interventions related to the resident's risk for an alteration in his mood and psychosocial well-being were initiated on 2/10/25 and included: -"Adjust environment to promote comfort i.e.	F 657		

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room temperature, furniture arrangement, lighting, personal belongings.
-CSW [certified social worker] to initiate referrals as needed/indicated.
-Depressive symptoms: Encourage positive conversation during cares and interactions, offer praise and encouragement, empathize with feelings and concerns.
-Provide opportunities for resident to engage in meaningful conversation and activities with others.
-Staff to monitor and provide ongoing conversation regarding routine and preferences."
*No revisions were made to those interventions since they were initiated.
*Interventions related to the resident's depression diagnosis initiated on 2/25/25 and revised on 3/3/25 included:
-"Consult with pharmacy, healthcare provider, etc. to consider dosage reduction when clinically appropriate.
-Depression: attempt non-pharmacological interventions such as one-one [one on one] visits, offer counseling if agrees, monitor for adverse effects of medications and effectiveness of medications."
*Interventions related to the resident's use of anti-depressant medication were initiated on 2/10/25 and included "Monitor resident condition based on clinical practice guidelines or clinical standards of practice r/t [related to] use of Sertraline [anti-depressant medication]."

Interview on 3/28/25 at 9:10 a.m. with social service directors (SSD)/CSW I and J revealed:
*SSD/CSW J had documented the above care plan interventions related to resident 51's risk for a decline in his mood and psychosocial well-being.

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*She stated those interventions were generic.
-She was expected to have revised the interventions to ensure they had been "person-centered" and individualized to have reflected the current and ongoing needs of resident 51 during his nursing home stay.
*Her care plan had not reflected:
-What individualized accommodations were to have been offered or made to improve the resident's environmental comfort.
-If any counseling service referrals had been made or services provided.
-How staff were to attempt to engage the resident in meaningful conversation and activities.
-SSD/CSW J stated the one-on-one visits with the resident would have been her responsibility to have implemented and documented. She had not known about that intervention so there had been no follow-up.
*Care plan interventions related to resident 51's anti-depressant medication monitoring and depression diagnosis had been documented by minimum data set (MDS) nurse C.

Interview on 3/28/25 at 1:10 p.m. with MDS nurse C regarding resident 51's care plan revealed she:
*Had documented the interventions on his care plan related to depression and anti-depressant medication use monitoring.
*No monitoring tool had been implemented to measure the type and frequency of resident 51's depression symptoms.
-Should have identified the staff person responsible for implementing that intervention on the care plan and communicated that responsibility to them.
*Agreed the intervention related to a medication dose reduction should have been updated to reflect the resident had an increase in his

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anti-depressant medication. A dose reduction was currently contra-indicated.
*Had not known if the one-on-one visits she had referred to in her interventions were implemented.
-Should have identified the staff person responsible for implementing that intervention on the care plan and communicated that responsibility to them.

2. Observation and interview on 3/24/25 at 4:04 p.m. with resident 6 in her room revealed:
*There was a cushion in her wheelchair.
*She reported she had a "sore" on her buttocks that staff was applying cream to.
*There was no PPE in her room or outside the door to her room.

Interview on 3/24/25 at 5:19 p.m. with registered nurse (RN) F regarding resident 6's skin revealed:
*She previously had a pressure ulcer to her right heel that was healed.
*She had some excoriation (skin was scraped off) on her buttocks that the CNAs were applying a cream to.

Review of resident 6's 3/26/25 care plan revealed:
*A focus area of "The resident has respiratory infection: Covid 19".
-A intervention for the focus area was, "DROPLET and CONTACT PRECAUTIONS: Wear gowns, gloves, N95 masks (if available), and eye protection when changing contaminated linens. Bag linens and close bag tightly before taking to laundry. Isolation x10 days dx [diagnosis].
*A focus area of "The resident requires Enhanced

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F 657	Continued From page 16 Barrier Precautions R/T [related to] wounds. -An intervention for the focus area was, "Don [put on] gown and gloves when performing high contact care activities including: dressing, bathing, transferring, providing hygiene such as shaving or brushing teeth, changing linens, repositioning, checking and changing, device care, and/or use, and wound care." 3. Interview on 3/26/25 at 10:37 a.m. with RN S regarding resident 6 revealed: *Her right heel wound had resolved "almost" three weeks ago, and she was no longer on EBP for this. *She had COVID over a month ago and was no longer on transmission-based precautions. 4. Interview on 3/36/25 at 8:22 a.m. with Minimum Data Set (MDS) nurse C regarding care plans revealed: *She was responsible for updating resident care plans with each resident's MDS assessment. *Anyone on the interdisciplinary team could update resident care plans. *Clinical care leader (CCL)/infection preventionist (IP) D was responsible for updating resident care plans that addressed resident wounds or infections. *It was her expectation that care plan updating be an ongoing process and occur any time there was a change in resident condition or care. *Resident 6's care plan had not been updated after the resolution of her right heel wound and after she was taken off transmission-based precautions for COVID. 5. Interview on 3/26/25 at 1:58 p.m. with CNA O revealed: *She was a travel CNA and had recently been	F 657		

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F 657	Continued From page 17 assigned to this facility. *She indicated she referenced a resident's care plan or Kardex (a report of residents' care needs and interventions) to determine what cares were to be provided for a resident and how to provide the cares. 6. Interview on 3/27/25 at 10:16 a.m. with CCL/IP D regarding care plans revealed: *She was responsible for updating residents' care plans related to infections, wounds, transmission and enhanced barrier precautions. *Care plan updating was a working interdisciplinary team collaboration. *Care plans should be updated anytime there was a change in resident condition or care needs in addition to quarterly. *She agreed resident 6's care plan was not up to date and should have been. 7. Interview on 3/27/25 at 12:18 p.m. with director of nursing (DON) B regarding care plans revealed: *It was the responsibility of the nurses, clinical team, and herself to update resident care plans. *She expected resident care plans to be updated anytime there was a change in the residents' plan of care. Review of the provider's 12/2/24 Care Plan policy revealed: *"Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. Any problems, needs and concerns identified will be addressed through use	F 657		

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F 657	Continued From page 18 of departmental assessments, the Resident Assessment Instrument (RAI) and review of the physician's orders." *"The plan of care will be modified to reflect the care currently required/provided for the resident." Review of the provider's 4/2/24 standard and transmission based precautions policy and procedure revealed that the use of EBPs was indicated for residents with: *"Chronic wounds (pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous statis ulcers) and residents with indwelling medical devices,)central lines, hemodialysis catheters, indwelling urinary catheters, feeding tubes, and tracheostomies)." *"EBP are also needed for residents with centers for disease control and prevention (CDC) targeted and epidemiologically important (facility discretion) MDRO infection and colonization, when contact precautions do not apply." multi-drug-resistant organisms (MDRO) when contact precautions do not otherwise apply." *"High contact resident care activities include transfers, dressings, assisting during bathing, providing hygiene, changing briefs or assisting with toileting, working with resident in therapy gym, specifically when anticipating close physician contact while assisting with transfers and mobility, changing linens, device care or use." Review of the provider's 10/30/24 infection, prevention and control program policy and procedure revealed: *Purpose -"To establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable	F 657		

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F 657	Continued From page 19 environment and to help prevent the development and transmission of communicable diseases and infections." *"Infection prevention and control program is a program that prevents, identifies, reports, investigates, and controls infections and communicable diseases for all residents, staff, and visitors, following nationally accepted standards and guidelines."	F 657	Unable to correct prior deficient practice. Resident 20's medication record has been updated. All residents who receive medication have the potential to be at risk when medication administration and order completion is not followed per policy. Medical director notified of deficient practice and omissions. Education will be provided by the Director of Nursing or designee to all nursing staff on ensuring all physician's orders are being followed per policy. Night shift will second check each order to ensure that it is entered into the MAR/TAR for completion. Director of Nursing or designee will audit up to 5 residents for completion of physician's orders weekly and audit for Unavailable medications with proper physician notification x3, every other week x3, and monthly x3. Director of Nursing or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Director of Nursing or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	5.9.25
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, observation, interview, and policy review, the provider failed to ensure: *The physician was notified of medications not administered due to unavailability as directed in the provider's policy for one of one sampled resident (20). *A physician's order to take vital signs every six hours was followed for one of one sampled resident (38) for an infection. Findings include: 1. Review of resident 20's medication administration record (MAR) revealed: *She had physician's order for "Benefiber Oral Tablet Chewable (Wheat Dextrin) [fiber supplement] 1 tablet by mouth in the morning for constipation related to DRUG INDUCED CONSTIPATION". -In March 2025 resident 20's Benefiber was	F 658		

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documented not available 13 times.
--Unlicensed medication aide (UMA) L had documented all the medication not available in March 2025 for the Benefiber.
*She had a physician's order for "Citracal Plus Tablet (Multiple Minerals-Vitamins) [calcium with vitamin D supplement] 1 tablet by mouth one time a day related to VITAMIN D DEFICIENCY".
-Resident 20's Citracal was documented as not available on 3/24/25 and 3/25/25 by two different UMAs.

2. Observation on 3/26/25 at 10:15 a.m. of the medication cart revealed:
*There was a bubble-pack medication card with one Citracal tablet in a bubble, and one empty bubble.
-The dispensed date on the Citracal card was 3/25/25.
*There was a bottle of Benefiber powder with a dispensed date of 1/10/24 and was labeled with "#4".
-The bottle was unopened.
*There was no medication card that contained Benefiber tablets.

3. Interview on 3/26/25 at 10:25 a.m. with UMA L revealed:
*The monthly medication delivery for all medication carts was scheduled for 3/27/25.
*The Citracal had been received from the pharmacy with 28 tablets in February, which left the facility two tablets short for the month.
*UMA L had requested the Citracal from pharmacy on 3/23/25 and 3/25/25 and both times she had indicated on the medication request that the facility had no remaining tablets for administration.
*UMA L stated that she had documented the

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Benefiber as unavailable because the medication order was for a tablet and the medication available in the medication cart was the powder.
*She explained that resident 20 had previously been on the Benefiber tablets but per her daughter's request the order had been changed to the Benefiber powder.
*When resident 20 was returned from a hospital admission the order was changed back to a tablet.
*UMA L indicated she had alerted Minimum Data Set (MDS) nurse C and registered nurse (RN) F of the Benefiber order being for a tablet instead of the powder when resident 20 was readmitted to the facility from the hospital.

4. Review of pharmacy Medication Reorder Sheet revealed:
*A 3/23/25 Medication Reorder Sheet which indicated Resident 20's Citracal had been reordered from the pharmacy by fax at 1:36 p.m.
-The reorder form also indicated there were no tablets that remained for administration.
*A 3/25/25 Medication Reorder Sheet which indicated Resident 20's Citracal had been reordered from the pharmacy by fax at 12:14 p.m.

