STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 5/5/25 through 5/8/25. Strand-Kjorsvig Community Rest Home was found not in compliance with the following requirements: F554, F655, F657, F658, F695, F699, F755, F761, F812, F835, F865, F868, F880, F881, and F882.	F 000		
F 554 SS=E	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure: *Four of four sampled residents (3, 8, 9, and 18) had been assessed to determine their ability to safely self-administer medications. *Three of four sampled residents (3, 9, and 18) had a physician's orders to self-administer those medications as directed in the provider's policy. Findings Include: 1. Observation and interview on 5/5/25 at 1:39 p.m. and 1:57 p.m. with resident 9 in his room revealed: *There was a nebulizer machine (a machine that converts liquid medication into an inhalable mist) on the floor to the left of his recliner. *He sat in his recliner and held his nebulizer mask to his face to administer the medication. *He reached down and shut off that nebulizer	F 554	Resident 3, 8, 9, and 18 assessed for ability to self-administer medications. Ensured resident 3, 8, 9, and 18 have physician's orders to self-administer medications. Assessed all other necessary residents for self-administration of medication and proper physician orders. All nurses educated with documentation on self-administration of medications by DON or designee by 6/22/25. Administrator, DON, and interdisciplinary team will review and revise policies and procedures as necessary. Policies will be reviewed with all necessary staff and PRN ongoing. ADON or designee will audit all resident that have self-administration weekly for 4 weeks and monthly for 2 months or longer as determined by audit results. ADON or designee will report findings at monthly QAPI meetings until audit is complete and issue no longer needs to be addressed.	6/22/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Samuel Van Voorst | Administrator | 6/9/25

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 554	Continued From page 1	F 554		

machine, then turned it back on when the surveyor stated she would return.
-He kept the nebulizer machine on the floor, so it was easy for him to reach, and it was quieter there.
*He stated that the nurse would put the medication in the nebulizer mask, and he would administer his nebulizer treatment.
*He hung the nebulizer mask from the tack on his calendar between the four nebulizer treatments he received each day.
-He was unsure when the nebulizer mask would need to be cleaned, but thought the nurse did that once a day.
*There were two unmarked clear plastic medication cups on his bedside stand, one containing a green gel and the other a light-yellow ointment.
-He stated that the light-yellow ointment was a thick lotion for his feet. "It would be nice if the staff would rub it in. That cream is as thick as axle grease."
-The green gel was Biofreeze (pain-relieving gel) for when the therapist came and "worked on" his neck.
*The nurse had left those creams there for him to use when he needed them.
*He stated that the nurse also brought his antacid medication and left that in a small cup next to his bed for him to take when he woke up each morning.
-He had been angry that the nurse would wake him up and had told the nurse he wanted to refuse that medication so he could sleep.
--The nurse now left the medication on his nightstand each morning and did not wake him.

Observation on 5/5/25 at 4:04 p.m. with resident 9 in his room revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 554	Continued From page 2	F 554		

*The nebulizer machine was on the floor to the left of his recliner.
*He sat in his recliner and held his nebulizer mask to his face to administer the medication.

Observation and interview on 5/6/25 at 11:20 a.m. with resident 9 in his room during the administration of a nebulizer treatment by licensed practical nurse (LPN) F revealed:
*He had a bottle of Neomycin-Polymyxin otic solution (antibiotic ear drops) on the shelf above his sink that expired in August 2022.
*There were two clear plastic medication cups on his bedside stand that contained a light-yellow ointment and were not labeled with a resident's name or the cups' contents.
*After the completion of the nebulizer administration, while LPN F rinsed the nebulizer mask out in the sink, resident 9 stated he usually did not rinse out his mask after he completed his nebulizer treatments, and he would "just hang it on here" as he pointed to a tack on the wall beside his recliner.

Observation and interview on 5/6/25 at 4:25 p.m. with resident 9 regarding the antibiotic ear drops in his room revealed:
*The drops were from when he had an ear infection when he lived at home, "a couple of years ago."
*He stated he now puts a couple of drops in his ears "when they itch."
*He was unaware that they had expired.

Review of resident 9's electronic medical record (EMR) revealed:
*He was admitted on 12/2/24.
*He had a Brief Interview of Mental Status (BIMS) assessment score of 11, which indicated he was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 554	Continued From page 3	F 554		

moderately cognitively impaired.
*A 12/3/24 physician's order for "Omeprazole [an antacid] Oral Capsule Delayed Release 20 MG [milligrams]." "Give 1 capsule by mouth in the morning for esophageal varices," was scheduled for administration at 6:00 a.m. every day.
*A 5/1/25 physician's order for "Ipratropium-Albuterol Inhalation Solution [an inhaled medication to ease breathing by opening the airway in the lungs] 0.5-2.5 (3) MG/3ML [milliliter] 1 vial inhale orally four times a day for bronchitis for 5 Days."
*A 2/27/25 physician's order for "Biofreeze External Cream 10%... Apply to [the] affected area topically every 6 hours as needed for Pain. Apply to [the] affected area up to QID [four times a day] PRN [as needed]."
*A 12/2/24 physician's order for "Aquaphor External Ointment Apply to dry skn [skin] topically as needed for Bilateral [both] feet." "Apply BID [two times a day] PRN."
*There was no physician's order for his self-administration of medications.
*There was no documentation that he had been assessed for his ability to safely self-administer medications.
*His care plan did not address self-administration of medications.

Observation and interview on 5/6/25 at 4:38 p.m. with LPN I regarding resident 9's medication orders revealed:
*Resident 9 did not have an order for the antibiotic ear drops.
-She was unaware that those drops were in his room and thought his family would have brought them to him from home.
*She confirmed that the light-yellow ointment was Aquaphor and the green gel was Biofreeze.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 554	Continued From page 4 *She confirmed that resident 9 did not have a physician's order for self-medication administration for any of his medications. *She stated, "Nobody in the facility has a self-medication order." *She had not left medications at resident 9's bedside. *She confirmed that he would need a physician's order for his self-administration of the Biofreeze, antibiotic ear drops, and nebulizer treatments. -She did not think he needed a physician's order for the Aquaphor. 2. Observation and interview on 5/7/25 at 9:28 a.m. with resident 8 in his room revealed: *There was a bottle of cream with a prescription label on it on the table to the left of his chair and a bottle of powder with a prescription label on it on the shelf above his sink. *He stated he put the cream on his feet twice a day and used the powder "about three times a week" when he got himself washed and dressed in the morning. Review of resident 8's EMR revealed: *He was admitted on 8/12/22. *He had a BIMS assessment score of 15, which indicated he was cognitively intact. *A 3/4/25 physician's order for "Nystatin Powder ... Apply to groin folds topically two times a day ...MAY KEEP NYSTATIN IN HIS ROOM." *A 3/4/25 physician's order for "Sarna External Lotion 0.5-0.5%... Apply to feet & legs topically two times a day for Dry skin MAY KEEP SARNA IN HIS ROOM." *There was no documentation that he was assessed for his ability to safely self-administer medications. *His care plan did not address his	F 554		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 554	Continued From page 5 self-administration of medications Interview on 5/6/25 at 4:38 p.m. with LPN I regarding resident 8's medications revealed she confirmed that resident 8 self-administered the above-listed medications, and that he had physician's orders to keep his Sarna lotion and nystatin powder at his bedside. 3. Observation and interview on 5/5/25 at 1:26 p.m. with resident 3 in her room revealed: *There was an assembled nebulizer mask draped over a nebulizer machine on her bedside stand. *She stated she rinsed out the nebulizer mask in the sink after she completed her nebulizer administration, reassembled the mask and then laid it on her bedside table. *She verified that she administered her own nebulizer treatment after the nurse brought in the nebulizer medication and set up the treatment. Review of resident 3's electronic medical record (EMR) revealed: *She was admitted on 2/6/25. *She had a Brief Interview of Mental Status (BIMS) assessment score of 15, which indicated she was cognitively intact. *She had a 4/21/25 physician's order for "Albuterol Sulfate Inhalation Nebulization Solutions 2.5 MG/0.5 ML [an inhaled medication to ease breathing by opening the airway in the lungs] (Albuterol Sulfate) 1 vial inhale orally three times a day" and "every 4 hours as needed for SOB [shortness of breath]". *There was no physician's order for her self-administration of medications. *There was no documentation that she was assessed for her ability to safely self-administer medications.	F 554		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 554	Continued From page 6 *Her care plan did not address her self-administration of medications. 4. Observation on 5/6/25 at 2:53 p.m. of resident 18's room revealed a partial container of Vicks Vapor Rub medicated ointment was on the arm of his recliner. Review of resident 18's EMR revealed: *He was admitted on 10/2/23. *He had a BIMS assessment score of 8, which indicated he was moderately cognitively impaired. *He did not have a physician's order for the Vicks Vapor Rub medicated ointment. *He did not have a physician's order for his self-administration of medications. *There was no documentation that she was assessed for his ability to safely self-administer medications. *His care plan did not address his self-administration of medications or the storage of medications in his room. 5. Interview on 5/6/25 at 2:47 p.m. with LPN I revealed she stated: *There were no residents who were to self-administer medications in the facility. *For a resident to self-administer medications it would have required a physician's order for medication self-administration. Continued interview on 5/6/26 at 2:55 p.m. with LPN I regarding the Vicks Vapor Rub medicated ointment in resident 18's room revealed: *Vicks Vapor Rub was a medicated ointment and it would have required a physician's order for administration. *Resident 18 did not have a physician's order for Vicks Vapor Rub or the self-administration of it.	F 554		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 554	Continued From page 7 *He did not have a medication self-administration assessment documented in his EMR to support he was assessed for his ability to safely self-administer medication. 6. Interview on 5/8/25 at 9:21 a.m. with director of nursing (DON) C revealed: *She would consider medications in a resident's room that the resident was taking or applying independently, as self-administration of medication. *She expected no medications to be stored at a resident's bedside without a physician's order for self-administration. *It was their policy only nebulizer treatments were assessed for self-administration. *She was aware that resident 9 had been self-administering his nebulizer treatment, had antibiotic ear drops and prescribed creams in his room, and that a nurse had left his omeprazole at his bedside without waking him. -She verified that resident 9 did not have a physician's order or assessment for self-administration of medications. *She was aware that resident 8 had a lotion and a powder at his bedside because he had requested those, and they had obtained an order from his physician. *They had completed a self-administration assessment in 2022 when resident 8 had self-administered his nebulizers. -She confirmed there was no self-administration assessment done for resident 8's lotions or powders to ensure he was safe to self-administer those. *She verified that resident 3 did not have a physician's order or assessment for self-administration of medications. *She was unaware that resident 18 had Vicks	F 554		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 554	Continued From page 8	F 554		

Vapor Rub medicated ointment in his room.
-She verified resident 18 did not have a physician's order or assessment for self-administration of medications.
*She stated there were residents in the facility with cognitive impairment who wandered into other resident rooms.
*One of the cognitively impaired residents who wandered into residents' rooms had a history of rummaging through items in other residents' rooms.
*She agreed that some of their policies did not reflect their processes, and some of those policies, including those related to nebulizers, were inconsistent with other policies they had.
*She confirmed there were no residents who had been assessed for self-administration of medication.
*She confirmed there were no residents who had a physician's order for self-admininstration.

7. Review of the provider's January 2018 Self-Administration of Medications policy revealed:
*"In order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer."
*"If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility during the care planning process."
*"For those residents who self-administer, the interdisciplinary team verifies the resident's ability

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 554	Continued From page 9	F 554		

to self-administer medications by means of a skill assessment conducted on a quarterly basis or when there is a significant change in condition."
*"The results of the interdisciplinary team assessment of resident skills and of the determination regarding bedside storage are recorded in the resident's medical record, on the care plan. For each medication authorized for self-administration, the label contains a notation that it may be self-administered."
*"If the resident demonstrates the ability to self-administer medications, a further assessment of the safety of bedside medication storage is conducted."
*"Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the rooms of, or room with, residents who self-administer."

Review of the provider's 4/1/21 Self-Administration of Medications policy revealed:
*"To ensure doctor orders are followed and correctly documented, ensuring the highest level of care is provided..."
*"The only Medications that residents... will [be] able to be self-administer[ed] are inhaled medications. Refer to "self-Administration of Nebulizer Treatments." for more details."

Review of the provider's 4/1/22 Self-Administration of Nebulizer Treatments policy revealed:
*"...Inhaled medications may be taken without supervision after a nurse or CMA [certified medication aide] setup, a doctor order [is] on file, and Self-Administration of Nebulizer Treatments Assessment is completed."
*"Resident must be evaluated by nursing for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 554	Continued From page 10 appropriateness of their ability to self-administer Nebulizer Treatments. Assessments will be completed quarterly based on MDS scheduling. Nursing is responsible for obtaining doctor order, care planning the self-administration of inhaled meds along with any restrictions..."	F 554		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655	Cannot correct prior noncompliance. Will ensure baseline care plan is completed and provide a written summary of baseline care plan to resident or resident representative within 48 hours of admission. DON and nurses educated with documentation on baseline care plans by 6/22/25. Administrator, DON, and interdisciplinary team will review and revise policies and procedures as necessary. All necessary staff educated on policy. DON or designee will audit baseline care plans on new admissions weekly for 4 weeks and monthly for 2 months or longer as determined by audit results. DON or designee will report findings at monthly QAPI meetings until audit is complete and issue no longer needs to be addressed.	6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 655	Continued From page 11 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, interview, observation, and policy review, the provider failed to complete a baseline care plan and provide a written summary of the baseline care plan to the resident or their representative for four of four recently admitted sampled residents (9, 19, 25, and 79) within 48 hours of their admission to the facility. Findings include: 1. Review of resident 9's electronic medical record (EMR) revealed: *He was admitted on 12/2/24. *His Brief Interview of Mental Status (BIMS) assessment score was 11, which indicated he was moderately cognitively impaired. *His baseline care plan was initiated on 12/2/24. *The section "Signature and Representative" and the date had been left blank. *There was no documentation that indicated the care plan was reviewed with him, his representative, or that he had been provided or offered a copy of his baseline care plan within 48 hours of his admission.	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 655	Continued From page 12	F 655		

Interview on 5/6/25 at 4:25 p.m. with resident 9 regarding his care plan revealed he did not recall if anyone had reviewed his care plan or his medications with him in the first 48 hours after he had been admitted to the facility.

