STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435056	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER: WINNER REGIONAL HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 805 E 8TH ST, WINNER, SD 57580

(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 12/17/24 through 12/19/24. Winner Regional Healthcare Center was found not in compliance with the following requirements: F695, and F700. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 12/17/24 through 12/19/24. The area surveyed included resident neglect related to resident incontinence. Winner Regional Healthcare Center was found in compliance.	F 000		
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, interview, record review, and policy review, the provider failed to ensure: *One of one resident (9) receiving oxygen had appropriate exchange and maintenance of the cannula. *One of one resident (27) receiving oxygen at night had a current physician order for use and was care planned. Findings include:	F 695	The ADON corrected the oxygen tubing immediately upon discussion with the surveyor. All new tubing was placed for each resident of the facility and dated.	01/13/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Brian Williams TITLE CEO (X6) DATE 01.10.2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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
	435056	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNER REGIONAL HEALTHCARE CENTER	805 E 8TH ST WINNER, SD 57580

(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 1 1. Observation and interview on 12/17/24 at 9:57 a.m. with resident 9 in her room revealed: *She was seated in her wheelchair. *Her oxygen nasal cannula tubing connected to her oxygen concentrator was dated in black ink "9/5/24." *She stated she used her nasal cannula at nighttime. Observations on 12/18/24 and 12/19/24 revealed resident 9's oxygen nasal cannula tubing was dated "9/5/24." Interview on 12/18/24 at 9:27 a.m. with registered nurse (RN) H regarding changing resident oxygen tubing revealed: *The night shift staff were expected to change oxygen tubing weekly. *There were labels they could use on the oxygen tubing. *Staff were to document in the residents' charts who used oxygen when they had changed the oxygen tubing. Review of resident 9's electronic medical record (EMR) revealed: *She was admitted on 4/9/20. *Her Brief Interview for Mental Status (BIMS) assessment score was 8, meaning she was moderately cognitively impaired. *Her diagnoses included: -Chronic diastolic congestive heart failure. -Dependence on supplemental oxygen. -Intervertebral disc degeneration. -Chronic atrial fibrillation (a heart arrhythmia that causes the upper chambers of the heart to beat irregularly and quickly). *A physician's order for 2 liters of oxygen by nasal	F 695	The charts of all residents that require oxygen/neb treatments were audited for physician orders. The orders are found in the MAR of each resident. It is a required and a task to sign off on in the residents' charts. Tubing will be changed and dated each week. Weekly audits will take place by the ADON/designee. These audits will monitor that oxygen/nebulizer tubing is changed and dated each week. Also, that it is signed off each week by the night shift nurse/designee. Audits began on 12/31/2024 and will continue weekly by the ADON/designee for 3 months with the goal of 100% compliance. The ADON/designee will present the audit results at the QAPI meeting monthly. QAPI committee will be responsible for the decision to continue the audit after 3 months, if errors continue to occur. Mandatory meeting/education will occuron 1/13/2025 and 1/16/2025 to educate on the oxygen tubing policy and appropriate way to monitor orders, sign that the task was completed, and to date all new neb and oxygen tubing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435056	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNER REGIONAL HEALTHCARE CENTER	805 E 8TH ST WINNER, SD 57580

(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 2 cannula every night dated 5/9/24. *A physician's order to change oxygen and nebulizer tubing once a week on Sundays during the night shift dated 8/6/23. *The changing of her oxygen tubing once a week on Sunday night shifts had been documented as complete by staff on 12/1/24, 12/8/24, and 12/15/24. Interview on 12/19/24 at 9:01 with director of nursing (DON) B regarding resident 9's oxygen tubing revealed: *She confirmed that residents' oxygen tubing was to be changed weekly on Sunday by the night nurses. *She agreed based on the above observations of resident 9's oxygen tubing that it had not been changed since 9/5/24. *She stated they do not perform chart audits or supervise staff to ensure they are performing and documenting oxygen tubing changes correctly. 2. Observation and interview on 12/17/24 at 12:24 pm of resident 27 her room revealed: *There was an oxygen concentrator with tubing and cannula attached. -There was no visible indication of a dating mechanism for changing the tubing. *She used oxygen at night when she needed it. -She thought the oxygen flow rate was about 2 liters. -She thought they changed the tubing weekly but she wasn't sure. Review of resident 27's electronic medical record (EMR) revealed: *The Medical Administration Record (MAR) did not reference her use of oxygen. *The Treatment Administration Record (TAR)	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435056	A. BUILDING ____ B. WING ____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNER REGIONAL HEALTHCARE CENTER	805 E 8TH ST WINNER, SD 57580