5. Review of resident 20's electronic medical record (EMR) revealed:
*Resident 20's 2/12/25 readmission orders indicated the Benefiber order as, "wheat dextrin 3 gram/3.5 gram powder 1 dose by mouth daily."
-The order was entered as "Benefiber Oral Tablet Chewable (Wheat Dextrin) [fiber supplement] 1 tablet by mouth in the morning for constipation related to DRUG INDUCED CONSTIPATION".
-The order was entered and cosigned by MDS C and RN S.
*A 3/24/25 progress note indicated the Citracal

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Plus tablet was "currently unavailable, pharmacy contacted and awaiting delivery".
*There was no documentation that indicated the physician was notified regarding the Citracal or the Benefiber not having been given related to the medication not having been available.

6. Interview on 3/26/25 at 5:04 p.m. with MDS nurse C regarding medication orders revealed:
*If a staff came to her with a medication question, she would help the staff "figure out" the order.
*She would look at the original order and compare it to the MAR and the pharmacy label.
*She was not previously aware of the Benefiber order being a tablet and the medication available in the medication cart was a powder.
*She indicated that if the medication order was for a tablet and the facility had the medication as a powder, she would agree that the medication was not available for administration.
*She expected the pharmacy to have been notified of the medication not being available and to request the form of the medication that was indicated on the order.
-The pharmacy typically was able to provide the medications requested the same day the medication was ordered.
*It was her expectation that the physician would have been notified the medication was not administered due to the medication not being available for administration.
*She thought someone had entered the Benefiber order incorrectly when resident 20 was readmitted from the hospital.
*The admission and readmission orders for residents were typically entered and verified by the nursing office staff.

7. Review of resident 38's EMR revealed:

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F 658	Continued From page 23 *She had a urine sample sent to her physician's office to be tested for an infection. *The physician was waiting for the urine culture and sensitivity [results to determine treatment]. *On 3/22/25 a physician's order to "Monitor VS [vital signs] every 6 hours and notify on call [physician] of HR [heart rate] >[greater than]110 [beats per minute], SBP [systolic blood pressure] < [less than] 90, RR [respiratory rate] > 22 [breaths per minute], or Temp [temperature] >100.4 [degrees Fahrenheit] every 6 hours" with an end date of -Resident 38's vital signs were being monitored to determine if there was a change in her vital signs which could indicate a worsening infection. --A variation from the indicated margins would require the facility to notify the resident's physician for immediate interventions. -The order entered into the EMR did not include the link to enter the vital signs within the order to have them documented into the EMR vital signs tab. *Review of resident 38's vital signs documentation revealed: -On 3/22/25 her vital signs were documented at midnight, 5:07 a.m., 11:42 a.m., 5:00 p.m., and 9:09 p.m. -On 3/23/25 her vital signs were documented at 3:09 p.m. and 9:41 p.m. -On 3/24/25 her vitals signs were documented at 5:56 a.m. and 12:52 a.m. -On 3/25/25 her vital signs were documented at 2:25 a.m., 6:03 a.m., 12:25 p.m., and 5:33 p.m. -On 3/26/25 her vital signs were documented at 5:15 a.m. and 9:13 p.m. 8. Interview on 3/27/25 at 8:45 a.m. with licensed practical nurse (LPN) K revealed: *He indicated the physician orders often were	F 658		

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F 658	Continued From page 24 received by fax. *Once an order was received, he would enter the order into the resident's EMR, fax the order to the pharmacy, and if there was a medication that needed to be administered immediately, he would obtain it from the emergency medication supply, otherwise he would wait for the medication to arrive from the pharmacy. *If a medication was not available for administration or was not given, he would notify the pharmacy immediately. *If the medication was unable to be obtained from the pharmacy or the facilities emergency medication supply, he would notify the physician. *He stated the nurses and CMAs completed and documented residents' vital signing the EMR. *Vital signs were charted into the EMR. *He verified there was no documentation that indicated resident 38's vital signs had been taken as ordered by the physician. *He was not aware there was a physician order for resident 38 to have her vital signs taken every 6 hours until he was told in shift report that morning (3/27/25) that the order was completed. 9. Interview on 3/27/25 at 12:18 p.m. with director of nursing (DON) B revealed: *She expected that physician orders be followed. *The pharmacy delivered medications to the facility daily and medications typically arrived at the facility the same day it was ordered. *The process for new physician orders was for the nurse to read, sign, and enter the order into the resident's EMR. *The order process was to be completed by the nurse that was in charge of that resident's care and the order should be double-checked and cosigned that the order was entered into the EMR correctly.	F 658		

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F 658	Continued From page 25 *She expected the physician to be notified if a medication was held or not administered for any reason. *She was aware the physician had not been notified for the medications that were documented as not administered due to medication not being available. Review of the provider's 3/4/25 Medications: Acquisition Receiving Dispensing and Storage policy revealed "Licensed nursing employees are responsible for ordering from the pharmacy and checking all new orders of medications from the physician's orders." Review of the provider's 3/4/25 Medication: Administration Including Scheduling and Medication Aides policy revealed: *"A provider's order for any medication is required and must include: diagnosis, name of medication, dose, route, frequency, and STOP order if indicated." *"If a medication is not available for 24 hours, the provider must be notified that the medication is not available and must be given direction for how to proceed." *"Follow the "Six Rights": Right medication, right dose, right resident, right route, right time and right documentation." *"Perform three checks: Read the label on the medication container and compare with the MAR when removing the container from the supply drawer, when placing the medication in an administration cup/syringe and just before administering the medication."	F 658		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4)	F 700		

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F 700	Continued From page 26 §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview and policy review, the provider failed to ensure residents who used assist/grab bars (bed rails) had: *A routine assessment, when a assist/grab bar was initiated and quarterly, was completed for four of eight sampled residents (6, 8, 33, and 38). *A signed consent for the use for the assist/grab bars for one of six sampled resident (6), with cognitive impairment, and a power of attorney (POA). *Received education on the risks of use versus benefits of the use of assist/grab bars for five of six sampled residents (6, 23, 26, 33, and 38). *Other attempted interventions were documented	F 700	Unable to correct prior deficient practice. Resident 6, 8, 33, and 38 along with any resident who currently utilizes a bed rail will have all had the physical restraint user defined assessment updated along with validation of the proper consents, education, and alternative intervention documentation confirmed. All residents who are recommended for a bed rail have the potential to be at risk. Education will be provided by the Director of Nursing or designee to all nursing staff on the restraint policy and bed rail functions. Only nurse managers will be able to request that bed rails be installed after the process has been followed. Director of Nursing or designee will audit completion up to 5 residents on the bed rail process weekly x3, every other week x3, and monthly x3. Director of Nursing or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Director of Nursing or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	5.9.25

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F 700	Continued From page 27 on five of eight sampled residents (6, 13, 23, 33, and 38). Findings include: 1. Observation on 3/24/25 at 2:14 p.m. of resident 33's room revealed she had bilateral (on both sides) assist/grab bars in the upright position near the head of her bed. Review of resident 33's electronic medical record (EMR) revealed: *She was admitted on 8/26/21. *Her Brief Interview of Mental Status (BIMS) assessment score was 11, which indicated she had moderate cognitive impairment. *Her 11/9/24 Physical Device and/or Restraint Evaluation and Review assessment revealed: -She consented for her own assist/grab bars with known cognitive impairment and a POA. -"No barriers" were documented related to "Learning barriers related to education/educational material provided." -There were no documented attempted alternatives identified. *Her care plan revealed: -She has a focus area of "has impaired cognitive function relating to vascular dementia e/b [evidence by] cognitive impairment, forgetfulness, decision making impairments". -Her POA had given prior consents via phone for resident 33 to receive liquor and to be photographed. 2. Observation on 3/24/25 at 2:24 p.m. of resident 26's room revealed she had bilateral assist/grab bars in the upright position near the head of her bed. Review of resident 26's EMR revealed:	F 700		

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F 700	Continued From page 28	F 700		

*She was admitted on 3/23/20.
*Her 2/17/25 BIMS assessment score was 12, which indicated she had moderate cognitive impairment.
*Her 2/23/25 Physical Device and/or Restraint Evaluation and Review assessment revealed there was no documentation to reflect education had been provided related to the risk vs benefit of the use of resident 12's assist/grab bar.

3. Observation on 3/24/25 at 4:04 p.m. of resident 6's room revealed she had bilateral assist/grab bars in the upright position near the head of her bed.

Review of resident 6's EMR revealed:
*She was admitted on 1/14/25.
*Her 2/21/25 BIMS assessment score was 15, which indicated she was cognitively intact.
*There was no Physical Device and/or Restraint Evaluation and Review assessment completed.

4. Observation on 3/24/25 at 5:04 p.m. of resident 13's room revealed she had an assist/grab bar in the upright position near the head of her bed on the right side.

Review of resident 13's EMR revealed:
*She was admitted on 2/21/20.
*Her 2/4/25 BIMS assessment score was 15, which indicated she was cognitively intact.
*Her 2/10/25 Physical Device and/or Restraint Evaluation and Review assessment revealed:
*There was no attempted alternative to the assist/grab bars documented.
*Review of resident 13's 3/26/25 care plan did not identify that she had an assist/grab bar on her bed.

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F 700	Continued From page 29 5. Observation on 3/25/25 at 11:29 a.m. of resident 8's room revealed she had bilateral assist/grab bars in the upright position near the head of her bed. Review of resident 8's EMR revealed: *She was admitted on 5/17/24. *Her 2/12/25 BIMS assessment score was 8, which indicated she was moderately cognitively impaired. *Her 8/23/24 Physical Device and/or Restraint Evaluation and Review assessment indicated, "Resident does not have grab bars on her bed since moving rooms. Resident has no difficulty without [the] use of them". 6. Observation on 3/25/25 at 11:30 a.m. of resident 23's room revealed she had an assist/grab bars in the upright position near the head of her bed on the left side. Review of resident 23's EMR revealed: *She was admitted on 3/26/20. *Her 2/11/25 BIMS assessment score was 12, which indicated he had moderate cognitive impairment. *Her 2/18/25 Physical Device and/or Restraint Evaluation and Review assessment revealed: -There was no attempted alternative to the assist/grab bars documented. -There was no education documented related to risk versus benefit of use, the resident's ability to use the assist/grab bars or the resident's understanding of use. 7. Observation on 3/25/25 at 11:32 p.m. of resident 38's room revealed she had bilateral assist/grab bars in the upright position near the head of her bed.	F 700		

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F 700	Continued From page 30	F 700		

Review of resident 38's EMR revealed:
*She was admitted on 5/3/23.
*Her 2/20/25 BIMS assessment score was 15, which indicated she was cognitively intact.
*Her 8/19/24 Physical Device and/or Restraint Evaluation and Review assessment revealed:
-There was no attempted alternative to the assist/grab bars documented.
-There was no education documented related to risk versus benefit of use, the resident's ability to use the assist/grab bars or the resident's understanding of use.