2. Review of resident 19's EMR revealed:
*She was admitted on 4/22/24.
*Her BIMS assessment score was 8, which indicated she was moderately cognitively impaired.
*Her baseline care plan was initiated on 4/22/24 and indicated it was "In Progress."
*The following sections were incomplete:
-"Active diagnoses contributing to admission" had been left blank.
-"Signature and Representative" and the date had been left blank.
-"Signatures of Staff Completing the Baseline Care Plan" had been left blank.
*There was no documentation that indicated the care plan was reviewed with her, her representative, or that she or her representative had been provided or offered a copy of her baseline care plan within 48 hours of her admission.

Interview on 5/7/25 at 2:49 p.m. with resident 19 regarding her care plan revealed she did not recall if anyone had reviewed her care plan or her medications with her in the first 48 hours after she had been admitted to the facility.

3. Observation and interview on 5/6/25 at 8:55 a.m. with resident 79 in her room revealed she:
*Could not remember the exact date she was admitted, but she knew it was in March 2025.
*Had been in and out of the hospital at least two times since she was admitted due to blood loss.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 655	Continued From page 13 *Did not know what a care plan was. Review of resident 79's EMR on 5/7/25 revealed: *She was admitted on 3/3/25. *Her 3/10/25 BIMS assessment score was 10, which indicated she was moderately cognitively impaired. *Her baseline care plan had been initiated on 3/3/25 but was not completed. *The baseline care plan was labeled 'Errors" in the EMR. *There were no progress notes that indicated a baseline care plan was reviewed or given to the resident or her representative. 4. Observation and interview on 5/5/25 at 1:44 p.m. with resident 25 in his room revealed he: *Was lying in bed with his eyes open and a CPAP (a machine that uses air pressure to keep breathing airways open) on. *Had a black equalizer boot (a boot used to improve stability and decreased pain and swelling) on his right leg. *Had been admitted to the facility a few weeks ago after he broke his right ankle *Stated he was at the facility to receive therapy services and planned to return home after his therapy was completed. Review of resident 25's EMR revealed: *He was admitted on 4/8/25. *His BIMS assessment score was 15, which indicated he was cognitively intact. *His baseline care plan was initiated on 4/8/25. *His baseline care plan did not indicate his use of a CPAP machine. *His baseline care plan did not contain a signature or date that would indicate the care plan was reviewed with him, if he was offered or provided a copy of his baseline care plan or when	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 655	Continued From page 14	F 655		

that may have occurred.

Follow-up interview on 5/7/25 at 9:42 a.m. with resident 25 in his room revealed he did not:
*Recall reviewing his plan of care with a staff member.
*Receive or was offered a copy of his care plan.

5. Interview on 5/8/25 at 11:30 a.m. with director of nursing (DON) C regarding residents' baseline care plans revealed:
*The baseline care plan was initiated at the time of resident's admission.
*She reviewed the baseline care plan with the resident or resident representative on admission.
*She offered the resident or the resident representative a copy of the baseline care plan but stated they rarely accepted it.
*She verified resident 19, 25, and 79's baseline care plans were incomplete and did not contain documentation to support that those residents' care plans had been reviewed with the residents or their representative or that a copy of the baseline care plans were offered to them.

6. Review of the provider's February 2025 Care Planning Process policy revealed:
*"Using an interdisciplinary approach, each resident will have an individualized plan of care which addresses the resident's current care needs and severity of condition, impairment, disability, or disease."
*"An interim plan of care [baseline care plan] will be developed by the Admission nurse within 24 hours after admission utilizing the resident profile. Specific care needs will be transferred to the CNA pocket care plan."
-The provider policy did not contain that the baseline care plan was to be reviewed with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 655	Continued From page 15 resident or resident representative within 48 hours of admission.	F 655		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to ensure care plans were reviewed and revised to reflect the current care needs for seven of twelve	F 657	Resident 7, 8, 9, 14, 17, 19, and 25 care plans have been revised and updated by MDS coordinator. All other residents care plans reviewed and revised by MDS coordinator or designee. Care plans on residents will be reviewed, revised, and updated quarterly and as needed to reflect their current needs. DON, MDS Coordinator, SSD, and Activities Director and/ or designee will update information on care plans. Administrator, DON, medical director, and interdisciplinary team will review and revise policies as necessary. All necessary staff educated of policy. DON or designee will audit 3 care plans once per week for 4 weeks, and monthly for 2 additional months or longer as determined by audit results. DON or designee will report findings at monthly QAPI meetings until audit is complete and issue no longer needs to be addressed.	6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 657	Continued From page 16 sampled residents (7, 8, 9, 14, 17, 19, and 25). Findings include: 1. Observation and interview on 5/5/25 at 1:39 p.m., 1:57 p.m. and again at 4:04 p.m. with resident 9 in his room revealed: *There was a large table that took up most of his room with a puzzle on it. He stated he spent much of his time working on puzzles. -He had completed several puzzles that were hung throughout the facility. *He had been admitted from [name of institution] and would be transferred to another facility. Review of resident 9's electronic medical record (EMR) revealed: *He was admitted on 12/2/24. *His Brief Interview of Mental Status (BIMS) assessment score was 11, which indicated he was moderately cognitively impaired. *There was no documentation in his care plan that indicated his activity interests related to puzzles or his discharge plans. 2. Observations and interview on 5/5/25 at 2:35 p.m. and 5:22 p.m. with resident 17 and her husband revealed: *Resident 17 shared a room with her husband, who was an assisted living resident, and they sat in separate recliners in their room. *Resident 17 had an electric recliner that she was unable to operate independently. *Resident 17's husband stated that only he and the staff operated the resident's electric recliner when she would rest to elevate her feet. -Sometimes he needed to elevate the recliner so she could get up when it was time to go to dinner. *She did not attempt to operate the recliner on her own.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 657	Continued From page 17 *Resident 17 did not respond to any questions. Interview on 5/5/25 at 5:01 p.m. with certified nursing assistant (CNA) M regarding resident 17 revealed: *At times, she would sit in either recliner in her room. *She would follow simple directions, but did not respond to any questions asked of her. Observation and interview on 5/5/25 at 8:34 a.m. with resident 17 and physical therapy assistant (PTA) P revealed: *Resident 17 followed simple commands, walked with PTA P holding her hand, and her speech was unintelligible. *PTA P stated that resident 17 was on a "maintenance and positioning program" that included therapy twice a week and elevating her feet in her recliner. *PTA P had educated the staff that resident 17 was to sit in her recliner for "half an hour twice a day with her feet elevated." *Resident 17 was unable to operate the remote and was to sit in her recliner with her feet elevated only when her husband was in the room. *She had never seen resident 19 touch the recliner remote. Interview on 5/7/25 at 4:07 p.m. with CNA L revealed: *Resident 17 sat with her feet elevated in the recliner only when her husband was in the room because "it was safer." *She knew what care each resident required because it was in their care plan in the EMR. -She was unsure if resident 17's use of the recliner or positioning program would be included in her care plan.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 657	Continued From page 18	F 657		

Review of resident 17's EMR revealed:
*She was admitted on 8/23/23.
*Her 3/17/25 Minimum Data Set (MDS) indicated she was rarely understood or able to understand others and was severely cognitively impaired.
*There was no documentation in her care plan that indicated her participation in a therapy maintenance and positioning program, or that her feet were to be elevated while in her recliner with her husband's supervision.

Interview and review of resident 17's positioning program on 5/8/25 at 9:15 a.m. with director of nursing (DON) C revealed:
*She was not aware that resident 17 was on a positioning program provided by PTA P.
*That positioning program included the instruction to "Please ensure pt [resident 17] is elevating LE's [lower extremities] in recliner at least 2X [two times] per day for edema management. Once in the am [morning] and once in PM [afternoon]. Spouse is also educated and showed how to work recliner if she does try to get up."
*She expected that the positioning program and the instruction for elevating her lower extremities in the recliner to be included in resident 17's care plan.

3. Observations and interview on 5/5/25 at 2:32 p.m. and again on 5/6/25 at 2:06 p.m. with resident 19 in her room revealed:
*There were signs in her room to provide reminders on where her snacks were located.
*Her hands were tremoring and she rubbed her fingers together.
*She answered questions with brief responses.
*She was lying on her bed, and her legs were in constant movement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 657	Continued From page 19 *There were no bed rails on her bed. Observations on 5/5/25 at 5:27 p.m. and again on 5/6/25 at 7:33 a.m. with resident 19 in the dining room revealed: *She was seated at the table in a dining room chair. *She held tightly to the chair and would scoot forward and back in that chair. *At times, she would stand and then return to sitting. *She appeared restless and anxious. *Her upper body was stiff, and her arms appeared tense. Review of resident 19's EMR revealed: *She was admitted on 4/22/24. *Her BIMS assessment score was 3, which indicated she was severely cognitively impaired. *Her diagnoses included Wernicke's Encephalopathy (a neurological condition caused by lack of vitamin B1), anxiety disorder, amnestic disorder (memory loss), and drug-induced subacute dyskinesia (a movement disorder caused by certain medications). *Resident 19's progress notes indicated: -On 4/28/24, Resident 19 " ...has been anxious since [the] beginning of [the] shift." -On 6/24/24, "Resident brought up to [the] nurse station. Crying and shaking ... PRN [as needed] Ativan [a medication for anxiety] given." -On 8/2/24, "Due to her being upset, pacing, and repeatedly questioning things [she] was given Lorazepam [a medication for anxiety] again this evening." -On 10/30/24, "Unfortunately her anxiety is keeping her from being distracted/redirected. She was given a prn [PRN] Ativan before lunch and [it] is not effective in managing symptoms at this	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 657	Continued From page 20 time. Update provided to [physician]. -On 12/17/24, "She is pacing about the facility in an anxious state." -On 2/25/25, "Resident noted to be pacing up and down the hallways ...PRN lorazepam given." -On 4/7/25, she "is up much of the night asking for medications to help her sleep ... Current PRNs are not very effective." *Her care plan indicated that resident 19 used "bilateral top quarter rails to enable her independence with bed mobility, repositioning, and transfers in and out of bed," which was initiated on 5/1/24. *There was no documentation in her care plan that indicated current or past non-pharmacological interventions that had been tried to address resident 19's anxiety symptoms. Interview on 5/8/25 at 7:43 a.m. with LPN/social service designee (SSD) D revealed: *She was aware of resident 19's history of anxiety, pacing, and crying, and confirmed that those behaviors were still present. *She completed sections of the care plan related to the resident's code status, discharge to home planning, their religion, and who they received mental health services from. *She did not complete sections related to the resident's mood or behavior; she thought nursing had completed that section. Interview on 5/8/25 at 8:37 a.m. with DON C and LPN/SSD D regarding resident 19's care plan revealed: *LPN/SSD D completed bed rail assessments and care planned the use of the bed rails. *Resident 19 had been assessed for the use of bed rails, had bed rails on her bed, and then had requested that the bed rails be removed.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 657	Continued From page 21 *The use of bed rails was not removed from her care plan because resident 19 often changed her mind and forgot what she had requested, and she may want them back on the bed in the future. *DON C confirmed that resident 19's care plan should have been updated when the bed rails had been removed. *DON C confirmed that resident 19's care plan did not reflect her current care needs and interventions used to manage her anxiety, pacing, and crying, or the status of the mental health services they had been working to implement. 4. Observation and interview on 5/7/25 at 9:28 a.m. with resident 8 in his room revealed: *There was a bottle of cream with a prescription label on it on the table to the left of his chair, and a bottle of powder with a prescription label on it on the shelf above his sink. *He stated he put the cream on his feet twice a day and used the powder "about three times a week" when he got himself washed and dressed in the morning. Review of resident 8's EMR revealed: *He was admitted on 8/12/22. *He had a BIMS assessment score of 15, which indicated he was cognitively intact. *A 3/4/25 physician's order for "Nystatin Powder ... Apply to groin folds topically two times a day ...MAY KEEP NYSTATIN IN HIS ROOM." *A 3/4/25 physician's order for "Sarna External Lotion 0.5-0.5%... Apply to feet & legs topically two times a day for Dry skin MAY KEEP SARNA IN HIS ROOM." *There was no documentation in his care plan that addressed his self-administration of those medications.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 657	Continued From page 22 Interview on 5/6/25 at 4:38 p.m. with LPN I regarding resident 8's self-administration of medications revealed she was unsure if that should have been included in his care plan. 5. Observation and interview on 5/5/25 at 4:07 p.m. with resident 7 in his room revealed: *He was sitting in his recliner. *He was not sure if he had been offered counseling sessions. *His biggest concern at that time was the food he was being served. Review of resident 7's EMR revealed: *He was admitted on 11/22/22. *His 3/31/25 BIMS assessment score was 11, which indicated he was moderately cognitively impaired. *His diagnoses included: -Post-traumatic stress disorder (PTSD), unspecified. -Delirium due to a known physiological condition. -Personal history of other mental and behavioral disorder. -Major depressive disorder, recurrent, severe with psychotic symptoms. Review of resident 7's 4/1/25 care plan revealed: *He had a focus area of, "an ADL [activities of daily living] self-care performance deficit r/t [related t]) delirium/depression/PTSD. *The goal for the area was to maintain his current level of function through the next review. *There were no interventions included in his care plan to suggest how to address issues that may arise from his PTSD. Interview on 5/6/25 at 4:36 p.m. with licensed LPN/SSD D regarding resident 7 and residents	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 657	Continued From page 23	F 657		

with a PTSD diagnosis revealed:
*If a resident had a PTSD diagnosis, they were to be set up with an appointment with behavioral health services.
*PTSD was to be entered into the care plan.
*She was not aware of any interventions entered into resident 7's care plan for his PTSD that would educate staff to help him cope or to prevent potential triggers for retraumatization.