(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 3 contained no tasks related to oxygen equipment maintenance or changing of equipment such as oxygen tubing or cannula. *There was no physician order for the use of oxygen. *The care plan did not indicate that resident 27 used oxygen. *There was no indication on the "pocket care plan" that was used each day by certified nurse aides that resident 27 used oxygen. Interview with director of nursing (DON) B on 12/19/24 at 10:13 am regarding residents' use of oxygen revealed: *Use of oxygen required a physician's order. *She would have expected that oxygen use would have been documented in transfer orders received from hospital. -Staff were to ensure that orders were entered in the resident's EMR. -Staff were to enter the associated tasks including tubing changes in the resident's TAR. -Oxygen use was to be addressed in the resident's care plan. Review of the provider's 2/2020 Cleaning of Oxygen and Nebulizer Equipment policy revealed: *"Nebulizer masks, cannulas, tubing are changed weekly." *"Weekly, as assigned on the duties schedule, the charge nurse or designee replaces all oxygen masks, cannulas, and tubing."	F 695		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435066	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNER REGIONAL HEALTHCARE CENTER	805 E 6TH ST WINNER, SD 57580

(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 700	Continued From page 4 a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review the provider failed to ensure side rail assessments were completed for safe and appropriateuse for three of seven sampled residents (1, 9, and 14) wh used them for repositioning. Findings include: 1. Observation and interview on 12/17/24 at 10:47 a.m. with resident 14 in her room revealed: *She was seated in her wheelchair. *Her bed hadside rails on the top half of each side (bilateral) of her bed. *She stated she used the side rails to move around in bed. Review of resident 14's electronic medical record (EMR) revealed: *She was admitted on 11/10/23.	F 700	A list of residents that require side rails was obtained. The initial risk assessment was completed by the therapy dept and verified in each chart. All residents with side rails will have a completed quarterly assessment completed by 1/13/2025 by ADON/DON/designee. Quarterly assessments will be completed by the LPN/RN on duty. The quarterly assessment is found in the assessment tab of the EMR. This had been identified prior to the state survey and a new process was being initiated. Each month a list of quarterly assessments will be given to the nurse/ADON/DON, that will need to be completed at the time of the MDS review. The policy will be reviewed with staff at the mandatory meeting/education that will occur on 1/13/2025 and 1/16/2025. Audits will be conducted monthly, to ensure quarterly assessments are being completed by nursing staff. The audits will begin 1/13/2025. This will continue for 3 months. The ADON/DON/designee will present the audit results at the QAPI meeting monthly. QAPI committee will be responsible for the decision to continue the audit after the 3 months, if errors continue to occur.	1/13/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435056	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNER REGIONAL HEALTHCARE CENTER	805 E 8TH ST WINNER, SD 57580