8. Interview on 3/26/25 at 2:25 p.m. with Minimum Data Set (MDS) nurse C revealed:
*She expected the Physical Device and/or Restraint Evaluation and Review assessments to be completed prior to the implementation of a resident's assist/grab bars.
*She completed the Physical Device and/or Restraint Evaluation assessment for residents with assist/grab bars with the quarterly MDS.
*She was unaware there was missing documentation within the assessments and there were assessments not completed upon initiation of the assist/grab bars and quarterly.

Interview on 3/27/25 at 12:18 p.m. with director of nursing (DON) B revealed:
*It was her expectation the completion of the Physical Device and/or Restraint Evaluation assessments be completed by a licensed nurse prior to the application of assist/grab bars.
*The Physical Device and/or Restraint Evaluation assessment would determine if an assist/grab bar was appropriate to be initiated for the evaluated resident.
*Once the assist/grab bar was placed on the bed

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F 700	Continued From page 31 "others would know" that the assessment was completed. *It was the licensed nurse's responsibility to assess for the resident's risk for entrapment. *She indicated it was MDS nurse C's responsibility to complete the Physical Device and/or Restraint Evaluation and Review assessment with the quarterly MDS. Review of the provider's 10/29/24 Restraint policy revealed: *"Anytime a device, material or equipment is attached or placed adjacent to the resident's body, a determination will be made by a licensed nurse as to whether it is or could be a restraint for the individual resident and a Physical Device and/or Restraint Evaluation and Review UDA is completed by a Licensed Nurse." *"If the device, material or equipment is not a restraint, it must be reviewed quarterly and with significant change in condition in conjunction with the care plan to ensure that it continues to not be a restraint for the resident."	F 700	Unable to correct prior deficient practice. All residents have the potential to be at risk when their requests are not followed per policy and their call lights are not answered in a timely manner. Education will be provided by the Director of Nursing or designee to all staff on resident's rights and ensuring that resident's requests are being followed along with answering call lights in a timely manner. Call light provider has been contacted to install equipment to support pagers for call light system. Bathing preferences and call light response times will be addressed on initial care conference for compliance. Director of Nursing or designee will audit up to 5 residents on completion of bathing preferences and call light response time weekly x3, every other week x3, and monthly x3. Director of Nursing or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Director of Nursing or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	5.9.25
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.	F 725		

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F 725	Continued From page 32 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, grievance review, and facility assessment review, the provider failed to have enough sufficient staff available to promote resident's rights, physical, mental, and psychosocial well-being for: *Eleven of fifteen sampled residents (7, 13, 14, 15, 18, 20, 26, 33, 38, 42, and 306) who were dependent on the staff to assist them with grooming, bathing, and toileting. *Five of five additional residents (22, 36, 45, 54, and 55) who had filed grievances on bathing and extended call light response time. Findings include: 1. Observation and interview on 3/24/25 at 2:14 p.m. with resident 33's in her room revealed, she: *Had multiple long gray facial hairs extending from her chin. *Reported that there were times when it took staff a "long time" to answer her call light. *Had waited longer to have her call light answered at night.	F 725		

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F 725	Continued From page 33 Review of resident 33's electronic medical record (EMR) revealed: *She was admitted on 8/26/21. *Her Brief Interview of Mental Status (BIMS) assessment score was 11, which indicated she had moderate cognitive impairment. *Her care plan indicated she required assist of one staff member for dressing, grooming, and bathing. 2. Interview on 3/24/25 at 3:21 p.m. with resident 7 revealed, she: *Was told her physician ordered her two baths per week, but she had been receiving one bath weekly. *Had expressed her desire for more than one bath weekly with the CNAs, but no one else had come to talk to her about it and nothing had changed. *Expressed concerns about her call light not being answered promptly. -Staff told her that her call light was not working but it was now. Review of resident 7's EMR revealed, she: *Was admitted on 12/23/24. *Had a BIMS assessment score of 15, which indicated she was cognitively intact. *She required assistance of for bed mobility, transfers, dressing, toilet use, and personal hygiene. Review of resident 7's 2/2/25 grievance revealed: *She indicated she was placed on a bedpan at 3:00 a.m. and the staff member told her, "I will be back." -The staff member had not returned, she fell asleep, woke up feeling the bed pain, and started	F 725		

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F 725	Continued From page 34 to feel pain. -She turned on her call light and thought she felt someone touch her shoulder and leave. -She again turned on her call light and thought someone came in and left again. -She then started yelling, but "nobody came". -She knew it was about the time of a staff shift change because she looked at her cell phone and it was morning. -Someone entered her room, removed the bedpan from under her, and assisted her with her care needs. -She indicated by that time her bedding was soaked [with urine]. *The CNA that placed resident 7 on the bedpan stated she did so sometime between 3:30 a.m. and 4:30 a.m. -She indicated she had forgotten to remove the bedpan and forgot to tell the oncoming shift. 3. Interview on 3/24/25 at 3:30 p.m. with resident 20's daughter/power of attorney (POA) revealed: *She indicated she visited her mother daily. *Her mother was hard of hearing and legally blind. *She indicated she felt the facility was "short-staffed". *She felt the staff rushed the residents when providing their care. *There were times when staff did not apply her mother's compression socks or put in her hearing aids before taking her to breakfast. *When resident 20 was in the dining room, staff often did not take the time to explain to her where her food was on her plate or assist her with eating meals. *Her mother has had multiple falls. *Resident 20 was scheduled for a bath weekly. *She previously was bathed twice weekly but	F 725		

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F 725	Continued From page 35 resident 20's daughter/POA was told she no longer received twice weekly baths because there was not enough staff to accommodate that. Review of resident 20's electronic medical record (EMR) revealed: *She was admitted on 7/22/20. *Her 2/17/25 Brief Interview of Mental Status (BIMS) assessment score was 6, which indicated she had severe cognitive impairment. *She was scheduled to have been bathed weekly. *Her Sit-Stand-Walk Data Collection Tool assessment indicated she preferred two or more baths per week. *Her care plan revealed she required assist of one staff member for bathing, dressing, personal hygiene, and toilet use. *She required set up assistance and cueing for eating. 4. Interview on 3/24/25 at 5:04 p.m. with resident 13 revealed: *She had at times waited for her bathroom call light to be answered for a half hour. *She thought she had waited as long as an hour and ten minutes for her bathroom call light to be answered. *She was bathed once weekly. *She had notified facility management that she would like to bathe more than once weekly but was told she could not because there was not enough staff to accommodate that. Review of resident 13's EMR revealed: *She was admitted on 2/21/20. *Her 2/4/25 BIMS assessment score was 15, which indicated she was cognitively intact. *She was documented to have been bathed weekly.	F 725		

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F 725	Continued From page 36	F 725		

*Her Sit-Stand-Walk Data Collection Tool assessment indicated she preferred two or more baths per week.
*Her care plan revealed she required assistance from one staff for toilet use, and transfers.
-She required set up assistance for dressing, grooming, eating, wheelchair mobility, and oral care.

Review of resident 13's 2/20/25 grievance revealed:
*During 2/19/25 care conferences resident 13 and her daughter expressed concerns regarding:
-Her bathroom her call light response time was often 30 to 60 minutes.
-She did not know week to week if she was going to receive a bath.
-She had gone 15 days between baths previously.
-Her preference for bathing was twice weekly and always on Fridays.
-She would have liked to receive more assistance from staff with "clothing mgt [management].
*Investigation stated, "Unable to view call light response time."
*Response to resident 13's grievance included:
-"Staff was educated on call light response time; review Call light Policy at daily huddles."
-"Whirlpool completed on 01/31; 02/07; 02/14; 02/21 and 02/28. Preference is twice a week and will strive to accommodate twice weekly. Care plan updated regarding clothing management."

5. Interview on 3/25/25 at 8:53 a.m. with resident 26 in her room revealed:
*She indicated she was assisted to bed "last night" by a male staff member and he did not put her into her pajamas.
*When she woke up in the morning, she was in the same clothes she had worn the day before

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and the morning staff member helped her change her clothing.
*She felt staff took a long time to answer her call light.
-It often took between 10 to 15 minutes but was longer at times when she was in the bathroom.
*She indicated she usually got a bath on Sundays but recently she has had to "fuss" in order to get a bath.
*She stated she felt, "they don't have time for me."

Review of resident 26's EMR revealed:
*She was admitted on 3/23/20.
*Her 2/17/25 BIMS assessment score was 12, which indicated she had moderate cognitive impairment.
*Her care plan revealed she required assistance of one staff member for bating bed mobility, dressing, toilet use, and transfers.
-She required set up assistance by a staff member for eating, oral care, and personal hygiene.

6. Interview on 3/25/25 at 11:32 a.m. with resident 38 revealed:
*She usually received her bath weekly.
*She had not received a bath in the past week.
*She thought the facility was "short-staffed" but felt the staff was doing the best they could.
*Staff had told her they were "short-staffed".
*She did not feel there was a specific time of day that the call light response times were longer than other times.

Review of resident 38's EMR revealed:
*She was admitted on 5/3/23.
*Her 2/20/25 BIMS assessment score was 15, which indicated she was cognitively intact.