6. Observation on 5/5/25 at 12:59 p.m. of resident 14's room revealed a sign on his door that read, "Do Not Disturb".

Review of resident 12's EMR revealed:
*He was admitted on 5/24/23.
*His BIMS assessment score was 12, which indicated he had moderate cognitive impairment.
*His diagnoses included anxiety disorder, major depressive disorder, hallucinations, post-traumatic stress disorder (PTSD), and vascular dementia with psychotic disturbance, mood disturbance, and anxiety.
*He was a military service veteran.
*There was a focus area in resident 14's care plan that stated resident 14, "became angry with another resident and struck him in the left cheek with a closed fist. [Resident 14] stated he got angry when he asked this resident a question and he didn't respond to him."
-Interventions for this focus area were, "Staff will monitor [resident 14's] and the other resident's whereabouts in the dining room. Writer explained to [resident 14] that he is not allowed to touch anyone else. [Resident 14] voiced understanding."
*His care plan did not address his behaviors, triggers, or interventions related to his diagnoses.
*"There was no information in the care plan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 657	Continued From page 24	F 657		

related to the "Do Not Disturb" sign that was posted on the resident's door.

Interview on 5/7/25 at 9:48 a.m. with licensed practical nurse (LPN) I revealed:
*Staff utilized pocket care plans, the communication binder, and resident care plans to determine the care that each resident required.
*She verified the pocket care plans were currently not up to date and did not include some of the more recently admitted residents and their needs.
*She indicated resident 14 could get "worked up at times" when he thought people were stealing from him.
*She was aware of an incident when resident 14 struck another resident in the face with a closed fist.
*She indicated staff would talk to him after the incidents or at times when he was worked up, and he would calm.

Interview on 5/8/25 at 8:59 a.m. with LPN/SSD D revealed:
*She verified resident 14 had an altercation with another resident and had struck another resident in the face with a closed fist.
*Resident 14's care plan had a focus area of "sees mental health provider from [a nearby town] for mental health needs" with an intervention that stated, "Attend appointments as scheduled and PRN [as needed]."
*She stated behaviors, triggers, and interventions for residents' behaviors should have been identified in their care plan.
*She verified there were no behaviors or interventions related to resident 14's PTSD, anxiety, or hallucination diagnoses in his care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 657	Continued From page 25 Interview on 5/8/25 at 11:53 a.m. with DON C revealed: *Resident 14 had not seen a mental health provider since early 2024. *He had not and was not seeing a mental health provider in the town indicated on his care plan on a scheduled or as needed basis. 7. Observation and interview on 5/5/25 at 1:44 p.m. with resident 25 in his room revealed: *He was lying in bed with his eyes open and a CPAP (a machine that uses air pressure to keep breathing airways open) on. *He stated he had worn his CPAP for several years and he had brought it into the facility from home when he was admitted. Review of resident 25's EMR revealed: *He was admitted on 4/8/25. *His BIMS assessment score was 15, which indicated he was cognitively intact. *He had diagnoses of other forms of dyspnea (difficulty breathing), and obstructive sleep apnea (intermittent airflow blockage during sleep). *His care plan did not address his respiratory diagnoses or the use of his CPAP machine. 8. Interview on 5/8/25 at 11:30 a.m. with director of nursing (DON) C revealed: *Care plans could be updated by the direct resident care nurses, the social service designee, the Minimum Data Set (MDS) nurse, and herself. *She indicated most of the residents' care plan updates were completed by the MDS nurse. *She expected residents' care plans to be updated quarterly, annually, with a resident's significant change and any time there was a change in the care for the resident. *The residents' care plans did not reflect the	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 657	Continued From page 26 current care needs and interventions that had been implemented or needed to meet those needs. *The provider had not completed any formal audits of residents' care plans but she and the MDS nurse reviewed resident care plans weekly for residents scheduled to have their quarterly or annual MDS assessments completed. 9. Review of the provider's updated February 2025 Care Planning Process revealed: *"To define the personnel's responsibility in initiating and maintaining the resident's care plan." *"To ensure a comprehensive, individualized plan of care for each resident." *"Using an interdisciplinary approach, each resident will have an individualized plan of care which addresses the resident's current care needs and severity of condition, impairment, disability, or disease." Review of the provider's March 2025 Facility Assessment policy revealed "Find out what resident's preferences and routines are; what makes a good day for the resident; what upsets him/her and incorporate this information into the care planning process. Make sure staff caring for the resident have this information and are aware of preferences."	F 657		
F 658 SS=E	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.	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 658	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on record review, observation, interview, and policy review, the provider failed to ensure: *A physician-ordered Abnormal Involuntary Movement Scale (AIMS) assessment was completed and the results were communicated for one of one sampled resident (19) who received an antipsychotic medication. *The physician was notified of one of one sampled residents' (25) insulin having been held related to low blood sugars. Findings include: 1. Observations and interview on 5/5/25 at 2:32 p.m. and again on 5/6/25 at 2:06 p.m. with resident 19 in her room revealed: *There was a tremoring of both of her hands, and she rubbed her fingers together. *She answered questions with brief responses. *She was lying on her bed, and her legs were in constant movement. Observations on 5/5/25 at 5:27 p.m. and again on 5/6/25 at 7:33 a.m. with resident 19 in the dining room revealed: *She was seated at the table in a dining room chair. *She held tightly to the chair and would scoot forward and back in that chair. *At times, she would stand and then return to sitting. *She appeared restless and anxious. *Her upper body was stiff, and her arms appeared tense. Review of resident 19's electronic medical record (EMR) revealed: *She was admitted on 4/22/24.	F 658	AIMS assessment on resident 19 completed. All other residents checked for orders on AIMS assessments and completed AIMS if necessary. Unable to correct past noncompliance of notifying physician of resident 25's insulin being held. Will ensure physicians are notified of low blood sugars going forward. Reviewed to ensure physician was notified if blood sugar was low and insulin was held. All nurses educated by DON or Designee with documentation AIMS assessments and notifying physicians of low blood sugars by 6/22/25. Administrator, DON, and interdisciplinary team will review and revise policies and procedures as necessary. All necessary staff educated on policy. DON or designee will audit all residents with low blood sugars and AIMS assessments weekly for 4 weeks and monthly for 2 months or longer as determined by audit results. DON or designee will report findings at monthly QAPI meetings until audit is complete and issue no longer needs to be addressed.	6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 658	Continued From page 28 *She had a Brief Interview of Mental Status (BIMS) assessment score of 3, which indicated she was severely cognitively impaired. *Her diagnoses included Wernicke's Encephalopathy, anxiety disorder, amnestic disorder, and drug-induced subacute dyskinesia. *A 3/13/25 physician's order: "Complete AIMS assessment in 1 month and fax results." And "Nursing to provide fax status update in 1 month on mood/behaviors and PRN [as needed] Lorazepam [medication used for anxiety] use." *AIMS assessments were completed on 11/3/24 and 2/23/24. *There was no documentation that an AIMS assessment had been completed since 2/23/24. *There was no documentation that the physician had been provided the results of the ordered AIMS assessment or had been provided a status update on resident 19's mood/behaviors or Lorazepam use. Interview on 5/8/25 at 8:23 a.m. with director of nursing (DON) C regarding resident 19's 3/13/25 physician's orders revealed: *DON C confirmed that resident 19's last AIMS assessment was completed on 2/23/24. *On 3/24/25, she communicated the results of resident 19's Patient Health Questionnaire-9 (PHQ-9) (an assessment of the degree of depression) to the physician. *She confirmed that they had not conducted the AIMS assessment as ordered on 3/12/25 or provided an update on the use of resident 19's Lorazepam. *She expected that the AIMS assessment would have been completed in mid-April, and the result of that assessment would have been provided to the physician along with an update on resident 19's mood/behaviors and Lorazepam use.	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 658	Continued From page 29	F 658		

Review of the provider's 1/1/25 revised Physician Visit and Physician Delegation policy revealed:
*"It is the policy of this facility to ensure the physician takes an active role in supervising the care of residents."
*"The Licensed Nurse should: a. Track the due dates of physician visits ...e. Provide records such as weight and vital sign records, accident reports, etc. for physician review."
*"The Director of Nursing or Designee should: a. Conduct monthly audits for timeliness of physician visits.

Review of the provider's Physician Medication Orders policy revealed it did not address the following physician orders unrelated to medications.

Request for policies related to following physicians' orders resulted in the above-referenced policies. There were no additional polices for review.
2. Interview on 5/5/25 at 1:44 p.m. with resident 25 in his room revealed:
*He had diabetes.
*His blood sugars had been running lower than normal since he admitted to the facility and his physician had been adjusting his insulin doses.

Review of resident 25's EMR revealed:
*He was admitted on 4/8/25.
*His BIMS assessment score was 15, which indicated he was cognitively intact.
*He had a diagnosis of diabetes.
*He had a physician's order to have his blood sugars checked before meals and at bedtime everyday.
*He had a physician's order for "Novolog Injection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 658	Continued From page 30	F 658		

Solution 100 units/ ML (Insulin Aspart) [a fast-acting insulin] Inject 25 units subcutaneously [under the skin into the fatty tissue] with meals".

Review of resident 25's April 2025 MAR and associated progress notes revealed:
*4/10/25 at 5:30 p.m. his insulin was held with a progress note at 7:15 p.m. that stated "Resident's BG [blood glucose or blood sugar] was 97 before supper. Resident ate supper. Writer rechecked BG and it was 128. Writer held 30 units and will recheck [blood sugar] at HS [bedtime].
*4/18/25 at 5:30 p.m. his insulin dose was held, his blood sugar was documented as 71 with a progress note at 4:15 p.m. that stated, "only 71, holding".
*4/19/25 at 11:30 a.m. his insulin dose was held, his blood sugar was 236 with a progress note that stated, "Held due to not eating lunch".
*4/19/25 at 5:30 p.m. his insulin dose was held with a blood sugar of 88 with a progress note that stated, "he is not hungry but will try to eat something".
*4/20/25 at 7:30 a.m. his insulin dose was held with a blood sugar of 72.
*4/20/25 at 5:30 p.m. his insulin dose was held with a blood sugar of 213 with a progress note that stated, "Not eating supper".
*4/21/25 at 5:30 p.m. his insulin dose was held with a documented blood sugar of 82, and a progress note that stated, "Held due to first blood sugar 60 and after snack it went up to 82".
*4/22/25 at 7:30 a.m. his insulin dose was held with a blood sugar of 73.
*4/23/25 at 7:30 a.m. his insulin dose was held with a blood sugar of 78.
*4/24/25 at 7:30 a.m. his insulin dose was held with a blood sugar of 68.
*4/24/25 at 5:30 p.m. his insulin dose was held

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 658	Continued From page 31	F 658		

with a blood sugar of 102.
*4/25/25 at 7:30 a.m. his insulin dose was held with a blood sugar of 95.
*4/25/25 at 11:30 a.m. his insulin was held with a blood sugar of 119.
*4/25/25 at 5:30 p.m. his insulin dose was held with a blood sugar of 144 and a progress note that stated, "holding due to not planning to eat much".
*4/26/25 at 7:30 a.m. his insulin was held with a blood sugar of 68.
*4/26/25 at 5:30 p.m. his insulin was held with a blood sugar of 120.
*4/27/25 at 7:30 a.m. his insulin was held with a blood sugar of 84.
*4/28/25 at 7:30 a.m. his insulin was held with a blood sugar of 89.
*4/30/25 at 5:30 p.m. his insulin was held with a blood sugar of 126 and a progress note that stated, "Holding due to a hypoglycemic [low blood sugar] episode at HS recently".
*From 4/8/25 until 4/28/25 there was no low blood sugar parameter that would indicate at what blood sugar value the insulin should have been held.
*On 4/28/25 at 9:10 a.m. a progress note read, "Faxed [medical director N] for parameters to hold his [resident 25's] Novolog 30 units with meals. His blood sugars have been running low, and staff has [have] been holding this at times. Sent recent blood sugars and medication list that he is on for Diabetes. Awaiting response."
*On 4/28/25 there was a physician's order that stated, "Hold [insulin] if blood sugar is less than 80" added to his insulin order.
*Review of resident 25's May 2025 MAR revealed on 5/3/25 at 5:30 p.m. his insulin was documented as held with a blood sugar of 87.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 658	Continued From page 32	F 658		

Review of resident 25's May 2025 MAR and associated progress notes revealed on 5/3/25 at 5:30 p.m. his insulin was held with a blood sugar of 87 and a progress note that stated, "holding due to episodes of hypoglycemia [low blood sugar]".

Interview on 5/7/25 at 9:48 a.m. with licensed practical nurse (LPN) I related to physician notifications revealed:
*She would have notified the resident's physician via fax or a phone call is she held an insulin without a physician's order for a low blood sugar.
*She was aware resident 25's insulin had been held related to low blood sugars but did not know if the physician had been notified of the low blood sugars or that his insulin had been held.
*She stated if a resident's insulin was held related to a low blood sugar and the resident did not have parameters identified by the physician for when to hold the insulin for a low blood sugar, she was to notify the physician but admitted she had not always notified the physician.
-If she notified the physician, she would document that in a progress note in the resident's EMR.
*There was no facility identified number of resident refusals of a medication that would indicate the provider was to be notified.
*After a "few" resident medication refusals she would talk with the resident regarding the refusals to determine why the medication was being refused and then would notify the provider.