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F 725	Continued From page 38 *Her Sit-Stand-Walk Data Collection Tool assessment indicated she preferred one bath per week. *There was no documentation to support she had been bathed since 3/15/25, 10 days prior. 7. Resident group interview on 3/25/25 at 1:59 p.m. revealed: *One resident stated she would like more baths, especially when it was "hot out". *Another resident stated she had gone 12 days without a bath, she began to cry and then stated they [staff] told her they were too busy to give her a bath and that made her upset. She then stated, "I have to suffer" because the staff are "too busy to give me a bath". *Another resident stated she didn't receive help "soon enough." She expanded to state she waited an hour and ten minutes last week for staff to respond to her call light. Usually, the call light response time was 20 minutes, and she then stated the wait time "kills me." *Another resident stated that call light response wait times varied from a few minutes to an hour. 8. Interview on 3/24/24 at 2:28 p.m. with resident 306 and his daughter in his room revealed: *Resident 306 was admitted for rehabilitation after a hospitalization *He stated he hadn't been able to regain his strength after his cancer diagnosis and treatment *He stated he always had to ask for a bath and never knew when or if he was going to get one. *He was told by staff, "I'll be right back to give you a shower," and three hours later, he still hadn't had one. *He stated, "They always say we're short-staffed." *He stated he wanted a shower but "they talked me into a bath."	F 725		

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F 725	Continued From page 39 *His daughter stated she would like for him to "get on a bath schedule." Review of resident 306's EMR revealed: *He was admitted on 2/11/25. *His 2/12/25 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated he was cognitively intact. *His diagnoses included personal history of malignant neoplasm of prostate (prostate cancer), weakness, difficulty in walking, not elsewhere classified, and unsteadiness on feet. *His 2/11/25 Sit-Stand-Walk Data Collection Tool assessment indicated he preferred two or more baths per week. *His 2/11/25 care plan contained an intervention that indicated he needed staff assistance for transfers. *From 2/23/25 to 3/25/25 he had documented bathing on 3/3/25, 3/5/25, 3/10/25, and 3/20/25. A follow-up interview on 3/26/25 at 4:13 p.m. with resident 306 and his wife in his room revealed: *His wife stated, "One bath a week is not enough." *He stated he had previously shared his concerns about not getting a shower with the social worker. 9. . Interview on 3/24/25 at 3:02 p.m. with resident 15 in her room revealed: *She stated, "I didn't get a bath last week, and they're working on getting one for this week." *She stated, "It does not feel like there's enough help here." Review of resident 15's EMR revealed: *She was admitted on 1/20/25. *Her 1/21/25 BIMS assessment score was 15, which indicated she was cognitively intact.	F 725		

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F 725	Continued From page 40 *Her 1/20/25 Sit-Stand-Walk Data Collection Tool assessment indicated she preferred one bath per week. *From 2/23/25 to 3/25/25 she had a bed bath documented on 2/27/25, 3/6/25, and 3/13/25. *It was documented that she refused a bath on 3/20/25. *There was no documentation that indicated she had been bathed since 3/13/25, 12 days prior. A follow-up interview on 3/26/25 at 4:36 p.m. with resident 15 in her room revealed: *She did not refuse a bath last week. *She would prefer two or three baths per week. 10. Interview on 3/24/25 at 3:26 p.m. with resident 18 in her room revealed: *She was supposed to get a bath that day but did not. *She was told by staff that they would "try to get her a bath tonight." Review of resident 18's EMR revealed: *She was admitted on 8/21/24. *Her 9/13/24 BIMS assessment score was 12, which indicated she was moderately cognitively impaired. *Her diagnoses included difficulty in walking, unsteadiness on feet, repeated falls, and muscle wasting and atrophy (decrease in size). *Her 2/27/25 Sit-Stand-Walk Data Collection Tool assessment indicated she preferred one bath per week. *She had documented baths on 3/3/25, 3/10/25, 3/19/25, and 3/24/25, all at 2:14 p.m. -The bath that was documented on 3/24/25 at 2:14 p.m. was the same day she said that she was supposed to get a bath but did not and was told by staff that they would try to get her a bath	F 725		

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F 725	Continued From page 41 that night. A follow-up interview on 3/26/25 at 4:42 p.m. with resident 18 regarding her preferences revealed she would like to have a bath every day if possible. 11. Interview on 3/24/25 at 4:14 p.m. with resident 42 in her room revealed: *She stated, "We only get a bath once a week because they're short on help." *She would prefer more frequent baths. Review of resident 42's EMR revealed: *She was admitted on 2/17/25. *Her 2/18/25 BIMS assessment score was 12, which indicated she was moderately cognitively impaired. *Her diagnoses included weakness, muscle wasting and atrophy, difficulty in walking, not elsewhere classified, and unsteadiness on feet. *Her 2/17/25 Sit-Stand-Walk Data Collection Tool assessment indicated she would like two or more baths per week. *She had a 2/24/25 physician order for two baths per week. *From 2/23/25 to 3/25/25 she had baths documented on 3/4/25, 3/10/25, and 3/17/25. 12. Interview on 3/24/25 at 5:05 p.m. with resident 14 in her room revealed: *She no longer waited for the staff to answer her call light when she needed to use the bathroom. *She used to wait for assistance to the bathroom but had incontinent episodes because she had to wait too long. *She stated, "Sometimes I don't see anyone from 8:00 in the morning until 8:00 at night, except the person who brings in my room [meal] tray. They	F 725		

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F 725	Continued From page 42 don't have enough help." Review of resident 14's EMR revealed: *She was admitted on 10/23/24. *Her 1/29/25 BIMS assessment score was 15, which indicated she was cognitively intact. Review of the 2/6/25 grievance filed by resident 14 revealed: *She had concerns about not getting her bedtime medications on time. *She did not get her medications until midnight. *She had concerns about medications being left at her bedside. *The provider's investigation documentation of medication pass times included "nothing [no medications] administered after midnight." *The provider's resolution included: -"Reassured res [resident] that meds [were] to be passed per schedule." 13. Review of the provider's grievances from the previous year revealed: A 1/16/24 grievance filed on behalf of resident 54 by family indicated: *Resident 54 was not getting a bath since he was admitted. *Extended call light staff response times. *The provider's investigation documentation included: -"When [the] resident was admitted, bathing was added but not finalized to show on tasks. Completed on 1/18/24." -Call light audit from 1/11/14 through 1/16/24 revealed: --Three call light response times over 10 minutes. --One call light response time over 15 minutes. --Two call light response times over 20 minutes.	F 725		

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F 725	Continued From page 43 --Two call light response times over 30 minutes. *The provider's follow-up included: "Will educate nurses about call light response time." A 7/30/24 grievance filed by resident 55 for her call light being on for an hour indicated: *A call light audit confirmed the resident's call light was on for 56 minutes. *Resolution documentation included: "Education provided to CNA/nurse that all call lights are to be answered promptly." An 8/13/24 grievance filed on behalf of resident 22 for not getting a bath indicated: *The provider's audit of Tasks documentation revealed resident 22 had a: -Bed bath on 8/2/24 at 9:59 p.m. -Whirlpool bath on 8/5/24 at 12:01 p.m. -Bed bath on 8/9/24 at 10:14 p.m. -Bath documented as refused on 8/12/24 at 1:22 p.m. A 2/6/25 grievance filed on behalf of resident 45 with concerns about her bathing schedule indicated: *The provider's investigation documentation included: "bathing schedule reviewed and resident is getting her bathing completed." -No audit was included. A 2/18/25 grievance filed by resident 36 regarding extended call light response time indicated: *Resident 36 reported that the shampoo machine was so loud that nobody heard anything. *A call light audit revealed a response time of 29 minutes and 26 seconds. *T provider's follow-up comments included: "Education to staff: be extremely cognizant of loud equipment used, i.e.; shampoo machine;	F 725		

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F 725	Continued From page 44 conduct an additional and intention rounding to ensure residents needs are addressed." An additional 2/26/25 grievance filed on behalf of resident 45 regarding bathing and call light response time indicated: *A family member reported that resident 45 had only received three baths since arriving at the facility. *The resident's call light was on for an hour. *The provider's follow-up comments included: -"Education to staff on following bathing schedule." -"Call light response time; strive for timely manner to answer." *No audits were included. Interview on 3/26/25 at 1:45 p.m. with Clinical care leader (CCL)/infection preventionist (IP) D regarding resident bathing revealed if no bath aide was available the certified nursing assistant (CNA) that was working on the floor providing resident cares would be responsible to provide the resident's bathing according to the bath schedule. Interview on 3/26/25 at 2:25 p.m. with Minimum Data Set (MDS) nurse C revealed: *The resident preferences related to bathing was documented in the Sit-Stand-Walk Data Collection Tool assessment in the EMR. -MDS nurse C completed this assessment quarterly. *CCL/IP D maintained the resident bath schedule and MDS nurse C believed she went by the preferences documented on the Sit-Stand-Walk Data Collection Tool assessment to make the bath schedule. *It was her expectation that the preferences	F 725		

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F 725	Continued From page 45 documented in the Sit-Stand-Walk Data Collection Tool assessment be followed when scheduling the resident's bathing. Interview on 3/27/25 at 8:01 a.m. with CNA M revealed: *Residents usually received one bath per week. *There were times the bath aide was reassigned to work as a CNA on the floor to provide resident cares. *If the bath aide was reassigned to the floor each CNA would be responsible to complete the resident's bathing according to the bathing schedule. *She thought the bath aide was reassigned to work the floor at least one day per week. Interview on 3/27/25 at 8:22 a.m. with CNA P revealed: *There was a resident bathing schedule located in the nurses' station. *The residents' baths were to be completed by the CNA assigned to provide resident bathing for that shift. *There were times when a bath aide was not scheduled to work. *There were times the bath aide was reassigned to work on the floor to provide resident care. *If there was no bath aide scheduled the "float" CNA would usually complete the resident baths. *If there was no float or a bath aide the CNAs assigned to work on the floor were to complete the baths scheduled for that day. *In the last three weeks, on the days he had worked, there had been three or four times when no bath aide was available to complete the assigned residents' baths. *It was his expectation that call lights be	F 725		

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F 725	Continued From page 46 answered as soon as possible. *He answered the bathroom call lights first. *He indicated that nurses and CNAs were responsible for answering the call lights. Interview on 3/27/25 at 8:45 a.m. with licensed practical nurse (LPN) K revealed: *He expected residents' call lights to be answered by "around" five minutes. *He indicated it was everyone's responsibility to respond to call lights. Interview on 3/27/25 at 10:16 a.m. with CCL/IP D revealed: *She indicated the residents were interviewed regarding their bath preferences. *She was not aware who completed the interview, when the interviews were to be completed, or where to locate the information obtained during the interview. *Residents could discuss their concerns and preferences with staff or during care conferences. *It was her expectation that anyone could answer a call light. Interview on 3/27/25 at 10:37 a.m. with administrator A revealed: *That she expected staff do their best to accommodate resident choices. *Regarding grievances, she expected staff to follow policy, complete a thorough investigation, and complete periodic reevaluations after the initial grievance resolution. *She stated that anyone could answer a resident's call light. *She referred to the facility assessment when the staffing policy was requested. Interview on 3/27/25 at 12:18 p.m. with director of	F 725		

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nursing (DON) B revealed:
*She expected staff to follow the bathing schedule.
*She indicated it was everyone's responsibility to answer call lights.
*She expected call light response times would be what the policy stated.
*Call light response audits were periodically completed on a case-by-case basis.
-The north call lights were able to be audited through the call light system.
-The south call lights were audited by a leadership member by activating a call light and then waiting in the room and timing the response of the staff member to respond to the call light.

Interview on 3/27/25 at 1:04 p.m. with CCL E regarding call light response times revealed:
*She was responsible for the coordination of QAPI (quality assurance and performance improvement) for the facility.
*The facility had identified call light response times as an area that needed improvement.
-A performance improvement plan (PIP) was initiated regarding staff response times to resident call lights.
--A trend was identified during this PIP of call light response times being the longest between 7:00 a.m. and 9:00 a.m.
--The PIP was completed on 12/9/24.

Review of the provider's 8/12/24 Facility Assessment revealed:
*"The assessment indicated:
-The provider had "appropriate staffing to meet the needs of the residents".
-The "acquity [acuity] & [and] needs of [the] residents" were met by "[The provider] monitors the acuity level and the PPDs [per patient day

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F 725	Continued From page 48 hours] of the facility. We ensure we have the appropriate staffing levels based on national and state averages. We ensure that if we have a high acuity level[,] we adjust staffing to meet the needs of the residents." -"[Provider] utilizes an interdisciplinary approach to meet the needs of our population and its individuals across all shift[s] including nights and weekends, using data from MDS, case mix index, and considering care planned interventions ... As the needs of the population change as indicated by the number of residents served, acuity levels, MDS results and care plans the staffing pattern is adjusted to meet those needs. We consider variability in care needs across day, evening and night shifts, including weekends and holidays, and adjust as necessary. We confirm needs are met by engaging in frequent communication with residents, their families and representatives with regular care conferences, rounding, quality assurance audits, resident group meetings, availability of suggestion/concern forms and email surveys." -The following is measured and monitored "to ensure proper ongoing care and service meet resident needs". --"Care plans, Care conferences/Family conversations, Medicare Meeting, continuous staff meetings, QAPI meetings, Quarterly and annual MDS assessments, resident council meetings, concern forms, and quality of life meeting." -Coordination and continuity of care is measured and monitored by "Scheduling will be done. We will monitor through resident council and other means as well to ensure coordination and continuity of care is being done." Refer to F561.	F 725		

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F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services 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, and job description review, the provider failed to assess, document, and implement interventions for one of one sampled resident (51) with a mood disorder. Findings include: 1. Observation and interview on 3/24/25 at 3:13 p.m. with resident 51 and his spouse revealed: *The resident's room was without any personal items from home. *He enjoyed music but had no way to listen to it. He was Lutheran and would not have objected to having clergy from that faith visit him. His spouse was working with a visually impaired service provider so the resident had access to books on tape. *He was admitted to the facility after back surgery after a complicated and extensive hospitalization. -His goal was to return home with his spouse after his rehabilitation stay at the facility. *His pain had improved since he was admitted to the facility. *The resident's affect was flat. *In early March 2025, the resident's physician had recommended he see a counselor for worsening depression. -The resident's spouse had asked that a male counselor see the resident. She was told there were no male counselors available to have met with the resident. No other counseling alternatives had been discussed or provided for the resident.	F 745	Unable to correct prior deficient practice. Resident 51 had a new PHQ-9 and BIMS assessment completed. Resident declined any professional support that was offered. Resident's food preferences were communicated to the dietary department. Resident 51 ha since discharged. All residents who trigger for further social services follow up through PHQ-9 scores or interdisciplinary team referral have the potential to be at risk. Job Description has been reviewed with licensed social worker by the administrator. Education has been provided by Director of Nursing or designee to all nursing staff to ensure that all physician's progress notes have follow up required. Administrator or designee will audit up to 5 residents on completion of social services documentation on residents identified as being at risk for psycho-social decline weekly x3, every other week x3, and monthly x3. Administrator or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the administrator or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	5.9.25

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F 745	Continued From page 50 Interviews on 3/25/25 at 2:00 p.m. and on 3/26/25 at 4:45 p.m. with resident 51 in his room revealed: *He had a history of depression and was taking anti-depressant medication. His depression had worsened his admission to the facility. -He felt he had lost weight because "nothing tasted good." He had feelings of "imprisonment," and a sense of "loss of control" of his body. He was a "loner" and remained in his room most of the time. *His spouse had visited him regularly and he had a few friends who had stopped by to see him occasionally. -It had felt good "to unload" how he was feeling with his friends. *Caregivers had been good about engaging with him during routine care. He would have liked to have someone who could sit down to talk with him each week about his "loss of control." *At home the resident had enjoyed sitting in his own recliner and using his home computer. Having personal items that surrounded him at home brought him "joy." Review of resident 51's electronic medical record (EMR) revealed: *His admission date was 2/10/25. *His 3/26/25 Brief Interview for Mental Status assessment score was 13 which indicated he had little or no cognitive impairment. *His 2/11/25 PHQ-9 (Patient Health Questionnaire - a self-report tool used to assess depression symptom severity) assessment score was 8 which indicated he had mild depression. *A 2/11/25 physician's history and physical progress note (PN): "Psychiatric/Behavioral: Positive for confusion (now improved) and sleep	F 745		

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disturbance. The patient is nervous/anxious (He is concerned about what the future may hold)."
*A 2/18/25 physician's PN: "Staff and his [resident 51's] wife note that he is depressed. His wife would like his sertraline (anti-depressant medication) increased." A physician's order was written on that same date changing the sertraline dose from 50 mg (milligrams) daily to 100 mg daily.
*A 2/20/25 interdisciplinary care conference PN had discussed the resident's weight loss, his improved pain management, and his current medications.
-"Social Services: [resident's spouse] would like home health at discharge and plan is to discharge home with wife. [Resident 51] is a full code, no concerns from social services at this time."
*A 3/4/25 physician's 30-day post admission PN revealed resident 51's chief complaints had been a poor appetite and depression.
-"He [resident 51] admits to feeling depressed. He feels down at times and wishes his life were over. He has thought about suicide but did not verbalize a method. He feels worthless and not any good to his children or grandchildren." His energy level was poor and his concentration was decreased.
-The resident had agreed that "counseling was not a bad idea." A physician's order was written on that same date: "[Counseling agency] may see for psychological counseling."
*There was no nurse PN documented on 3/4/25 after the physician's visit that acknowledged any communication had occurred between the nursing staff and the physician.
*SSD/CSW I's PN documentation between 2/20/25 and 3/20/25 regarding resident 51's mood state revealed:
-On 3/5/25 the resident's spouse had asked

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F 745	Continued From page 52 SSD/CSW I if a male counselor was available to visit with resident 51. -On 3/6/25 SSD/CSW I had documented the counseling agency resident 51 had been referred to for counseling had no male counselor available to have met with the resident. -There was no documentation to support what other counseling alternatives had been investigated or offered to resident 51. *On 3/18/25 registered dietician (RD) R's PN: "Resident has not been eating and has noted to state 'I'm going to starve myself' per IDT [interdisciplinary team] at QOL [quality of life] meeting - this was stated a few weeks ago." Review of the 2/11/25 through 3/25/25 weekly QOL/Nutrition meeting minutes revealed: *Resident 51's weight loss was discussed during those meetings. -There was no documentation in those minutes related to RD R's above documentation regarding resident 51's statement about starving himself. Interviews on 3/25/25 at 1:00 p.m. and again on 3/26/25 at 4:00 p.m. with SSD/CSW I and SSD/CSW J regarding resident 51's mood state revealed: *One of SSD/CSW I's responsibilities was monitoring and responding to the psychosocial well-being of the residents. *She was aware resident 51's depression symptoms had worsened since his admission and his anti-depressant medication was increased on 2/19/25. In response, she had not but could have: -Initiated one-to-one visits with the resident and identified, and implemented other interventions to have addressed his mood state. -Collaborated with the activities department to have followed-up on those things above that the	F 745		

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resident had identified that had enhanced his quality of life.
-Confirmed a daily mood symptom monitoring task had been initiated to assess if the resident's mood state continued to worsen or had improved.
-Readministered a PHQ-9 assessment for comparison with the last completed PHQ-9.
*SSD/CSW I had only spoken with resident 51's wife and not the resident regarding the above physician-ordered counseling services so she had not known the resident's preference for a male versus a female counselor. She had not informed the resident of her inability to find a male counselor or discussed with him any other alternatives to assist him with the management of his depression.
*SSD/CSW I had not known about the above statements made by resident 51 to his physician during their 3/4/25 visit.

Interview on 3/27/25 at 8:00 a.m. with administrator A regarding resident 51's mood state decline revealed:
*Psychological services could have been arranged for resident 51 through a telehealth service provider the facility had access to.
*The QOL/Nutrition meeting was an interdisciplinary team whose focus was discussing residents who had weight loss and were at risk for or had factors that affected their well-being.
-She stated weight loss had mostly been discussed during those meetings, but her goal was for the inclusion of residents' QOL issues. "It just hasn't happened yet."

Interview on 3/28/25 at 9:45 a.m. with administrator A and director of nursing (DON) B regarding the physician's on-site resident visits

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F 745	Continued From page 54 revealed: *The physicians had a list of residents they were expected see during their on-site resident visits. -Nursing staff had discussed with the physician pertinent non-emergent changes or developments related to the residents on the physician's visit list as well as residents not on the list. *Nursing staff received a hand-off report from the physician after the physician's visits had been completed. That report included a review of new physician's orders and resident recommendations. *It was the responsibility of that nursing staff to ensure information from that hand-off communication was relayed to the appropriate interdisciplinary team members -That usually occurred during weekday interdisciplinary "stand-up" meetings. If the matter was more urgent, a personal conversation or telephone call was expected to have occurred. *The nursing staff who had received hand-off communication from the physician was expected to have made a progress note entry regarding that communication. *Administrator A and DON B had not known: -SSD/CSW I was not notified of the comments made by resident 51 during his 3/4/25 physician visit. -There was no documentation to support if nursing staff had received a physician's hand-off report after resident 51's 3/4/25 physician visit. A Mood/Behavior policy was requested from administrator A on 3/28/25 at 9:00 a.m. A Behavioral Causes and Interventions policy was provided which had not addressed the provider's process for managing resident's mood disorders.	F 745		

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F 745	Continued From page 55 Review of the revised 3/19/25 Social Services job description revealed: *It was SSD/CSW I's responsibility to: -"Provide leadership for the delivery of medical Social Services, expertise and/or consultation and acts as a liaison by representing at the local, regional, and state levels." -"Develop and review service plans in consultation with clients and perform follow-ups assessing the quantity and quality of services provided."	F 745		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F 755	Unable to correct prior deficient practice. Residents who receive narcotics have the potential to be at risk when their narcotic documentation is not completed per policy. Education will be provided by the Director of Nursing or designee to all nursing staff on the controlled medication policy. Ensuring all narcotics are signed for up on receipt and 2 licensed nurses sign for destruction of fentanyl patches. New destruction sheets have been placed in narcotic count binders. Director of Nursing or designee will audit up to 5 residents on completion of new narcotic records and fentanyl patch destruction log weekly x3, every other week x3, and monthly x3. Director of Nursing or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Director of Nursing or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	5.9.25