Interview on 5/7/25 at 10:50 a.m. with medical director N revealed:
*It was her expectation to be notified immediately if insulin was being held for symptomatic hypoglycemia (low blood sugar) for a resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 658	Continued From page 33 *She stated it would be difficult to manage a resident's insulin regimen if the staff were holding insulin and she was not notified. *She was aware resident 25 was having low blood sugars and some adjustments had been made to his insulin regimen. *She recently ordered a low parameter to be added to his scheduled fast acting insulin, which indicated the low blood sugar value in which the staff were to hold his insulin. *He did not have the low blood sugar parameter for holding his insulin at the time of his admission. Documentation of the physician having been notified of the held insulin doses was requested from the facility but was not provided by the end of the survey on 5/8/25. Interview on 5/7/25 at 2:15 p.m. with director of nursing (DON) C revealed: *The facility did not have a policy regarding physician notification related to held or refused medications. *It was her expectation the physician was notified if medications were held without a physician's order. 3. Review of the provider's April 2013 Diabetes-Clinical Protocol policy revealed: *"The staff will identify and report complications such as foot infections, skin ulcerations, increased thirst, or hypoglycemia." *"The physician will help the staff clarify and respond to these episodes." Review of the provider's 3/5/25 Blood Pressure and Blood Sugar Parameter Policy revealed: *"If blood sugar levels are above 400 or below 70 alert the provider. Unless other parameters are	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 658	Continued From page 34 noted on residents' chart by their physician." *"Chart communication with family and provider." Review of the provider's October 2021 Notification of Resident Changes policy revealed: *"It is the policy of the facility that a resident's change in physical, medical, or psychological condition or treatment is promptly communicated to the resident, the designated resident's representative (if applicable) and the Primary Care Provider." *"The charge nurse on duty at the time of the event will be responsible for immediate notification to the resident, resident representative(s) and the PCP [primary care provider] regarding the following: -c. A need to alter treatment significantly (a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment)."	F 658		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to ensure: *Proper infection control practices had been followed for cleaning and storage for two of two	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 695	Continued From page 35 sampled residents (9 and 25) who required respiratory devices (Continuous Positive Airway Pressure (CPAP) machine (a device that uses air pressure to keep breathing airways open) and a nebulizer), had appropriate cleaning and storage. *One of one sampled resident (25) receiving oxygen at night had a current physician order for use of a CPAP machine, and was care planned. Findings include: 1. Observation and interview on 5/5/25 at 1:39 p.m. and 1:57 p.m. with resident 9 in his room revealed: *There was a nebulizer machine (a machine that converts liquid medication into an inhalable mist) on the floor to the left of his recliner. *He sat in his recliner and held his nebulizer mask to his face to administer the medication. *He reached down and shut off that nebulizer machine, then turned it back on when the surveyor stated she would return. -He kept the nebulizer machine on the floor, so it was easy for him to reach, and it was quieter there. *He stated that the nurse would put the medication in the nebulizer mask, and he would administer his nebulizer treatment. *He hung the nebulizer mask from the tack on his calendar between the four nebulizer treatments he received each day. -He was unsure when the nebulizer mask would need to be cleaned, but thought the nurse did that once a day. Observation and interview on 5/6/25 at 11:20 a.m. with resident 9 in his room during the administration of a nebulizer treatment by licensed practical nurse (LPN) F revealed: *After the completion of the nebulizer	F 695	There are currently no CPAP machines in the facility at this time. Education will be provided to nurses by DON or Designee on appropriate cleaning and storage on CPAP machines with documentation by 6/22/25. Administrator, DON, and interdisciplinary team will review and revise policies and procedures as necessary. All necessary staff educated on policy. ADON or designee will audit cleaning and storage of all CPAP machines weekly for 4 weeks and monthly for 2 months or longer as determined by audit results. ADON or designee will report findings at monthly QAPI meetings until audit is complete and issue no longer needs to be addressed.	6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 695	Continued From page 36	F 695		

administration, while LPN F rinsed the nebulizer mask out in the sink, resident 9 stated he usually did not rinse out his mask after he completed his nebulizer treatments, and he would "just hang it on here" as he pointed to a tack on the wall beside his recliner.

Review of resident 9's electronic medical record (EMR) revealed:
*He was admitted on 12/2/24.
*His diagnoses included chronic obstructive pulmonary disease, cancer of his right lung, pulmonary embolism, and bronchitis.
*He had a Brief Interview of Mental Status (BIMS) assessment score of 11, which indicated he was moderately cognitively impaired.
*A 5/1/25 physician's order for "Ipratropium-Albuterol Inhalation Solution [an inhaled medication to ease breathing by opening the airway in the lungs] 0.5-2.5 (3) MG/3ML [milliliter] 1 vial inhale orally four times a day for bronchitis for 5 Days."
*A 5/6/25 physician's order for "Ipratropium-Albuterol Inhalation Solution ...0.5-2.5 (3) MG/3ML 1 vial inhale orally every 4 hours as needed for bronchitis."
*There was no documentation in his EMR that his nebulizer mask and tubing were to have been cleaned, by whom, or how often that should have been completed.

2. Observation and interview on 5/5/25 at 1:44 p.m. with resident 25 in his room revealed:
*He was lying in bed with his eyes open and a CPAP (a machine that uses air pressure to keep breathing airways open) on.
*He stated he had worn his CPAP for several years and he brought it into the facility from home when he was admitted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 695	Continued From page 37 Review of resident 25's EMR revealed: *He was admitted on 4/8/25. *His BIMS assessment score was 15, which indicated he was cognitively intact. *He had diagnoses of other forms of dyspnea (difficulty breathing), and obstructive sleep apnea (intermittent airflow blockage during sleep). *There was no physician's order for the use of his CPAP in his EMR. *There was no documentation in his EMR that indicated his CPAP mask and tubing was being cleaned. *His initial baseline care plan did not indicate the use of the CPAP. *His current care plan did not address his respiratory diagnoses or the use of his CPAP machine. Follow up interview on 5/7/25 at 9:40 a.m. with resident 25 in his room revealed: *The nurses would empty and refill his CPAP reservoir with distilled water every night and as needed. *No one had cleaned his CPAP tubing or mask that he was aware of since admission. 3. Interview on 5/7/25 at 9:48 a.m. with licensed practical nurse (LPN) I revealed: *Nebulizer delivery devices were to be replaced weekly on Fridays by the night nurse. *The replacement of the devices was to be charted in the resident's medication administration record (MAR). *Nebulizer deliver devices were to be rinsed out and cleaned after each use by running them under tap water. *The mask and tubing of the CPAP machine were to be cleaned weekly by the night nurse with a	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 695	Continued From page 38	F 695		

vinegar and water solution.
*The cleaning of respiratory devices were to be charted in the resident's MAR.
*She was unsure of the exact process used for the cleaning of the CPAP mask and tubing by nights since resident 25 wore his CPAP mask at night.

4. Interview on 5/8/25 at 11:30 a.m. with director of nursing (DON) C revealed:
*Nebulizer delivery devices were to be replaced weekly and that was to be documented in the resident's MAR.
*It was her expectation the nebulizer deliver devices were to be disassembled, rinsed out with tap water, and left to dry on a towel after every use for infection control purposes.
*The nebulizer machine was to be stored in a location such as on a bedside table not in the floor.
*The mask and the tubing of the CPAP machine was to be cleaned weekly with a vinegar and water mixture by the night nurse.
*The cleaning of the CPAP machine was to be documented in the resident's MAR.
*She was not aware there was not a physician's order for resident 25's CPAP use.
*She was not aware the cleaning of the CPAP tubing and mask was not being documented in resident 12's MAR.
*She was not aware resident 12's care plan did not address his CPAP use.
*She would expect there to be a physician's order for the CPAP, and the cleaning of the CPAP was documented in the EMR.
*She agreed the some of the facility policies did not reflect the provider's processes and practices, and some of the policies, including those related to nebulizers, were not consistent with each

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 695	Continued From page 39 other. 5. Review of the provider's June 2023 Cleaning of Durable Medical and Therapy Equipment policy revealed: *"CPAP: 1) Clean tubing and mask with warm water and soap, rinse well, and hang to dry daily." *"Nebulizer Treatments: Cleaning must be completed after each use. -1) Take nebulizer apart by removing tubing and setting aside. -2) Remove mouthpiece or mask and medicine cup from the top, -3) Rinse with sterile or distilled water and place on clean dry surface (be sure to use a barrier such as a paper towel) to dry after each use. -4) Let pieces air dry." Review of the provider's January 2018 Specific Medication Administration Procedures revealed: *"When treatment is complete, turn off nebulizer and disconnect T-piece, mouthpiece and medication cup." *"Rinse and disinfect the nebulizer equipment according to manufacturer's recommendations or: -1) Wash pieces (except tubing) with warm, soapy water daily. Rinse with hot water. Allow to air dry completely on paper towel. -2) [Once a week/three times a week/daily], disinfect the equipment by: --a. [Using a Microsteam bag in the microwave for time recommended on bag], OR --b. [Soaking for 5 minutes in 70% isopropyl alcohol and then rinse with sterile water]." *"When equipment is completely dry, store in a plastic bag with the resident's name and the date on it." *"Change equipment and tubing every [seven days].	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to assess two of two sampled residents (7 and 14) who had a diagnosis of post-traumatic stress disorder (PTSD) for their potential needs and interventions relating to trauma. Findings include: 1. Observation on 5/5/25 at 12:59 p.m. of resident 12's room revealed: *He had a sign on his door that read, "Do Not Disturb". *He had military décor in his room. Review of resident 12's EMR revealed: *He was admitted on 5/24/23. *His BIMS assessment score was 12, which indicated he had moderate cognitive impairment. *His diagnoses included anxiety disorder, major depressive disorder, hallucinations, post-traumatic stress disorder (PTSD), and vascular dementia with psychotic disturbance, mood disturbance, and anxiety. *He was a military veteran. *He had a history of suicidal thoughts, chemical dependency, visual hallucinations that were "distressing" to him. *He had a history of chemical dependency.	F 699	Unable to correct past noncompliance of assessing residents. All residents have been assessed for trauma informed care. DON, ADON, and MDS Coordinator will be educated on trauma informed care assessments by administrator or designee with documentation by 6/22/25. Administrator, DON, and interdisciplinary team will review and revise policies and procedures as necessary. All necessary staff educated on the policy. MDS Coordinator or designee will audit all trauma informed care assessments and then new admissions and residents who trigger for trauma informed care assessments weekly for 4 weeks and monthly for 2 months or longer as determined by audit results. MDS Coordinator or designee will report findings at monthly QAPI meetings until audit is complete and issue no longer needs to be addressed.	6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 699	Continued From page 41 *His care plan did not address behaviors, and triggers, or interventions related to his diagnoses. *There was an incident on 4/10/25 where resident 14 "struck [resident 20] in the left cheek with a closed fist." *It was documented in the provider's investigation, Resident 14 stated that resident 20 "had opened his door and peeked in and then shut the door. [Resident 14] went out and asked [resident 20] what he wanted. [Resident 20] did not answer [resident 14] and this made him angry so he punched him." 2. Interview on 5/6/25 at 4:22 p.m. with director of nursing (DON) C revealed the provider did not have a policy for addressing residents with a history of trauma or trauma informed care. 3. Interview on 5/7/25 at 9:48 a.m. with licensed practical nurse (LPN) I revealed: *Resident 14 had PTSD related to his military service. *She indicated resident 14 could get "worked up at times" when he thought people were stealing from him. *She was aware of an incident when resident 14 struck another resident in the face with a closed fist. *She indicated staff would talk to him after the incidents or times when he was worked up and he would calm. 4. Interview on 5/8/25 at 8:59 a.m. with LPN/social service designee (SSD) D revealed: *There were no assessments that were being completed for residents related to trauma informed care. -She asked about trauma on a resident's admission to the facility and "made note".	F 699		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 699	Continued From page 42	F 699		

--There was no documentation able to be located regarding that in resident 14's EMR.
*Resident 14's care plan had a focus area of "sees mental health provider from [another town] for mental health needs" with an intervention that stated, "Attend appointments as scheduled and PRN [as needed]."
*She was unable to locate documentation of resident 14 having attended appointments with the identified mental health provider.
*She stated behaviors, triggers, and interventions for the behaviors should have been identified in the resident's care plan for staff to be able to meet their needs.
*She verified there were no behaviors or interventions related to resident 14's PTSD, anxiety, or hallucination diagnoses in his care plan.

5. Interview on 5/8/25 at 11:53 a.m. with director of nursing (DON) C revealed:
*Resident 12 had not seen a mental health provider since early 2024.
*He had not and was not seeing a mental health provider on a scheduled or as needed basis as his care plan indicated.

6. Observation and interview on 5/5/25 at 4:07 p.m. with resident 7 in his room revealed:
*He was sitting in his recliner.
*He was not sure if he had attended any counseling sessions.
*His biggest concern at that time was the food he was being served.

Review of resident 7's EMR revealed:
*He was admitted on 11/22/22.
*His 3/31/25 BIMS assessment score was 11, which indicated he was moderately cognitively

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 699	Continued From page 43	F 699		

impaired.
*His diagnoses included:
-Post-traumatic stress disorder, unspecified.
-Delirium due to known physiological condition.
-Personal history of other mental and behavioral disorder.
-Major depressive disorder, recurrent, severe with psychotic symptoms.

Review of resident 24's 4/1/25 care plan revealed:
*He had a focus area of, "an ADL [activities of daily living] self-care performance deficit r/t [related to] delirium/depression/PTSD.
*A goal to maintain current level of function through the next review.
*No interventions to suggest how to address any issues that may arise from his PTSD.

7. Interview on 5/6/25 at 4:36 p.m. with LPN/SSD D regarding resident 7's PTSD diagnoses revealed:
*If a resident had a PTSD diagnosis, they were set up with an appointment with behavioral health services.
*PTSD was entered into the resident's care plan.
*She was not aware of any interventions that would directly address a resident's PTSD.
*She confirmed she had not completed a trauma-informed care assessment for resident 7.