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F 755	Continued From page 56 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, the provider failed to ensure: *Two nurses had signed for the receipt of controlled medications (medications at risk for abuse and addiction) on the controlled drug record for five of five residents (6, 15, 21, 24, and 31) who were prescribed controlled medications.. *One prescribed controlled liquid medication concentration was documented on the Controlled Drug Record for one of one resident (31). *The destruction of fentanyl patches for one of one sampled resident (6) was accurately documented appropriately by individuals authorized to destroy controlled medications. Findings include: 1. Observation on 3/24/25 at 2:30 p.m. of the controlled substance binders on the south medication carts revealed: *A handwritten Controlled Drug Record identified as resident 15's for 24 lorazepam (a controlled anti-anxiety medication) 0.5 milligrams (mg) tablets did not indicate when the medication was received or who verified the receipt of the medication. *A Controlled Drug Record identified as resident 6's for 60 pregabalin (a controlled medication for nerve pain) 75 mg tablets delivered on 3/8/25 did not contain a pharmacy representative signature that documented the delivery of the controlled	F 755		

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F 755	Continued From page 57 medication nor a nurse's signature that verified the receipt of the medication. 2. Observation on 3/26/25 at 11:30 a.m. of the controlled substance binders on the north medication carts revealed: *A handwritten Controlled Drug Record identified as resident 31's for 15 ml (milliliters) of morphine sulfate (a controlled pain medication) with no identified medication concentration, did not indicate when the medication was received or a signature of who verified the receipt of the medication. *A Controlled Drug Record identified as resident 24's for 60 tramadol (a controlled pain medication) 50 mg (milligrams) tablets delivered on 3/7/25 did not contain the signature of the nurse who verified the receipt of the medication. *A handwritten Controlled Drug Record identified as resident 24's for 4 patches of buprenorphine (a controlled medication to treat pain and opioid use disorder) 7.5 mcg (micrograms)/hr (hour) that did not indicate when the medication was received or a signature of who verified the receipt of the medication. *A Controlled Drug Record identified as resident 21's for 15 ml of morphine sulfate 100 mg/ml that did not contain the signature of the nurse to document the receipt of the medication. 3. Interview and review of the above controlled drug records on 3/24/25 at 2:48 p.m. with registered nurse (RN) G revealed she confirmed there were areas of documentation that had not been completed including signatures of receipt, dates of receipt, and a medication concentration. 4. Interview on 3/26/25 at 11:03 a.m. with RN S revealed:	F 755		

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F 755	Continued From page 58 *Medications arrived from the pharmacy at about 6:00 p.m. *The night nurse was responsible for checking the medications in when received from the pharmacy transport person. *When the nurse received the medication from pharmacy transport person the nurse was to sign a form that was retained by the pharmacy and the Controlled Drug Record for that medication was then to be placed in the controlled substance binders on the medication carts. 5. Observation on 3/24/25 at 2:30 p.m. of the controlled substance binders on the south medication carts revealed: *Resident 6's Controlled Drug Record indicated she was to receive fentanyl 25 mcg/hr (controlled pain medication) topical patches every three days. *There was no documentation in the Controlled Substance Binder of the disposal of the fentanyl patches that were removed from the resident when another patch was applied. 6. Interview on 3/26/25 at 10:33 a.m. with RN S and unlicensed medication aide (UMA) L regarding used fentanyl patch destruction revealed: *Resident 6's fentanyl patch was scheduled for removal every three days on her medication administration record (MAR). *When the fentanyl patch was removed from the resident, it was to be destroyed by two people and documented in a nurse's note within the scheduled removal area in the MAR. *RN S stated resident 6's fentanyl patch had been removed that morning and she had witnessed its disposal in the medication destroyer product container in the medication cart.	F 755		

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F 755	Continued From page 59 *RN S reviewed resident 6's nurse's notes and confirmed there was no documentation the fentanyl patch was destroyed. *RN S stated the process she had described was her practice to "cover myself" from suspicion of drug diversion. *She clarified two nurses did not sign the removal and destruction of the fentanyl patch, but rather the nurse that was charting in the MAR would indicate who witnessed the destruction. 7. Review of resident 6's electronic medical record (EMR) revealed: *She had a physician's order for "fentanyl Transdermal [through the skin] Patch 72 Hour 25 MCG/HR (Fentanyl) Apply 1 patch transdermally one time a day every 3 day(s) related to OTHER LOW BACK PAIN". *Resident 6's MAR included and area for documentation of the application and removal of the fentanyl patch at 10:00 a.m. every third day. *Review of resident 6's March 2025 nurses notes revealed: -On 3/17/25 a nurse's note included, "removed patch from RUQ [right upper quadrant] [of the abdomen], lead social service coordinator T in SWS [social work services] witnessed waste [destruction]of patch." -On 3/23/25 a nurse's note included, "CMA UMA L witnessed this nurse placing previous [fentanyl]patch in liquid waste container," --Per Administrative Rules of South Dakota (ARSD) the destruction or disposal of controlled medications were witnessed by two persons, both of whom must be a nurse or pharmacist. -There was no documentation to support the fentanyl patch was destroyed or there was a witness to the destruction on 3/2, 3/5, 3/8, 3/11, 3/14, or 3/20.	F 755		

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F 755	Continued From page 60 8. Interview on 3/27/25 at 8:45 a.m. with licensed practical nurse (LPN) K revealed: *A fentanyl patch should be destroyed by two nurses. *He was unable to identify where the destruction by two nurses was to be documented. 9. Interview on 3/27/25 at 9:41 a.m. with social service director (SSD)/certified social worker (CSW) I and SSD/CSW J revealed that lead social service coordinator T was not a licensed nurse. 10. Interview on 3/27/25 at 12:18 p.m. with director of nursing (DON) B revealed: *She expected when a controlled substance arrived from the pharmacy, the pharmacy form and the Controlled Drug Record were to be signed by the pharmacy courier and the nurse that received the medication after the medication and count were verified as accurate. *She expected the fentanyl patches to be destroyed according to the provider's policy. 11. Review of the provider's 3/4/25 Medications: Acquisition and Receiving Dispensing and Storage policy revealed: *"An employee will be responsible for signing for receipt of medication and obtaining the signature of the delivery person. It is preferred that a licensed nurse receive and verify the medications ... Licensed nurses and medications aides (when allowed by state law) are responsible for reconciling medications received." *"These medications must be labeled according to state pharmacy regulations. Cautionary and accessory instructions, as well as the expiration date, will be included. New labels will be applied	F 755		

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F 755	Continued From page 61 by the pharmacist or the pharmacist's agent as needed." Review of the provider's 6/27/24 Medications: Controlled policy revealed: *"Reconciliation: refers to a system of recordkeeping that ensures an accurate inventory of medications by accounting for controlled medications that have been received, dispensed, administered and/or, including the process for disposition." *"The location will along with their consultant pharmacist will establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation that determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled and meets all state and federal requirements for controlled medications." *"When a new controlled medication is delivered, the nurse in the skilled nursing facility will be responsible for counting the medication, Schedule II medications require an Individual Resident's Narcotic Record... or in the Controlled Substance Bound Book." *"Disposal of any medication will be carried out under local, state and federal guidelines or in consultation of the pharmacist for the appropriate disposal procedure. Documentation of medication disposal will be made using the [providers' form] or Controlled Substance Bound Book and will include the resident's name, medication name, prescription number (as applicable), quantity disposed, date and method of disposition and the involved nurse (s), consultant or other applicable individuals per state regulations." Review of the provider's 9/3/24 Medication:	F 755		

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F 755	Continued From page 62 Disposition (Disposal) policy revealed: *"Disposal of any medication will be carried out under local, state and federal guidelines or in consultation of the pharmacist in the appropriate disposal procedure. Documentation will include the resident's name, medication name, prescription number (as applicable), quantity, date of disposition and the involved staff member, consultant or other applicable individuals." *"For Controlled substances, two nurses or a nurse and a med [medication] aide must witness the destruction, document on the Individual Resident's Narcotic Record [provider's form number], or in the Controlled Substance Bound Book, to ensure accuracy of the count. Document in [the] medical record the reason for the destruction."	F 755	Unable to correct prior deficient practice. All residents who receive medications have the potential to be at risk when their orders are not followed per policy. Education will be provided by the Director of Nursing or designee to all nursing staff on the medication administration policy and ensuring that physician's orders are being followed. Director of Nursing or designee will audit up to 5 residents on completion of medication pass weekly x3, every other week x3, and monthly x3. Director of Nursing or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Director of Nursing or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	5.9.25
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, policy review, and manufacturer's recommendations review, the provider failed to ensure a medication error rate of less than 5 percent related to: *A topical pain medication was not applied according to the manufacturer's recommendations for two of two sampled residents (18 and 42) by one of one observed registered nurse (RN) (S). *An oral medication was given to one of one	F 759		

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F 759	Continued From page 63	F 759		

sampled resident (42) without a physician's order by one of one observed RN (S).
Those observations created a medication error rate of 10.71%.
Findings include:

1. Observation and interview on 3/26/25 from 7:42 a.m. through 8:28 a.m. of registered nurse (RN) S during medication (med) administration revealed:
*She dispensed an unknown amount of diclofenac sodium external gel 1% (for arthritis pain and inflammation) into a med cup and administered the gel to resident 18's right lower chest.
-The order on resident 18's medication administration record (MAR) indicated she was to receive two grams of the gel.
*She dispensed an unknown amount of diclofenac sodium external gel 1% into a med cup and administered the gel to resident 42's left elbow, right knee, and both wrists.
-The order on resident 42's MAR indicated she was to receive two grams of the gel to her hands and knees two times a day.
*When asked how she knew she was administering the correct dose she stated she thought two grams was "about 2.5 cc's [cubic centimeters]."
-She read the box for the diclofenac sodium gel and said, "Maybe that's just a guess."
*She administered vitamin C 1,000 milligrams by mouth to resident 42.
-There was no order on resident 42's MAR for the vitamin C.
-She indicated the administration of the vitamin C without an order was a medication error.

2. Interview on 3/27/25 at 8:44 a.m. with licensed

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F 759	Continued From page 64 practical nurse (LPN) K revealed: *The measuring device that was included in the box with the diclofenac sodium 1% gel was to be used to determine the dose of the gel to be administered. *He agreed the measurement device remained secured to the diclofenac sodium 1% gel box that was stored in the medication cart. *He agreed the tube in that box was partially empty. *He indicated that some staff members do not use the device when they administered the medication. 3. Interview on 3/27/25 at 12:18 p.m. with director of nursing (DON) B revealed it was her expectation: *That the measurement device in the diclofenac sodium 1% gel be used to determine the dose of the medication prior to administration to a resident. *That the correct dose of medication was to be administered. *That staff follow the "Six Rights" of medication administration and follow their policy. 4. Review of the manufacturers' 10/22 recommendations for the diclofenac sodium 1% gel revealed: *"User Guide" -Remove the dosing card from the inside of the carton. You should always use the dosing card to measure out the correct dose of diclofenac sodium topical gel." 5. Review of the provider's 3/4/25 Medication: Administration Including Scheduling and Medication Aides policy revealed: *"Procedure"	F 759		

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F 759	Continued From page 65 -"Review the MAR for medications due." -"Follow the "Six Rights": Right medication, right dose, right resident, right route, right time, and right documentation." -"Perform three checks: Read the label on the medication container and compare with the MAR when removing the container from the supply drawer, when placing the medication in an administration cup/syringe and just before administering the medication."	F 759		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761	Unable to correct prior deficient practice. Resident 28, 12, 50 and 6 all had their medications updated. All residents have the potential to be at risk when their medications are not labeled properly and the medication room temperatures are not documented per policy. Education will be provided by the Director of Nursing or designee to all nursing staff on properly labeling medication and ensuring that the medication room and refrigerators temperatures are being documented per policy. New temperature logs have been installed in each medication room. Education was provided by the Senior Director to nurse managers on removal of all expired materials and medications. Education will be provided by the Director of Nursing or designee to all nursing staff on expectations for identifying any type of medication or material that would break a seal would need an open date.	5.9.25

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F 761	Continued From page 66 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the provider failed to ensure: *Medications for two of two residents (28 and 12) were properly labeled. *Medications for four of four residents (28, 50, 6, 12) were dated when opened. *Temperatures for two of two medication rooms (north and south) were monitored for acceptable medication storage temperatures according to the provider's policy. *Expired nutritional supplements and supplies were removed from two of two medication rooms (north and south). Findings include: 1. Observation and interview on 3/24/25 at 2:40 p.m. of a south medication cart with registered nurse (RN) G revealed: *There was a plastic bag with resident 28's identifying information on the outside of the plastic bag. -In the plastic bag was a Levemir (long-acting) insulin pen. --The Levemir pen did not have a resident's name on the label. --It was marked as opened on 2/11/24. *RN G verified the date the Levemir was opened was marked 2/11/24 and there was no resident name on the insulin pen. *She indicated a medication should be labeled with a resident's name to determine who the medication belonged to. *She indicated resident 28 no longer received Levemir. *Resident 28's Latanoprost eye drops (medicated eye drops for glaucoma) had a label on the box that instructed to discard 42 days after opening.	F 761	Director of Nursing or designee will audit up to 5 residents completion of medication labeling and medication room temperatures weekly x3, every other week x3, and monthly x3. Director of Nursing or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Director of Nursing or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	

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F 761	Continued From page 67 -There was no date documented to indicate when the Latanoprost was opened. *Resident 50's Latanoprost eye drops did not indicate a date when it was opened. *Resident 6's Breo Ellipta inhaler (used to treat asthma and chronic breathing issues) had a label on the box that instructed to discard 42 days after opening. -The location on the label for the date the medication did not indicate a date when it was opened. *Resident 12's Breo Ellipta inhaler did not indicate a date when it was opened. *RN G verified resident 28's and 50's Latanoprost eye drops did not contain documentation to indicate when the eye drops were opened. *RN G verified resident 6's and 12's Breo Ellipta inhalers did not indicate when the inhalers were opened. *RN G stated she was aware of some medications that had shortened expiration dates after the medication was opened or removed from the refrigerator. *She verified she would not be able to determine when the expiration on the medications with the shortened expiration dates expired if there was no date documented on the medications. 2. Observation on 3/26/25 at 10:47 a.m. of the South medication room with RN S revealed: *Temperature logs for two refrigerators that were complete. *There was no thermometer in the South medication room. -There was no temperature log to record the temperatures of the medication room. *A lock box for controlled substances in a refrigerator where food was stored. *Five bottles of Pro-Stat (a protein supplement	F 761		

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F 761	Continued From page 68 drink) with an expiration date of 11/14/24. *A bottle of hydrogen peroxide labeled as opened on 4/24/24 with an expiration date of 10/24. *Two bottles of Prosource (a protein supplement drink) with an expiration date of 12/5/24. *Two 14 Fr (French) (measurement of the diameter of catheters and other medical tubes) urinary catheter (a flexible tube inserted into the bladder to drain urine) with an expiration date of 1/31/25. *A partial box of 10cc syringes with an expiration date of 12/1/24. 3. Observation and interview on 3/26/25 at 11:17 a.m. of a South medication cart with unlicensed medication aide (UMA) L revealed: *A Voltaren gel (a topical medication for arthritis pain and inflammation) box that had "[a resident's first name] #1" handwritten on it. -There was no pharmacy label with the medication's dosage, instructions, or the resident's identification. -There was no date documented on the medication to indicate when it was opened. *UMA L stated that the Voltaren gel belonged to resident 12. -She stated the resident's family provided the medication. 4. Observation and interview on 3/26/25 at 11:38 a.m. with clinical care leader (CCL)/infection preventionist (IP) D in the north medication room revealed: *Temperature logs for two refrigerators that were complete. -There was no temperature log to record the temperatures of the medication room. *A bin of 60cc syringes with an expiration date of 12/2014.	F 761		

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F 761	Continued From page 69 *Nurses and medication aides were assigned to check for outdated supplies and medications in the medication rooms and the medication carts once a month. *There was no formal process for the staff assignment or completion of that task. *She verified the temperatures were not monitored or documented in the north or south medication rooms. 5. Interview on 3/27/25 at 8:45 a.m. with licensed practical nurse (LPN) K revealed: *If a medication was brought from home by a resident or a resident's family, staff would encourage the medication to be taken back home with the resident's family. *When he administered medications, he expected the medication to have a pharmacy label that contained the medication name, administration information, and the dispensing pharmacy. *He verified that he would not be able to compare the administration information on the medication with the medication administration record (MAR) on resident 12's unlabeled Voltaren gel. 6. Interview on 3/27/25 at 12:18 p.m. with director of nursing (DON) B revealed: *Medications brought in by residents' families was generally discouraged but is addressed on a case-by-case basis. *If a medication was brought in by a resident's family and the medication must be used by the facility the pharmacist would work with the facility to reconcile the medication. *It was her expectation that those medications be labeled with resident and medication information in order to complete the six rights of medication administration and the three checks during	F 761		

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F 761	Continued From page 70 administration. *It was her expectation that medications be dated when opened. *She had not been aware the temperatures of the medication rooms needed to be monitored for safe storage conditions per the facility policy. 7. Review of the provider's 3/4/25 Medications: Acquisition Receiving Dispensing and Storage policy revealed: *"The resident may secure prescriptions from the pharmacy of his/her choice when not receiving Medicare A services." *"Licensed nursing employees are responsible for ordering from the pharmacy (except Schedule II medications) and checking all new orders of medications from the physician's orders." *"An employee will be responsible for signing for receipt of medication and obtaining the signature of the delivery person. It is preferred that a licensed nurse receive and verify the medications ... Licensed nurses and medications aides (when allowed by state law) are responsible for reconciling medications received." *"The location will routinely check for expired medications and necessary disposal will be done in accordance with state/pharmacy regulations." *"Refrigerators holding medications (such as insulin, etc) will be kept between 36 [degrees] F [Fahrenheit] and 46 [degrees] F. Medication rooms will be kept between 59 [degrees] F and 86 [degrees] F. Check refrigerator temperatures once in the morning and once in the evening." *"Although it is not recommended to store medications with food, if this is done, medications should be kept in closed, labeled containers or compartments with internal and external medication separated; and separate from fruit juices, applesauce and other foods."	F 761		

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F 761	Continued From page 71 *"Controlled drugs (Schedule II) and other drugs subject to possible abuse will be stored in separate, locked, permanently fixed compartments, except when a single unit package drug distribution is used. If the medication requires a refrigerator, these need to be locked in a separate container. These drugs will be reconciled at least daily through an appropriate system of records of receipt and disposition established by the licensed pharmacist." *"These medications must be labeled according to state pharmacy regulations. Cautionary and accessory instructions, as well as the expiration date, will be included. New labels will be applied by the pharmacist or the pharmacist's agent as needed." *"If a medication is not available, please document discussion per #6 of the Local Pharmacy Medication Ordering - R/S, LTC procedure with the physician in the PN-Communication/Visit with Physician/EMR. If a medication is not available from the pharmacy when the order is received, contact the prescriber to determine if a different medication is needed or to determine the time frame acceptable to wait for the medication. 8. Review of the provider's 3/4/25 Medication: Administration Including Scheduling and Medication Aides policy revealed: *"Procedure" -"Review the MAR for medications due." -"Follow the "Six Rights": Right medication, right dose, right resident, right route, right time, and right documentation." -"Perform three checks: Read the label on the medication container and compare with the MAR when removing the container from the supply	F 761		

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F 761	Continued From page 72 drawer, when placing the medication in an administration cup/syringe and just before administering the medication."	F 761		
F 880 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	F 880	Unable to correct prior deficient practice. Listed sinks have been cleaned. All residents have the potential to be at risk when the sinks are not clean and PPE is not worn per policy. Education will be provided by the Director of Nursing or designee on all staff that would provide direct care on proper PPE usage and ensuring that all sinks are clean per policy. Housekeeping checklists have been updated to reflect cleaning of the sinks. Director of Nursing or designee will audit up to 5 residents on PPE usage in EBP rooms and cleanliness of the listed sinks weekly x3, every other week x3, and monthly x3. Director of Nursing or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Director of Nursing or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	5.9.25

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F 880	Continued From page 73 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 Follow proper infection control practices and precaution interventions related to: *The use of personal protective equipment (PPE) to help prevent the transmission of infections for	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435134	A. BUILDING _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 74 three of three sampled residents (1, 31, and 24). *Maintaining the cleanliness of four of four handwashing sinks used by staff (Charting Station 1, Charting Station 2, Charting Area 151, and Charting Area 174) in two of two residential living units (North and South). Findings include: 1. Observation of resident 1's room on 3/24/25 at 3:10 p.m. revealed: *There was a magnet on the door frame of her room that indicated she was on transmission based precautions (TBP). -There were gowns outside of her room for staff to don (put on). Interview on 3/24/25 at 3:12 p.m. with resident 1 revealed: *Resident indicated that she is on EBP because "It tells people who are sick to not come into my room. - She verified they wear gloves when caring for her, but they do not wear gowns. Review of resident 1's electronic medical record (EMR) revealed: *Her 1/7/25 Brief Interview for Mental Status (BIMS) assessment score was 15, indicating she had no cognitive impairment. *Her 3/26/25 revised care plan indicated that she was on enhanced contact precautions (CP) requiring the use of gown and gloves on every entry into her room, regardless of the level of care being provided to the resident. -She had extended spectrum beta-lactamase (ESBL) (bacterial infection that is resistant to many antibiotics and highly contagious). -"Wear gowns when changing contaminated linens and brief."	F 880		