8. Review of the provider's March 2025 Facility Assessment policy revealed:
*"Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 699	Continued From page 44 individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities." *"Find out what resident's preferences and routines are; what makes a good day for the resident; what upsets him/her and incorporate this information into the care planning process. Make sure staff caring for the resident have this information and are aware of preferences." A policy for trauma informed care was requested on 5/7/25 from administrator B but one was not provided by the end of the survey on 5/8/25.	F 699		
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.	F 755	Unable to correct past noncompliance of accurate counts with documentation on medication cart and refrigerator. Narcotic count completed to ensure all were accurate and accounted for. Nurses will be educated on accurate counting and documentation with documentation by DON or Designee by 6/22/25. Administrator, DON, and interdisciplinary team will review and revise policies and procedures as necessary. Policy reviewed by all necessary staff. Nurse manager or designee will audit medication cart and fridge counts 3x/ week and adjust as deemed appropriate weekly for 4 weeks and monthly for 2 months or longer as determined by audit results. Nurse manager or designee will report findings at monthly QAPI meetings until audit is complete and issue no longer needs to be addressed.	6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 755	Continued From page 45 §483.45(b)(2) Establishes a system of records of 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 follow their policies for controlled medications (medications with risk for abuse, addiction, and potential theft) to ensure accurate counts and complete documentation of those medications in one of one medication cart and one of one refrigerators that contained controlled medications. Findings include: 1. Observation and interview with licensed practical nurse (LPN) F on 5/6/25 at 9:40 a.m. of a binder labeled "Narcotic Binder" on the east medication cart revealed: *A form in the front of the binder was labeled "Control E-Kit [emergency kit for controlled medications] Shift Count". *The area for the month and year o that form was blank. -LPN F verified that form was for May 2025. *That Control E-Kit Shift Count form had six medications identified on it: -"Tramadol [a pain medication] 50 mg [milligrams] PO [by mouth]". -"Oxycodone [a pain medication] 2.5 mg tab PO". -Morphine [a pain medication] 10 mg/0.5 ml [milliliters] PO/SL [sublingual]" .	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 755	Continued From page 46 -"Hydrocodone/APAP [a pain medication] 5/325 mg PO". -"Lorazepam[an antianxiety medication] 0.5 mg PO" . -"Lorazepam 2 mg/ml IM/IV [intermuscular/intravenous]". *That Control E-Kit Shift Count form had locations to document for each day of the month for both day and night counts that included: -The number of pills or syringes counted. -The initials of the persons that counted those medications with an indicator that there was to be two persons. *The Controlled E-Kit Shift Count form documentation indicated: -On 5/1/25 there was no second staff's initials for the day count and no count or initials for the night count. -On 5/2/25 no documentation was completed. -On 5/3/25 there was no count or initials for the day count, and no second staff's initials for the night count. -5/5/25 there was one missing initial for the night count. *Another form labeled "Narcotic E-Kit Numbers" was in the narcotic binder. -That form had areas for each day to document two staff's signatures for the "First Shift" and "Second Shift" and a number on the E-Kit lock tags for the "Gray Cupboard E-Kit", the "East Narc [narcotic] Drawer E-Kit", and the "Fridge E-Kit". -On 5/2/25 there were no numbers documented in the three columns and the second shift only had one signature documented. 2. Interview on 5/6/25 at 9:50 a.m. with LPN F revealed: *The Controlled E-Kit shift count form was how	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 755	Continued From page 47 the staff documented the counts emergency supply of controlled medications. *The controlled medications were to be counted at the change of shift by the oncoming and outgoing staff to verify the medications counts were accurate. *Each one of the three different emergency medication kits were sealed with a numbered tag. *The Narcotic E-Kit Form was where the tag numbers on each kit were documented to be sure no had broken the tag and accessed the kit without prior authorization from the pharmacy to remove a medication for administration to a resident. *The numbers on the identified tags were to be checked and documented at change of shift by two staff members on the Narcotic E-Kit Numbers form. *LPN F verified there was incomplete documentation on both forms for May 2025. *LPN F stated the controlled substances prescribed to individual resident were sent from pharmacy in a bubble pack medication card system and stored in a locked drawer in each medication cart. *The individual residents'controlled medications were counted at each change of shift but there was no form to document that count had occurred for those medications. 3. Interview on 5/6/25 at 10:22 a.m. with LPN I revealed: *The controlled medication counts were to be completed on the E-Kits and for each resident that was prescribed a controlled medication at the change of each shift by two nursing staff members authorized to administer medications. *The E-Kit controlled substances were stored in the east medication cart within the locked drawer	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 755	Continued From page 48	F 755		

and in a locked compartment in the refrigerator.
*The signatures on the forms were to indicate that the controlled medication counts were completed and accurate and the tags were checked and found to be in place and the tag numbers were accurate.
*There was no location to document the individual residents' controlled medications counts had been completed or who completed those counts to verify the accuracy of the amount of those medications present.

4. Review of April 2025 Control E-Kit Shift Count form revealed:
*The day counts did not have documentation of the second staff member's initials ten times.
*The night counts did not have documentation of the second staff member's initials nine times.

Review of March 2025 Control E-Kit Shift Count form revealed:
*The day count was missing documentation of the count on 3/17/25 and did not have documentation of the second staff member's initials nine times.
*The night counts did not have documentation of the second staff member's initials seven times.

Review of February 2025 Control E-Kit Shift Count revealed:
*The day count was missing documentation of the count two times and did not have documentation of the second staff member's initials seven times.
*The night count was missing documentation of the count two times and did not have documentation of the second staff member's initials five times.

Review of January 2025 Control E-Kit Shift Count revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 755	Continued From page 49 *The day count was missing documentation of the count five times and did not have documentation of the second staff member's initials eleven times. *The night count was missing documentation of the count three times and did not have documentation of the second staff member's initials thirteen times. Review of December 2024 Control E-Kit Shift Count revealed: *The day count was missing documentation of the count seven times and did not have documentation of the second staff member's initials nine times. *The night count was missing documentation of the count five times and did not have documentation of the second staff member's initials twelve times. 5. Review of April 2025 Narcotic E-Kit Numbers revealed: *On 4/3/25 no tag numbers were documented, and one signature was documented for the first shift and the second shift. *On 4/29/25 no tag numbers were documented. *Only one signature was documented for either the first or the second shift seven. 6. Interview on 5/8/25 at 11:30 a.m. with director of nursing (DON) C revealed: *It was her expectation that all controlled medications were to be counted by two licensed staff members or certified medication aides (CMA) at every change of shift. *The counts were to be documented on the Control E-Kit Shift Count in the front of the narcotic binder. *The signatures on the document would indicate	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 755	Continued From page 50	F 755		

the controlled medication counts had been completed and the counts were accurate.
*The tag numbers were to be verified and documented as accurate by two staff members, and she expected that to have been completed at the same time the controlled medications were counted.
*She was aware there was no location to document the counts were completed and by which staff members for the residents' controlled medications.
-She did not feel that there needed to be a form to document that. The staff were to complete the counts at the change of shifts and were to notify her if there was a discrepancy.
*She verified without the documentation of the counts of the residents' controlled medications she would not be able to determine who or when the last count had been completed.
*She was not aware of the frequency of missing or incomplete documentation on the Control E-Kit Shift Count forms or the Narcotic E-Kit tag numbers.

7. Review of the provider's 11/5/15 Storage of Facility E-Kit Documentation policy revealed "Emergency controlled substances [medications] must be stored in a double lock system and verified shift to shift".

Review of the provider's 12/1/15 Emergency Kits policy revealed "A Control E-Kit Shift Count will be used by facility staff to keep track and use for counting controlled case medications shift to shift on a monthly basis."

Review of the provider's undated Narcotic Count policy revealed:
*"Narcotics [controlled medications] will be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 755	Continued From page 51 counted by licensed nursing personnel to assure they are properly accounted for at the beginning and ending of each shift." *"The on-going and off-going nurse at shift change will perform a physical count of the narcotic drawer." *"Each nurse will sign the narcotic count sheet when the count is completed." Review of the provider's November 2017 Controlled Medication Storage policy revealed: *"At each shift change or when keys are surrendered, a physical inventory of all Schedule II, including refrigerated items, is conducted by two licensed nurses or per state regulation and is documented on the controlled substances accountability record or verification of controlled substances count report." *"Current controlled medication accountability records are kept in the MAR [medication administration record] or narcotic book."	F 755		
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	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 761	Continued From page 52 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review the provider failed to ensure: *Medications with shortened expiration dates [medications that, after opening, expire prior to the manufacturer's expiration date] were labeled properly and disposed of after having outdated for three sampled residents (3, 14, and 79) and one random resident (24) in two of two medication carts and one of one treatment cart. *Daily temperatures of one of one refrigerator containing medications were monitored and document according to the provider's policy for twelve of twelve months reviewed in 2024 and two of two months (March and April) in 2025. *Daily temperatures of one of one area used to store medications was monitored and documented according to the provider's policy. *Medication labels matched the current physician orders for four of four sampled residents (15, 19, 22, 25) according to the provider's policy. Findings include: 1. Observation and interview on 5/6/25 at 7:30 a.m. with licensed practical nurse (LPN) during medication pass revealed: *Resident 19's gabapentin (medication for	F 761	DON or designee checked that all expired medications have been removed from medication carts. Unable to correct past noncompliance for refrigerator temperatures and storeroom temperatures. Medication labels for resident 15, 19, 22, and 25 have been updated to match physician orders. Med aides and nurses will be educated by Don or Designee on expired medications, refrigerator temperatures, storeroom temperatures, and matching medication labels by 6/22/25. Administrator, DON, and interdisciplinary team will review and revise policies and procedures as necessary. All necessary staff educated on the policy DON or designee will audit medication room and refrigerator temperatures weekly for 4 weeks and monthly for 2 months or longer as determined by audit results. ADON or designee will audit expired medications and medication labels weekly for 4 weeks and monthly for 2 months or longer as determined by audit results. DON/ADON or designee will report findings at monthly QAPI meetings until audit is complete and issue no longer needs to be addressed.	6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 761	Continued From page 53	F 761		

seizures or nerve pain) pharmacy medication label read 400 mg (milligrams) give 1 cap three times daily and her order on the medication administration record (MAR) read gabapentin 100mg, give 400 mg three times daily.
*Resident 15's midodrine (medication for low blood pressure) pharmacy medication label read give 10 mg three times per day and her MAR stated 5 mg give two tabs daily with meals.
*Resident 15's duloxetine (medication for depression) pharmacy medication label read give 60 mg give one cap daily and her MAR stated 30 mg, give 2 caps in the morning.

2. Observation and interview on 5/6/25 at 9:50 a.m. of the medication carts with LPN F revealed:
*Resident 22's Lantus (long-acting insulin) insulin label with the directions for administration was covered by the opened and expired label and was not readable.
*Resident 79's Trelegy Ellipta inhaler (medication to treat breathing problems) was opened.
-The box had a sticker that had a location to document the medications opened date and expirations date, but neither the opened date nor the expired date were written on the sticker.
*Resident 3's Trelegy Ellipta inhaler was opened.
-The box had a sticker that had a location to document the medications opened date and expirations date, but neither the opened date nor the expired date were written on the sticker.
*Resident 79's Ventolin HFA (fast acting medication for breathing problems) inhaler was opened and was not marked with the date it was opened.
*Resident 24's Latanoprost (medication used to treat increased pressure in the eye) eye drops were marked as opened on 3/21/25 and had an expiration date identified as 5/2/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 761	Continued From page 54 *Resident 14's Latanoprost eye drops were opened and dated on 3/20/25 with an expiration date of 5/1/25. *LPN F was not aware there were medications with shortened expiration dates after they were opened or removed from the refrigerator other than insulin. *She verified the Latanoprost eye drops for residents 14 and 24 were outdated and remained in the medication cart for potential use. *There was a reference in the drawer of the medication cart that was identified as "MEDICATIONS WITH SHORTENED EXPIRATION DATES". 3. Review of the undated Medication with Shortened Expiration Dates reference revealed: *Ventolin HFA inhalers were to be discarded 12 months after the removal from its protective pouch. *Latanoprost eye drops were to be discarded six weeks after opening. *Trelegy Ellipta inhalers were to be discarded six weeks after opening the foil tray. 4. Observation, interview, and record review on 5/6/25 at 10:21 a.m. in the room located behind the nurses' station with LPN I revealed: *LPN I identified the black locked refrigerator in the room as the refrigerator that was used to store residents' medications. *She stated the temperature inside the refrigerator was measured and documented daily by the night nurse. -She verified there were dates with missing medication refrigerator temperatures for 2024 and 2025 on the documentation sheets. *She was aware there were medications with shortened expiration dates after opening and was	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 761	Continued From page 55 aware of the reference in the medication cart to help identify those medications. 5. Review of the documentation of the medication refrigerator temperatures for 2024 revealed: *January had three days without a documented temperature. *February had five days without a documented temperature. *March had six days without a documented temperature. *April had nine days without a documented temperature. *May had five days without a documented temperature. *June had seven days without a documented temperature. *July had six days without a documented temperature. *August had one day without a documented temperature. *September had six days without a documented temperature. *October had one day without a documented temperature. *November had five days without a documented temperature. *December had six days without a documented temperature. Review of the documentation of the medication refrigerator temperature for 2025 revealed: *March had one day without a documented temperature. *April had six days of documented temperatures that were out of the acceptable temperature range of 36 to 46 degrees Fahrenheit. -Five of those days the temperature of the medication refrigerator was 34 degrees	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 761	Continued From page 56	F 761		

Fahrenheit.
-One day the temperature of the medication refrigerator was 32 degrees Fahrenheit.

6. Observation and interview on 5/6/25 at 2:33 p.m. of the treatment cart with LPN I revealed:
*She would be unable to determine what the expiration date of a medication with a shortened expiration date was without the date documented that the medication was opened.
*There was a container of Silver Sulfadiazine cream that was labeled as "stock supply" and dated as opened on 2/4/24.
*Resident 25's Tresiba (long-acting insulin) injectable pen's pharmacy label indicated he was to receive 100 units daily and his MAR indicated he was to receive 90 units daily.
-There was no label or indication on the Tresiba pen that the dose of the medication had been changed.
*She was aware there were labels on oral medications and insulins that did not match the orders in the MAR and there was no indication the order had been changed on those medications' labels.
*She stated that pharmacy did not replace the labels on medications when the orders changed.
*The facility utilized certified medication aides to administer medications.
*She agreed she could not complete her checks for the correct medication doses when the labels and the MAR did not match but she would administer medications according to the instructions in the MAR.

7. Interview on 5/7/25 at 2:15 p.m. with director of nursing (DON) C revealed:
*The did not have a room identified as a medication room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 761	Continued From page 57 *Medications were stored in the locked cabinets and refrigerator located behind the nurses' station desk if they were not stored in the medication cart. *She stated the facility did not have a policy or documentation log for room temperatures where medications were stored. Interview on 5/8/25 at 11:30 a.m. with DON C revealed: *She was aware there were medications with shortened expiration dates after being opened or removed from refrigeration. *It was her expectation that all medications were dated with the date they were opened. *If there was an ordered medication dose change staff was supposed to apply a label on the medication container that indicated there had been a dose change. *She agreed the MAR and the pharmacy label not matching increased the risk for a medication error especially with the use of CMAs that may not be able to identify medications and could not calculate dosages. *After review of the documentation for the medication refrigerator temperatures she verified there was missing documentation of temperatures and there were temperatures in April that were outside of the acceptable range. *She was not aware there was documentation and temperatures outside of the acceptable range. *The temperature of the area where the medications were stored was not being monitored and documented. *She agreed the temperature of the room could not be verified as within an acceptable range if the temperature was not monitored and documented.	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 761	Continued From page 58 8. Review of the provider's 6/1/24 Medication: General Rules policy revealed: *"Only pharmacy can replace labels on medications. For order changes involving time changes or frequency changes, 'order change, see chart' labels may be used until the pharmacy replaces the label on medication." *"Medications will be given adhering to the 'Six Rights'. Right DRUG, Right RESIDENT, Right ROUTE, Right DOSE, Right MED FORM and Right TIME." *"The person administering the medication will also be responsible for Checking expiration dates." Review of the provider's 2/1/25 Medication Storage in the Facility policy revealed: *"Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are [to be] immediately removed from inventory, disposed of according to procedures for medication disposal, and reordered from the pharmacy, if a current order exists." *"All medications are maintained within the temperature ranges noted in the United States Pharmacopeia (USP) and by the Center for Disease Control (CDC). -1) Room Temperature 59 [degrees] F [Fahrenheit] to 77 [degrees] F (15 [degrees] C [Celsius] to 25 [degrees] C. -2) Controlled Room Temperature (the temperature maintained thermostatically) 68 [degrees] F to 77 [degrees] F (20 [degrees] C to 25 [degrees] C). -3) Refrigerated 36 [degrees] F to 46 [degrees] F (2 [degrees] C to 8 [degrees] C) with a thermometer to allow temperature monitoring."	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 761	Continued From page 59 *"The Facility should maintain a temperature log in the storage area to record temperatures at least once a day." *"Medications in multi-dose packaging will have a beyond-use dating of 60 days or manufacturer's expiration date if less than 60 days." *"The nurse will check the expiration date of each medication before administering it." *"No expired medication will be administered to a resident." *"All expired medications will be removed from the active supply and destroyed in the facility, regardless of [the] amount remaining."	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy	F 812	Dietary manager or desingee ensured all expired food items were immediately removed from the kitchen. Dietary staff will be educated by dietary manager or designee on ensuring food items are dated when opening and outdated items being discarded with documentation by 6/22/25. Administrator, dietary manager, and interdisciplinary team will review and revise policies and procedures as necessary. All necessary staff educated on the policy. Dietary manager or designee will audit food labels and expired food weekly for 4 weeks and monthly for 2 months or longer as determined by audit results. Dietary manager or designee will report findings at monthly QAPI meetings until audit is complete and issue no longer needs to be addressed.	6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 812	Continued From page 60	F 812		

review the provider failed to follow acceptable food safety practices by not having ensured that food packages were dated when opened and outdated food items were discarded from inventory in one of one observed kitchen. Findings include:

1. Observation on 5/5/25 at 1:03 p.m. of the dry food storage room revealed:
*One opened container of Rice Crispies cereal with no date on it.
*One opened container of Raisin Bran cereal with no date on it.

2. Observation on 5/5/25 at 1:27 p.m. of the walk-in refrigerator revealed:
*One carton of Vanilla Boost Glucose Control supplement with a use-by date of January 3, 2025.
*One opened package of shredded low moisture mozzarella cheese with a best by date of April 19, 2025.
*The mozzarella cheese had condensed into quarter-sized balls of cheese.

3. Interview on 5/5/25 at 1:34 p.m. with dietary manager E regarding opened and expired food items revealed:
*He was not aware of the unmarked opened food containers or the outdated food items.
*It was his expectation that containers of food would be dated when opened, and food items would be used or discarded before the use-by date.
*His expectation was that all dietary staff would monitor food items for food items that were past the use by date or expired.
*He checked used by dates when the weekly food truck delivery arrived.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 812	Continued From page 61 4. Review of the provider's 5/5/25 revised Expired Food policy revealed: *"Food products will be inspected on a regular basis to ensure that any products that are expired or near expiration will be identified and reported to the DM for further instructions." *"All products will be inspected weekly by Dietary Personnel on Wednesday before the arrival of the food truck." *"All items that are expired will be labeled (Do not use/Do not discard)." *"All staff must follow FIFO (First In First Out) and inspect the expiration date on all products that are needed for use before they are used in the operation." Review of the provider's 10/20/24 revised Storage of food opened in the storeroom or preparation area policy revealed: *"To make sure all items that are opened in the storeroom or main production area are covered, labeled and dated properly." *"1. Date the container when opened." *"2. Reseal the container." *"3. If the container cannot be resealed, you can place it in a Tupperware container with a tight lid and/or a zip lock bag if possible. Label and date the product."	F 812		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 835	Continued From page 62 This REQUIREMENT is not met as evidenced by: Based on interview, observation, record review, policy review, and job description review the provider failed to ensure the facility was operated under the supervision of administrator A to ensure quality management and the overall well-being of all 26 residents in the facility. Findings include: 1. Interview on 5/6/25 at 4:35 p.m. with administrator A regarding his schedule revealed: *He tried to be in the building weekly. *If he was unavailable, administrator B would be in the building once a week. *Administrator B started coming to the building once a week in January 2025. *Director of nursing (DON) C, business manager (BM) O, and dietary manger E were to be in the building on a full-time basis. 2. Interview on 5/7/25 at 9:59 a.m. with administrator B regarding department managers' time in the building revealed: *She did not know administrator A's schedule. *She was the full-time administrator for another facility. *If administrator A was unavailable, she would be in the building one day a week. *She started coming to the building on a weekly basis in January 2025 to help implement a new quality improvement plan. *The maintenance supervisor worked 10 hours a week and was on-call. *The minimum data set (MDS) coordinator worked in the facility on Mondays and Tuesdays and would work remotely after that. 3. Interview on 5/8/25 at 9:04 a.m. with licensed practical nurse (LPN)/social services designee	F 835	Assistant director of nursing has been hired to assist in additional duties. Refer to plan of corrections for tags F554, F655, F657, F658, F695, F699, F755, F761, F812, F685, F868, F880, F881, F882.	6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 835	Continued From page 63 (SSD) D regarding her schedule revealed: *She normally worked on Mondays and Thursdays as the SSD. *She would also fill in as a charge nurse when needed. *If a new resident admission was scheduled for a different day, she worked it out with DON C to cover the admission process. 4. Interview on 5/8/25 at 10:23 a.m. with administrator A regarding the day-to-day operations of the facility revealed: *He was the administrator of record for the facility. *DON C and BM O addressed most of the day-to-day activities in the building. *If there was an issue they could not address, they contacted administrator A or administrator B. *Administrator A or administrator B would come to the building and address the situation that day. *He agreed there were a lot of management issues delegated to DON C and BM O to ensure resident services were being provided and the regulation requirements were being met. 5. Interview on 5/8/25 at 11:44 a.m. with DON C regarding administrative oversight revealed: *Most of the facility's administrative duties fell upon her and BM O. *She stated she struggled to do her job as the DON while covering for other departments, including administration. *She would address issues in other departments, which took time away from completion of her director of nursing responsibilities. *If she had a major issue, she would call or email administrator A. *Administrator A's response time was not always timely.	F 835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 835	Continued From page 64 *Her responsibility of over-seeing the quality assurance meetings were turned over to administrator B as of 5/5/25 to lighten her work load. BM O was out of the office during the survey and unavailable for an interview. Review of the provider's undated Administrator job description revealed: *"The primary purpose of your job is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern long-term care facilities to assure that the highest degree of quality care can be provided to our residents." *"As the Administrator, you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties." *"Every effort has been made to identify the essential functions of this position. However, it in no way states or implies that these are the only duties you will be required to perform. The omission of specific statements of duties does not exclude them from the position if the work is similar, related, or is an essential function of the position." *"Plan, develop, organize, implement, evaluate, and direct the facility's programs and activities." *"Ensure that all employees, residents, visitors, and the general public follow established policies and procedures." *"Assume the administrative authority, responsibility and accountability of directing the activities and programs of the facility." *"Assist the Infection Control Coordinator, and/or Committee, in identifying, evaluating, and classifying routine and job-related functions to	F 835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 835	Continued From page 65 ensure that tasks involving potential exposure to blood/body fluids are properly identified and recorded." *"Assist the Quality Assurance and Assessment Committee in developing and implementing appropriate plans of action to correct identified quality deficiencies." Refer to F554, F655, F657, F658, F695, F699, F755, F761, F812, F865, F868, F880, F881, and F882.	F 835		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;	F 865	New QAPI system put in place by Administrator A and B and review with QAPI team on roles and expectations by 6/22. Administrator A and B will manage QAPI program going forward. Administrator, DON, and interdisciplinary team will review and revise policies as necessary. Policy will be reviewed by necessary staff. BOM or designee will audit QAPI to ensure deficiencies are identified and corrected as well as PIPs are implemented and monitored monthly for 3 months or longer as determined by audit results. BOM or designee will report findings at monthly QAPI meetings until audit is complete and issue no longer needs to be addressed.	6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 865	Continued From page 66 §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation	F 865		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 865	Continued From page 67 of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 865		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 865	Continued From page 68 Based on interview and policy review, the provider failed to ensure they had an effective quality assurance and performance improvement (QAPI) program that identified and corrected quality deficiencies when they occurred throughout the facility and that performance improvement projects (PIP) had been thoroughly identified, implemented, or monitored regarding medication administration and storage, care plans, the completion of assessments, oxygen equipment use, trauma informed care, safe food storage, and infection control. Findings include: 1. Interview on 5/8/25 at 11:22 a.m. with director of nursing (DON) C regarding quality assessment and assurance (QAA) and QAPI revealed: *She was responsible for overseeing the facility's quality management program, including QAA committee meetings and QAPI projects. *Each department manager conducted their own audits, discussed those audits with the QAPI committee, and implemented any plan needed for correction. *The QAPI committee was currently looking at areas that included restraints, skin infections, and ensuring call lights were within reach. *The QAPI committee's current PIP was focused on improving communication with the medical provider regarding laboratory results. *She was unaware of areas of non-compliance regarding : -Medication administration and storage concerns related to resident self-administration of medications, accountability, storage, labeling, and notification to the provider when medications were withheld. -Baseline Care Plan concerns related to providing those to the resident/representative within 48 hours of admission.	F 865		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 865	Continued From page 69 -Care Plan revisions accurately reflected the current care needs of the residents. -Ensuring that assessments were completed as ordered by the physician, and weekly skin assessments were completed by a licensed nurse. -Proper cleaning, storage, and supervision of oxygen equipment, -Trauma-informed care assessments were completed on residents who were identified as having Post Traumatic Stress Disorder (PTSD) -Safe food storage in the kitchen. -Infection Prevention and Control related to the use of personal protective equipment (PPE) for residents on enhanced barrier precautions (EBP), antibiotic stewardship, and training requirements of the infection preventionist. *She stated the QAPI committee was not aware of the issues above. *She confirmed their QAPI process had not been effective in identifying those quality issues that could have impacted the residents' care. *She had requested that another QAA member be assigned the responsibility for overseeing the QAPI program. Review of the providers' reviewed 12/1/23 QAPI plan policy revealed: *"The QAPI program will aim for safety and high quality with all clinical interventions and service delivery... by ensuring our data collection tools and monitoring systems are in place and are consistent for proactive analysis, system failure analysis, and corrective action." *"The scope of the QAPI program encompasses all types and segments of care and services that impact clinical care, quality of life, resident choice, and care transitions..." *"The governing body, administrator, and/or	F 865		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 865	Continued From page 70 management firm are responsible for the development and implementation of the QAPI program and for: 1) Identifying and prioritizing problems based on performance indicator data ... 3) Ensuring that corrective actions address gaps in the system and are evaluated for effectiveness..." Refer to F554, F655, F657, F658, F695, F699, F755, F761, F812, F835, F868, F880, F881, and F882.	F 865		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance	F 868	Administrator, board member, owner, or other designee will attend quarterly going forward. Administrator, DON, medical director, and interdisciplinary team will review and revise policies as necessary. Policy will be reviewed by necessary staff. BOM or designee will audit QAA attendance quarterly for 2 quarters. BOM or designee will report findings at monthly QAPI meetings until audit is complete and issue no longer needs to be addressed.	6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 868	Continued From page 71	F 868		

activities, including performance improvement projects required under the QAPI program, are necessary.