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F 880	Continued From page 75 -" Provide private room and use contact precautions." -She required enhanced barrier precautions (EBP) that required staff to wear gowns and gloves during resident care and activities due to her ESBL. -Staff were to "Don gowns and gloves when performing high contact care activities including dressing, bathing, transferring, providing hygiene such as shaving or brushing teeth, changing linens, repositioning, checking and changing, device care and/or use, and wound care." -"Physical therapy (PT) and occupational therapy (OT) are to use EBP in common areas when therapy activities have risk for repeated contact." -"Educate resident and /or family regarding the importance of good hand hygiene and the need for and duration of EBP." 2. Observation on 3/24/25 at 3:11 p.m. of resident 31's room revealed: *On the door frame outside of resident 31's room there was a magnet that indicated she was on TBP. -Inside of resident 31's room there were gowns and gloves for staff to don. Interview on 03/24/25 at 3:52 p.m. with resident 31 revealed staff do not wear gowns when doing cares with her, but they do wear gloves. Observation on 3/26/25 at 2:07 p.m. of resident 31's room revealed: *Certified nurse assistant (CNA) N and unlicensed medication assistant (UMA) L had exited resident 31's room after providing care for her, both only wearing gloves. *There now was a magnet on the door frame of her room that indicated resident 31 was on EBP.	F 880		

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F 880	Continued From page 76 Interview on 03/26/25 at 2:20 p.m. with CNA N revealed: *She verified that only gloves were worn when she provided cares for resident 31. -She had indicated typically gloves, gown, and a face shield is worn if working with bodily fluids, but stated "I have a tendency to forget." Observation and interview on 3/27/25 at 8:27 a.m. with CNA M revealed: *She had provided cares for resident 31 with glove use only. -She had verified that the resident is on EBP because "She has something in her urine." -She had indicated that they only transferred the resident out of bed to her chair, they were not doing anything with her urine or changing her brief. Review of resident 31's EMR revealed: *Her most recent care plan indicated that she was on EBP related to MDRO (multidrug-resistant organism) colonization. -Interventions on her care plan had indicated to "Don gown and gloves when performing high contact care activities including dressing, bathing, transferring, providing hygiene such as shaving or brushing teeth, changing linens, repositioning, checking and changing, device care and/or use, and wound care." -"Doff (remove) gown and gloves inside resident's room. Perform hand hygiene." -"Educate resident and /or family regarding the importance of good hand hygiene and the need for and duration of EBP." *Her 9/26/24, BIMS assessment score was 15, indicating she had no cognitive impairment.	F 880		

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F 880	Continued From page 77 3. Observation of resident 24's room on 3/24/25 at 3:12 p.m. revealed: *There was a magnet on the door frame of her room that indicated she was on TBP. -There were gowns outside of her room for staff to don. Interview on 03/25/25 at 10:55 a.m. with resident 24 revealed staff do not wear gowns when doing cares with her, but they do wear gloves. Review of resident 24's EMR revealed: *Her 7/24/24 BIMS assessment score was 15, indicating she had no cognitive impairment. *Her most recent care plan indicated that she requires to be on EBP related leg wound. -Interventions on her care plan had indicated to "Don gown and gloves when performing high contact care activities including dressing, bathing, transferring, providing hygiene such as shaving or brushing teeth, changing linens, repositioning, checking and changing, device care and/or use, and wound care." -"Educate resident and /or family regarding the importance of good hand hygiene and the need for and duration of EBP." Interview on 3/24/25 at 5:19 p.m. with clinical care leader (CCL)/infection preventionist (IP) D revealed: *While providing cares to a resident who is on EBP she would do the following: -She had indicated that she would apply her PPE before caring for a resident who is on EBP whenever she is having close contact with them such as working with the resident's linen, changing their clothes or assisting them with their activities of daily living (ADL)'s, or repositioning them.	F 880		

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F 880	Continued From page 78 -She would finish by doffing her PPE prior to leaving their room and then wash or sanitize her hands. 4. Interview on 3/26/25 at 2:50 p.m. with administrator A revealed: *She stated, she would expect staff to "Follow the Policy" and do exactly what the sign says on the door. -When asking Administrator A what the facility's policy is for EBP, she had indicated, gloves, gowns, and masks and whatever the signs tell them to be doing. 5. Interview with clinical care leader (CCL) E on 3/27/25 at 1:04 p.m. revealed: *Her expectation of staff would be for them to follow the precautionary measures by wearing the appropriate PPE according to the EBP policy when caring for the residents. *They have done a performance improvement plan (PIP) within the last year over EBP and had provided education for all staff. 6. Observation on 3/24/25 at 2:00 p.m. of the North Unit Charting Station 2 handwashing sink revealed: -There was a white build-up around the perimeter of the handwashing sink that was removed with a fingernail. That white build-up smelled like soap. -The faucet spout had a white lime build-up around it. Additional lime splashes and stains were observed throughout the inside of the sink basin, at the base of both hand controls, and at the base of the faucet spout. -There was an unidentified brown substance around the sink drain perimeter that was removable with a fingernail. *There was a container of disinfectant wipes near	F 880		

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F 880	Continued From page 79 that sink. 7. Observations on 3/24/25 at 2:30 p.m. and on 3/26/25 at 1:15 p.m. of the North Unit Charting Station 1 handwashing sink revealed the same observed findings described above for the Charting Station 2 handwashing sink. Observation and interview on 3/26/25 at 8:32 a.m. with RN G revealed: *After exiting an unidentified resident's room, RN G had used the Charting Station 2 handwashing sink to wash her hands. -The handwashing sink remained in the same uncleaned condition that it was observed to have been in on 3/24/25. *RN G did not know who was responsible for cleaning that sink or how frequently that sink was cleaned. She agreed the sink was unclean. 8. Observation on 3/26/25 at 1:15 p.m. of the South Unit Charting Area 151 handwashing sink revealed: *The faucet was dripping. -The faucet spout had white lime build-up around it. Additional lime splashes and stains were observed throughout the inside of the sink basin, at the base of the hand controls, and at the base of the faucet spout. -There was an unidentified brown substance around the sink drain perimeter that was removable with a fingernail. *There was no container of disinfectant wipes near that sink. 9. Continued observation of the South Unit Charting Area 174 handwashing sink and interview with certified nurse aide (CNA) M revealed: -The faucet spout had white lime build-up around	F 880		

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F 880	Continued From page 80 it. Additional lime splashes and stains were observed throughout the inside of the sink basin, at the base of the hand controls, and at the base of the faucet spout. -There was an unidentified brown substance around the sink drain perimeter that was removed with a fingernail. *There was a container of disinfectant wipes near that sink. *CNA M had thought the handwashing sink was cleaned daily by a housekeeper. She agreed that sink was unclean. 10. Interview on 3/27/25 at 8:05 a.m. with administrator A and environmental services supervisor Q regarding the cleaning of the above four handwashing sinks revealed: *Those handwashing sinks were expected to have been cleaned daily by housekeeping staff. -Disinfecting and cleaning those sinks and countertops was included on a daily cleaning checklist that housekeeping staff was expected to have followed. Review of the provider's undated "SNF [skilled nursing facility] Checklist for Cleaning Public Areas" checklist revealed disinfecting and cleaning the above handwashing sinks was listed as a task to have been completed daily.	F 880		

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K 000	INITIAL COMMENTS A recertification survey was conducted on 3/26/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Good Samaritan Society - St. Martin Village was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K353 and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 353 SS=C	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the	K 353	Unable to correct prior deficient practice. All residents have the potential to be at risk when fire when the flow tests are not completed on the sprinkler system per policy. Flow test for the sprinkler system were added into our TELS (maintenance work request system) to be checked off by a maintenance employee as they present as a task to be completed. Ancillary manager or designee will audit completion of quarterly flow tests weekly x3, every other week x3, and monthly x3. Ancillary manager or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Ancillary Manager or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	5.5.25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jana McCroden	Senior Director	4.18.25

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 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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K 353	Continued From page 1 provider failed to continuously maintain automatic sprinklers in reliable operating condition (quarterly flow test not done in May 2024). Findings include: 1. Record review on 3/26/15 at 11:00 a.m. revealed the required quarterly flow tests had not been performed in the past year. Quarterly flow tests had been performed on 2/21/24, 8/22/24, and 12/5/24. A quarterly flow test had not been performed in May 2024. Interview with maintenance supervisor at the time of the record review confirmed that condition. Failure to continuously maintain the automatic sprinkler system as required increases the risk of death or injury due to fire. The deficiency affected one of numerous required tests on the automatic sprinkler system.	K 353		
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review, observation, and	K 712	Unable to correct prior deficient practice. All residents have the potential to be at risk when fire drills are not conducted per policy. Fire drills were added into our TELS (maintenance work request system) to be checked off by a maintenance employee as they present as a task to be completed. Ancillary manager or designee will audit completion of fire drills weekly x3, every other week x3, and monthly x3. Ancillary manager or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Ancillary Manager or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	5.5.25

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K 712	Continued From page 2 interview, the provider failed to: *Conduct fire drills for a minimum of one per shift per quarter for 2024 and 2025 for all three shifts. A total of nine fire drills were held from March 2024 through March 2025. No fire drills were held for the third shift during that time period. *Conduct fire drills at varying times. Findings include: 1. Record review on 3/26/25 at 10:00 a.m. of the provider's documentation of fire drills for March 2024 through March 2025 revealed fire drills were conducted on: 3/27/24 at 9:40 a.m. 3/28/24 at 3:00 p.m. 3/29/24 at 7:00 p.m. 6/25/24 at 8:10 a.m. 6/26/24 at 2:17 p.m. 6/28/24 at 7:30 p.m. 9/23/24 at 10:15 a.m. 9/27/24 at 8:20 p.m. 11/15/24 at 11:20 a.m. 12/30/24 at 3:00 p.m. 12/30/24 at 7:50 p.m. 3/26/25 at 10:40 a.m. 2. Record review on 3/26/25 at 10:00 a.m. revealed the fire drill sign-off sheets for staff did not include: *Documentation of who received the fire alarm signal at the monitoring agency. *The time it was received at the monitoring agency. Interview with the administrator during the exit interview on 3/26/25 at 3:30 pm. confirmed their operation of three shifts. Interview with the maintenance supervisor during the exit interview	K 712		

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K 712	Continued From page 3 on 3/26/25 at 3:30 p.m. revealed the provider would perform quarterly fire drills for all shifts during the last month of the quarter. The deficiency had the potential to affect 100% of the building occupants.	K 712		

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E 000	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 3/26/25. Good Samaritan Society - St. Martin Village was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jana McCroden

TITLE: Senior Director

(X6) DATE: 4.18.25

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 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.

South Dakota Department of Health

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	68237	A. BUILDING: _____ B. WING _____	03/27/2025

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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) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 3/24/25 through 3/27/25. Good Samaritan Society - St Martin Village was found in compliance.	S 000		
S 000	Compliance/noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/24/25 through 3/28/25. Good Samaritan Society - St Martin Village was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Jana MCCroden

TITLE
Senior Director

(X6) DATE
4.18.25