§483.80(c) Infection preventionist participation on quality assessment and assurance committee.
The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and policy review, the provider failed to ensure the quality assessment and assurance (QAA) committee had included the required members of at least one of who was the administrator, owner, a board member, or other individual in a leadership role. The provider had no evidence of the administrator, owner, board member, or other designee having attended QAA meetings at least quarterly for 15 months of meeting attendance records reviewed (February 2024 through May 2025).
Findings include:

1. Interview on 5/7/25 at 10:49 a.m. with medical director (MD) N regarding the provider's QAA and Quality Assessment and Performance Improvement (QAPI) meetings and program revealed:
*She attended QAPI meetings quarterly and did not recall seeing administrator A present at those meetings "routinely".
*She was unaware of how often administrator A was at the facility or how often he attended the QAPI meetings in the past two years.
*She expected that the administrator would be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 868	Continued From page 72 involved in identifying and correcting areas of concern identified in the QAPI program. -She indicated the facility "could use his support." 2. Interview on 5/8/25 at 11:22 a.m. with director of nursing (DON) C regarding QAA and QAPI revealed: *She was responsible for overseeing the facility's quality management program, including QAA committee meetings and QAPI projects. *The QAA committee was expected to meet monthly. *The provider's QAPI committee was comprised of department managers and DON C. *The medical director and the consultant pharmacist attended QAPI meetings quarterly. *Administrator A attended the QAPI meeting that week for the first time in "quite a while." *Administrator B had been at the facility approximately three hours a week for the last couple of months, but she had not attended a QAPI meeting. *She had requested that another QAA member be assigned the responsibility for overseeing the QAPI program. 3. Review of the provider's previous 15 months of monthly QAPI Meeting Attendance records revealed: *Between 2/13/24 and 5/6/25, administrator A attended two QAPI meetings. -He attended on 6/25/24 and 5/6/25. *None of the meetings were attended by the owner, a board member, or another individual in a leadership role. Review of the providers' reviewed 12/1/23 QAPI plan policy revealed: *Governance and Leadership:	F 868		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 868	Continued From page 73 -"The governing body, administrator, and/or management firm are responsible for the development and implementation of the QAPI program and for: 1) Identifying and prioritizing problems based on performance indicator data. 2) Incorporating resident and staff input that reflects organizational processes, functions, and services provided to residents. 3) Ensuring that corrective actions address gaps in the system and are evaluated for effectiveness. 4) Setting clear expectations for safety, quality, rights, choice, and respect. 5) Ensuring adequate resources exist to conduct QAPI efforts." *"The QAPI program will be structured to incorporate input, participation, and responsibility at all levels. The Governing Body and QAPI Committee of the nursing center will develop a culture that involves leadership-seeking input from nursing center staff, residents, their families, and other stakeholders; encourages and requires staff participation in QAPI initiatives when necessary; and hold staff accountable for taking ownership and responsibility of assigned QAPI activities and duties." *QAPI Committee Members were listed as: Medical Director, Director of Nursing, Administrator, Infection Control Officer, Environmental Manager, Activities Director, Social Services Designee, Dietary Manager, and Business Manager. Refer to F835 and F865.	F 868		
F 880 SS=E	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	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 74 comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the	F 880	Proper PPE and EBP (Enhanced Barrier Precautions) signs for all necessary residents has been set up in resident rooms by DON or Designee. All staff will be educated on EBP with documentation by DON or Designee by 6/22/25. Administrator, DON, and ADON will review and revise necessary policies and procedures for EBP. All necessary staff educated on the policy. DON or designee will audit EBP PPE weekly for twice weekly for 4 weeks and monthly for 2 months additional months or longer as determined by audit results. DON or designee will report findings at monthly QAPI meetings until audit is complete and issue no longer needs to be addressed.	6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 75 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure enhanced barrier precautions (EBP) were followed according to the provider's policy for two of two sampled residents (25 and 79) on EBP. Findings include: 1. Observation and interview on 5/6/25 at 9:08 a.m. with resident 79 in her room revealed: *A sign on her door stated she was on EBP and included the following: -Everyone must clean their hands, including before entering and when leaving the room. -Providers and staff must also wear gloves and a gown for the following high-contact activities: --Dressing.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 76 --Bathing/showering. --Transferring. --Changing linens. --Providing Hygiene. --Changing briefs or assisting with toileting. *Device care use: -Central line, urinary catheter, feeding tube, tracheostomy. -Wound care: any skin opening requiring a dressing. *There was no personal protective equipment (PPE) (gowns, gloves, and/or protective eyewear) available for use on or near the door. *She was not sure why the sign was on her door. Review of resident 79's EMR regarding EBP revealed: *She was readmitted on 5/5/25 following a hospital stay for a procedure. *She had an incision with staples from that procedure, with a physician's order to keep the area clean and dry. *There was nothing identified in her EMR that indicated the need for EBP. 2. Interview on 5/7/25 with certified nursing assistant (CNA) L at 2:15 p.m. regarding the EBP sign on resident 79's door revealed: *Resident 79 had returned from the hospital on Monday (5/5/25). *She was unsure why the EBP sign was on the resident's door. *Staff were to wear a gown and gloves when providing her care if she was on EBP. *Gowns were kept in the bottom drawer of the resident's dresser. *The nurse would inform the staff if there were any changes in infection control for residents so they would know what PPE to wear when caring	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 77 for the residents. 3. Observation and interview on 5/5/25 at 1:44 p.m. with resident 25 in his room revealed: *There was a sign on the outside of his door to his room that indicated he was on EBP. *There was no PPE available for use on his room door or near the room's entrance. *He stated he was at the facility to receive therapy services and planned to return home after his therapy was completed. *He indicated he had a surgical wound on his right lower leg that required a daily dressing change. *He stated the staff wore gloves when they changed his dressing and assisted him with cares, but they did not wear a gown. *He was not aware of any gowns being stored in or near the entrance to his room. Review of resident 25's EMR revealed: *He was admitted on 4/8/25. *He had a BIMS assessment score of 15, which indicated he was cognitively intact. *There was a physician's order that indicated, "Right ankle apply Silvadene [a topical antimicrobial cream] and change dressing daily. one time a day for surgical site. related to DISPLACED FRACTURE OF LATERAL MALLEOLUS OF RIGHT FIBULA [right ankle fracture]". Review of resident 25's care plan revealed: *An intervention for "Enhanced Barrier Precautions (EBP) to be used when providing cares for [resident 25]. EBP includes ABHR [alcohol-based hand rub] to hands before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 78 gloves and gown for the following High-Contact Resident Care Activities: when caring for [resident 25's] left ankle wound, assisting him with dressing, undressing, bathing/showering, transferring, changing linens, providing hygiene, and changing briefs or assisting with toileting." *Resident 25's care plan indicated he required assistance from one staff for showering, dressing, toileting, and transferring. 4. Interview on 5/6/25 at 4:47 p.m. with certified nursing assistant (CNA) Q revealed: *Residents were on EBP if they had catheters or wounds. *She usually only wore gloves when providing resident cares for residents on EBP. *She indicated she had previously worn gowns but was no longer was required to because the wounds (in relation to all residents on EBP for wounds) were covered. 5. Observation on 5/7/25 at 8:28 a.m. of resident 25 in the therapy area revealed: *No staff in the therapy area were wearing a gown or gloves. *Physical therapy assistant (PTA) P placed a gait belt on resident 25, assisted him to a standing position, and walked with him with a walker, and providing continuous contact assistance without wearing any PPE. 6. Interview on 5/7/25 at 9:36 a.m. with PTA P revealed: *She had been provided education related to EBP. *She was aware of which residents required EBP by the sign that was posted on the resident's room door. *She thought she only needed to wear PPE for	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 79	F 880		

EBP is she was in the resident's room and had not worn PPE in the therapy area while she provided therapy services for the resident.

7. Interview on 5/7/25 at 10:02 a.m. with licensed practical nurse (LPN) I revealed:
*Residents with catheters, wounds, and certain infections required EBP.
*The gowns were stored in the closets in the resident rooms.
*She would put on a gown as soon as she entered the room to provide cares for residents on EBP.

8. Interview on 5/8/25 at 11:30 a.m. with director of nursing (DON) C revealed:
*She was the infection preventionist (IP) for the facility.
*A gown and gloves were to be worn when providing direct resident care for residents with wounds, catheters, and the residents who had multidrug-resistant organisms (MDRO), which would require the resident to be on EBP.
*The same PPE required for in-room care for residents on EBP was to be worn in the therapy area for those residents.
*She had not thought of providing a PPE supply to be available for use in the therapy area.
*It was her expectation that all facility staff and therapy staff followed the requirements for EBP.

9. Review of the provider's February 2025 Enhanced Barrier Precaution Policy revealed:
*"EBP are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 80 colonized or infected with a MDRO as well as those at increased risk for MDRO acquisition (e.g., residents with wounds or indwelling medical devices). -High-contact resident activities include: --Dressing --Bathing/Showering --Transferring --Providing Hygiene --Changing linens --Changing briefs or assisting with toileting --Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator --Wound care: any skin opening requiring a dressing" *"Enhanced Barrier Precautions should be followed when performing transfers and assisting during bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility."	F 880		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview, policy review, and record review, the provider failed to implement an	F 881		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 881	Continued From page 81 effective antibiotic stewardship program according to their policy related to: *Ensuring residents' symptoms were present and documented prior to contacting their physicians related to potential infection. *Reviewing infections and antibiotics for possible trends. *Completing and annual summary of antibiotic use in the facility and reporting that to the QAPI committee. *Having an antibiogram (a table that shows which antibiotics are most likely to be effective against specific bacteria) done every 18-24 months to guide development or revision of antibiotic use protocols. *Following up annually with physicians regarding antibiotic use for residents. Findings include: 1. Interview on 5/8/25 at 9:34 a.m. with director of nursing (DON) C regarding the facilities antibiotic stewardship program and policy revealed: *She was the infection preventionist for the facility and was in charge of the antibiotic stewardship program. *The facility used a situation-background-assessment-recommendation (SBAR) form that was based off McGeer criteria for infection surveillance and monitoring. *The SBAR form was used for suspected respiratory, urinary, and soft tissue infections of the residents. *DON C stated the facility was not 100% compliant with the use of the SBAR form when a resident had symptoms of urinary tract infections because she felt "they [the staff] know" when a resident had a change in their health status. *When asked what not 100% compliant meant she stated the facility was noncompliant "almost	F 881	Don or designee ensured SBAR sheets provided at nurses station to ensure resident symptoms are present prior to contacting physician. Document started to track and review infections and antibiotics by DON. Education will be sent on antibiotic stewardship to physicians by 6/22/25. Administrator, DON, medical director, and interdisciplinary team will review and revise policies as necessary. DON or designee will provide education with documentation to all nurses about SBAR form and non-pharmacological interventions for infection prevention along with any policy and procedure updates. DON or designee will audit ongoing infections weekly for 4 weeks and monthly for 2 months or longer determined by audit results. DON or designee will report findings at monthly QAPI meetings until audit is complete and issue no longer needs to be addressed.	6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 881	Continued From page 82 always". *She stated if the staff waited for all the symptoms required with the criteria on the SBAR form to obtain a urinalysis (UA) order from the physician then the resident would have been more ill than if the urinary tract infection (UTI) was identified earlier. *DON C stated she had discussed this with medical director N and at times medical director N would refuse the order request for a UA by stating the resident required more symptoms for a UA to be ordered. *DON C was responsible for ensuring the facility received all lab and other diagnostic testing results that had been ordered at the facility and following up with the resident primary physician regarding the results. *She tracked the facility's use of antibiotic by printing out a report that was provided by the facility's contracted pharmacy that listed the antibiotics used by residents for the dates selected when the report was run. -That report included the resident name, the name of the antibiotic or antifungal medication with the instructions for use, when the medication was dispensed, when the medication was started, and the number of days the medication was administered. -That report did not include the diagnosis or indication for use of the medication, if the antibiotic was determined appropriate or necessary upon the receipt of the results of the diagnostic testing had been received. *She did not monitor infections related to the resident's location within the facility to identify potential clusters of residents with infections. *The only tracking she completed related to illness and antibiotic use was reviewing the monthly antibiotic use that was documented in	F 881		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 881	Continued From page 83 the report provided by the facilities contracted pharmacy during the monthly Quality Assurance and Performance Improvement (QAPI) meeting after she removed the antibiotics that were taken by residents for the prevention of infections from the report. Continued interview and review of the provider's 3/22/18 Antibiotic Stewardship Program policy with DON C revealed: *She had not been following the policy in the following areas: -She talked about the antibiotic use monthly but did not complete an annual summary. -There were no antibiotic stewardship meetings held as the facility policy indicated. -She did not complete random audits for resident's antibiotic use. -She did not track one outcome measure associated with antibiotic use monthly. -The facility did not have an antibiogram to review. -She did not follow up with the prescribing physicians annually regarding their use of antibiotics for the residents. Continued interview on 5/8/25 at 11:30 a.m. with DON C revealed she was not aware that the facilities infection rate for UTIs for long-stay residents was above the state and national average according to the facilities reported quality measures. 2. Review of the providers 3/22/18 Antibiotic Stewardship Program policy revealed: *"It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to	F 881		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 881	Continued From page 84 optimize the treatment of infections while reducing the adverse events associated with antibiotic use." *"The program includes antibiotic use protocols and a system to monitor antibiotic use. -a. Antibiotic use protocols: --i. Nursing stall shall assess residents who are suspected to have an infection and complete a Medical Care Referral Form prior to notifying the physician. --ii. Laboratory testing shall be in accordance with current standards of practice. --iii. The facility uses the (CDC's [Center for Disease Control] NHSN [National Healthcare Safety Network] Surveillance Definitions) to define infections. --iv. The Loeb Minimum Criteria are used to determine whether or not to treat an infection with antibiotics." *"Random audits of antibiotic prescriptions shall be performed to verify completeness and appropriateness (process measure). *"At least one outcome measure associated with antibiotic use will be tracked monthly, as prioritized from the facility's infection control risk assessment and other infection surveillance data. Examples include: tracking C. difficile infections, antibiotic resistance, or adverse drug events related to antibiotic use." *"At least annually, feedback shall be provided on the facility's antibiotic use data in the form of a written report shared with administration, medical and nursing staff, and the QAA [quality assessment and assurance] Committee." *"A review of the facility's antibiogram will be performed every 18-24 months to guide development or revision of antibiotic use protocols or prescribing practices." *"At least annually, each attending physician shall	F 881		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 881	Continued From page 85 be provided feedback on his/her antibiotic use data in the form of a written report". *"Documentation related to the program maintained by the Infection Preventionist, including but not limited to: -a. Action plans and/or work plans associated with the program. -b. Assessment forms. -c. Antibiotic use protocols/algorithms. -d. Data collection forms for antibiotic use, process, and outcome measures. -e. Antibiotic stewardship meeting minutes. -f. Feedback reports. -g. Records related to education of staff, residents, and families. -h. Annual reports." Review of the provider's 10/12/17 Infection Reporting policy revealed "The Infection Preventionist will report findings of surveillance activities, including at a minimum incident rates and types of infections, to the QAA committee, physicians, and other appropriate staff." 3. Review of the provider's March 2025 Facility Assessment revealed: *"We track and trend infections." *"We have monthly infection control meetings and quarterly QAPI meetings with our medical director, consulting pharmacist and Leadership team to discuss any issues." *"We have developed an Antibiotic Stewardship Policy and Procedure and have educated our staff, medical providers, pharmacy consultant, residents and their families."	F 881		
F 882 SS=E	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)	F 882		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 882	Continued From page 86 §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the provider failed to ensure that one of one designated infection preventionist (director of nursing C) had completed specialized training in infection prevention and control. Findings include: 1. Interview on 5/8/25 at 9:34 a.m. with director of nursing (DON) C revealed: *She was the designated infection preventionist for the facility. *She was haired on 10/7/21. *She had started the Center for Disease Control's (CDC) specialized infection prevention and control training, Nursing Home Infection Preventionist Training course, in October 2022. *She did not have a certification of completion for the Nursing Home infection Preventionist Training Course.	F 882	DON completed specialized training in infection control. Administrator, DON, and interdisciplinary team will review and revise policies and procedures as necessary. ADON or designee will audit IP training weekly for 2 weeks and monthly for 2 months or longer as determined by audit results. ADON or designee will report findings at monthly QAPI meetings until audit is complete and issue no longer needs to be addressed.	6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 882	Continued From page 87 *She was not aware that she had not completed the entire course. Record review of DON C's certificates of completion of modules of the CDC's Nursing Home Infection Preventionist Training Course revealed: *Module 1- Infection Prevention and Control Program with a completion date of 10/5/22. *Module 2- The Infection Preventionist with a completion date of 10/5/22. *Module 3- Integrating Infection Prevention and Control into the Quality Assurance Performance Improvement Program with a completion date of 10/5/22. *Module 4- Infection Surveillance with a completion date of 10/5/22. *Module 5- Outbreaks with a completion date of 10/5/22. *DON C had not completed 18 of the 23 modules required for completion of that course.	F 882		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10673	A. BUILDING: _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN POST OFFICE BOX 195 ROSLYN, SD 57261

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 5/5/25 through 5/8/25. Strand-Kjorsvig Community Rest Home was found not in compliance with the following requirements: S206, S210, S236, and S301.	S 000		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. All healthcare personnel must complete the orientation program within thirty days of hire and the ongoing education program annually thereafter. The orientation program and ongoing education program must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; (11) Abuse and neglect; and (12) Advanced directives. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section.	S 206	All current staff reviewed or completed annual training. IDT team reviewed and revised personnel training process for new employees as needed and all staff responsible for new employee training will be re-educated for correct compliance by 6/22/25. Business Office manager or designee will audit area identified to ensure compliance for all new hires weekly for 4 weeks and monthly for 2 months. Business office manager or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advised to discontinue monitoring.	6/22/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Samuel Van Voorst — TITLE: Administrator — (X6) DATE: 6/9/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10673	A. BUILDING: _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN POST OFFICE BOX 195 ROSLYN, SD 57261

(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 206	Continued From page 1 The facility shall provide additional personnel education based on the facility's identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee personnel records review, training transcript review, and interview, the provider failed to ensure training was completed on all the required topics for: *Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms for five of five sampled employees (F, G, H, I, and J) within 30 days of hire and annually. *Advance directives for two of five sampled employees (I and J) within 30 days of hire. Findings include: 1. Review of employee personnel records revealed: *Employee F was hired on 12/15/23. *Employee G was hired on 1/15/25. *Employee H was hired on 1/6/25. *Employee I was hired on 7/10/24. *Employee J was hired on 10/31/24. 2. Review of employee training records and online training transcripts revealed: *There was no documentation that employees F, G, H, I, and J had received training on incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms. *There was no documentation that employee I had received training on advance directives. *Employee J received training on advance directives on 1/30/25. -That was three months after she was hired. 3. Interview on 5/8/25 at 7:34 a.m. with director of nursing (DON) C and administrator B revealed:	S 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10673	A. BUILDING: _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN POST OFFICE BOX 195 ROSLYN, SD 57261

(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 206	Continued From page 2 *The provider used an online training program for employee-required training. *DON C confirmed employees F, G, H, I, and J had not completed training on incidents and diseases subject to mandatory reporting and the facility's reporting. -She had been unaware that those were required training topics. *They confirmed employee J had not received training topics on advanced directives within 30 days of hire. *Administrator B was unaware that the above trainings had not been completed. -She expected orientation and annual training to be completed within the required time frame. A staff education policy was requested on 5/7/25 at 4:35 p.m. and had not been provided before the survey exit.	S 206		
S 210	44:73:04:06 Personnel Health Program The facility shall have a personnel health program for the protection of the residents. Before assignment to duties or within fourteen days after employment, a licensed health professional must evaluate all personnel to ensure no personnel is infected with any reportable communicable disease that poses a threat to others. The evaluation must include an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease that may endanger the health of residents, and fellow personnel may not return to duty until the personnel is determined by a	S 210	Unable to correct noncompliance of health evaluation within 14 days of hire. Ensured all staff have a health evaluation completed. The health evaluation policy will be reviewed and revised by the IDT Team as needed and all staff responsible for new hires will be re-educated on correct process for compliance by 6/22/25. DON or designee will audit area identified to ensure compliance for all new hires weekly for 4 weeks and monthly for 2 months. DON or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10673	A. BUILDING: _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN POST OFFICE BOX 195 ROSLYN, SD 57261

(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 210	Continued From page 3 physician, physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee records review, interview, and policy review, the provider failed to ensure one of five sampled employees (J) was evaluated by a licensed health professional within 14 days from their start of employment. Findings include: 1. Review of licensed practical nurse J's employee records revealed: *She was hired on 10/31/24. *There was no documentation that a health evaluation had been completed. 2. Interview on 5/8/25 at 7:34 a.m. with director of nursing (DON) C revealed: *She would complete the employee health evaluation on the employee's first working shift. *If she were unavailable to complete the employee's health evaluation, she would assign that task to the charge nurse on duty. *She was unable to locate documentation that employee J's health evaluation had been completed. -She thought it may have been filed incorrectly. A health evaluation policy was requested on 5/8/25 at 7:30 a.m. and had not been provided before the survey exit.	S 210		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare	S 236		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10673	A. BUILDING: _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN POST OFFICE BOX 195 ROSLYN, SD 57261

(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 236	Continued From page 4 personnel or residents are as follows: (1) Each new healthcare personnel or resident shall receive an initial individual TB risk assessment and the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within twenty-one days of employment or admission to a facility. The qualified personnel must record the assessment and the test in the employee's record or the resident's medical record. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of admission or employment is considered a two-step test. A TB blood assay test completed within a twelve-month period prior to the date of admission or employment is an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare personnel or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin testing having been completed within the prior twelve months. Skin testing or a TB blood assay test is not necessary if documentation is provided by the transferring healthcare facility, healthcare personnel, or resident, of a previous positive reaction to either test. Any new healthcare personnel or resident who has a newly recognized positive reaction to the skin test or TB blood assay test must have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Based on employee records review, interview, and policy review, the provider failed to ensure one of five sampled employees (J) had received	S 236	Unable to correct noncompliance of TB screening within 21 days of hire. The tuberculosis policy will be reviewed and revised as needed by IDT Team and all staff responsible for new hires will be re-educated on correct process for compliance by 6/22/25. Business office manager or designee will audit area identified to ensure compliance for all new hires weekly for 4 weeks and monthly for 2 months. Business office manager or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10673	A. BUILDING: _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN POST OFFICE BOX 195 ROSLYN, SD 57261

(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 236	Continued From page 5 the two-step tuberculin (TB) skin test within twenty-one days of their employment. Findings include: 1. Review of licensed practical nurse J's employee records revealed: *She was hired on 10/31/24. *The documentation in her record revealed she had received the TB skin test on 12/2/24 and 12/27/24. -This was outside of the twenty-one day requirement. 2. Interview on 5/8/25 at 7:34 a.m. with director of nursing (DON) C revealed: *She completed the employee TB screening skin test on the employee's first working shift. *If she were unable to complete the employee's TB screening skin test, she would assign that task to the charge nurse on duty. *She was unsure why the above-listed TB screening skin test had been completed late. Review of the providers' revised February 2025 Infection Control and Prevention policy revealed: *"A two-step TB skin test will be completed on all staff members within 21 days of hire unless there is documentation of a two-step results within the past year."	S 236		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for all dietary or food-handling personnel. The training must include the following subjects:	S 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10673	A. BUILDING: _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN POST OFFICE BOX 195 ROSLYN, SD 57261

(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 301	Continued From page 6 (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee personnel records review, training transcript review, and interview, the provider failed to ensure training was completed on eight of the nine required dietary training topics for food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, and sanitation requirements for one of five sampled dietary staff members (K). Findings include: 1. Review of employee personnel records revealed that dietary employee K was hired on 2/20/25 as a "waiter." 2. Review of employee K's online training transcripts revealed there was no documentation that employee K had received training on food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, or sanitation. 3. Interview on 5/8/25 at 7:34 a.m. with director of	S 301	Unable to correct noncompliance of providing complete training to dietary staff member K. Dietary staff K will be educated on all dietary topics by Dietary manager or designee. Ensured all necessary staff completed training on dietary topics. Dietary training process for new employees will be reviewed and revised as needed by IDT Team and all staff responsible for new employee training will be re-educated for correct compliance by 6/22/25. Dietary manager or designee will audit area identified to ensure compliance for all new hires weekly for 4 weeks and monthly for 2 months. Dietary manager or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	6/22/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10673	A. BUILDING: _____ B. WING _____	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN POST OFFICE BOX 195 ROSLYN, SD 57261

(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 301	Continued From page 7 nursing (DON) C and administrator B revealed: *The provider used an online training program for employee-required training. *They confirmed there was no documentation to support that employee K had received the required dietary training on food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, or sanitation. *Administrator B was unaware that the above trainings had not been completed. -The training on the above-listed topics was assigned to be completed in May 2025 and had been missed in the initial required orientation training for employee K. -She expected the required orientation training to be completed within the required 30-day time frame of the employee's hire date. *Dietary manager (DM) E was responsible for ensuring that the dietary staff completed their required orientation and annual training. 4. Interview on 5/8/25 at 7:47 a.m. with DM E regarding orientation training for dietary employees revealed: *Business manager (BM) O assigned the training in the online training program. *DM E ensured that dietary staff completed their required training before they worked their first shift. *DM E was unaware that employee K had not completed training on the above-listed topics. A staff education policy was requested on 5/7/25 at 4:35 p.m. and had not been provided before the survey exit.	S 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/07/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	**801 S MAIN** **ROSLYN, SD 57261**

(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
K 000	INITIAL COMMENTS A recertification survey was conducted on 5/7/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Strand-Kjorsvig Community Rest Home was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K223 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to ensure two randomly observed corridor doors (soiled linen and laundry rooms) were equipped with functioning positive latching hardware.	K 223	Both corridor doors will be fixed or replaced with functioning positive latching hardware by maintenance director. Administrator will provide education to maintenance director on ensuring functioning positive latching hardware. Maintenance director or designee will audit functioning positive latching hardware on doors weekly for 4 weeks and monthly for 2 months. Maintenance director or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	6/22/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Samuel Van Voorst

TITLE
Administrator

(X6) DATE
6/5/25

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/07/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	**801 S MAIN** **ROSLYN, SD 57261**

(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
K 223	Continued From page 1 Findings include: 1. Observation and testing on 5/7/25 at 1:13 p.m. of the door from the soiled linen room into the corridor revealed that door was equipped with a closer, but it was not automatically latching into the door frame. That door hit its frame upon closing and was kept from fully latching into the frame. 2. Observation and testing on 5/7/25 at 1:18 p.m. revealed the corridor door from the laundry room was equipped with a closer, but it was not automatically latching into the door frame. That door hit its frame at the top corner upon closing and kept it from latching. Doors provided with closers are required to latch into their frames automatically. Interview with the maintenance director at the time of the observation and testing confirmed those findings. He stated he was unaware of those conditions. He further stated the top hinges of each of those doors had become loose since he had last checked them. He went on to say he believed that was causing them not to latch into their respective frames. Those deficiencies could affect 100% of the occupants of their smoke compartments.	K 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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
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 5/7/25. Strand-Kjorsvig Community Rest Home was found in compliance or found not in compliance with the following requirement: E004	E 000		
E 004 SS=D	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must	E 004	Emergency preparedness plan agreements will be updated by 6/22/25 and annually going forward. Administrator A and B educated on ensuring EP plan and agreements are reviewed at least annually. Dietary manager or designee will audit EP plan and agreements annually to ensure they are reviewed. Dietary manager or designee will report findings at monthly QAPI meetings until audit is complete, and issue no longer needs to be addressed.	6/22/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Samuel Van Voorst
TITLE: Administrator
(X6) DATE: 6/5/25

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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
E 004	Continued From page 1 develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to update the emergency preparedness plan agreements (evacuation transfer) annually. Findings include: 1. Record review on 5/7/25 at 3:38 p.m. revealed no documentation that the provider's current emergency preparedness plan memorandums of understanding/agreements were updated annually. For example, the transfer agreement had not been updated annually since 10/19/17. Interview with the administrator at that same time confirmed that finding. She stated they did not have a more current agreement.	E 004		