(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 700	Continued From page 5 *Her Brief Interview for Mental Status (BIMS) score was 14, meaning she was cognitively intact. *She had diganoses of: -Nondisplaced comminuted fracture of left patella (kneecap). -Parkinson's disease. -Pneumonia. *An order dated 5/8/24 for her to use side rails to bilateral sides of the bed, to aid her in self mobility and repositioning while in bed. *A 1/4 rail and side rail rationale and safety screen was completed on 5/7/24. *No other safety screens or assessments were completed for the use of the side rails. 2. Observation and interview on 12/17/24 at 9:57 a.m. with resident 9 in her room revealed: *She was seated in her wheelchair. *The top half of her bed had bilateral side rails. *She stated she used the side rails and "loved" them. Review of resident 9's EMR revealed: *She was admitted on 4/9/2020. *Her BIMS assessment score was 8, meaning she was moderately cognitively impaired. *A 1/4 rail and siderail rationale and safety screen was completed on 7/29/23. *She had a current physicians order for a side rail. *No other safety screens or assessments were completed for the use of the side rail. 3. Observation and interview on 12/17/10:22 a.m. with resident 1 in her room revealed: *She was seated in her motorized wheelchair. *The top half of her bed had a side rail on the left side of her bed. *She stated she used her side rail at night to help	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435056	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNER REGIONAL HEALTHCARE CENTER	805 E 8TH ST WINNER, SD 57580

(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 700	Continued From page 6 her turn. *She stated she had been living at the facility for seventeen years. Review of resident 1's EMR revealed: *She was admitted on 2/6/2015. *Her BIMS assessment score was 15, meaning she was cognitively intact. *A side rail use assessment was completed on 3/6/2019. *She had a current physicians order for a side rail. *An alarm/side rail/restraint consent for use was signed on 9/9/2022. *No other safety screens or assessments were completed for the use of a side rail. Interview on 12/19/24 at 8:16 a.m. with assistant director of nursing (ADON) C regarding side rail assessments revealed the therapy department completed the assessments for the side rails. Interview on 12/19/24 at 8:39 a.m. with physical therapist L regarding side rail assessments revealed: *The therapy department did the initial assessments. *The nursing department was responsible for completing the quarterly assessments. Interview on 12/19/24 at 9:32 a.m. with director of nursing (DON) B regarding side rail assessments revealed: *She had identified the quarterly side rail assessments were an issue. *The therapy department completed the initial assessments. *The nursing department was responsible for the quarterly assessments.	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435056	A. BUILDING ______ B. WING ______	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNER REGIONAL HEALTHCARE CENTER	805 E 8TH ST WINNER, SD 57580

(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 700	Continued From page 7 *She agreed the quarterly assessments were not being completed. Review of the provider's 6/2021 side rail policy revealed: *"Each resident will maintain his/her highest practical level of well-being in an environment that prohibits the use of side rail for discipline or to restrict movement and limits side rail use to circumstances in which the resident has been evaluated for transfers and safety with use of side rails to enhance mobility." *"10. A side rail assessment will be completed by therapy and/or nursing when there is a desire expressed by the resident or need reported by the nursing staff." *"11. Physicians orders for type and number of side rails will be obtained prior to placing the side rail on the bed." *"12. A side rail assessment form will be completed quarterly and prn by the MDS coordinator or designee in conjunction with OBRA MDS's and prn for use or desired change."	F 700		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/03/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435056	A. BUILDING _____ B. WING _____	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNER REGIONAL HEALTHCARE CENTER	805 E 8TH ST WINNER, SD 57580

(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 12/17/24. Winner Regional Healthcare Center was found in compliance.	E 000		

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

TITLE CEO

(X6) DATE 1/15/25

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/03/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435056	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNER REGIONAL HEALTHCARE CENTER	805 E 8TH ST WINNER, SD 57580

(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 12/17/24 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Winner Regional Healthcare Center was found in compliance.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]

TITLE: CEO

(X6) DATE: 1/13/25

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

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10713	A. BUILDING: ____ B. WING ____	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNER REGIONAL HEALTHCARE CENTER	805 EAST 8TH ST WINNER, SD 57580

(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 12/17/24 through 12/19/24. Winner Regional Healthcare Center was found not in compliance with the following requirements: S206 and S296.	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 personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (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; and. (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section. Additional personnel education shall be based on	S 206	Employee K and Employee I have completed the yearly education. Leadership Council met on 1/7/2025 and a policy will be developed stating that all employees will complete a required education within 60 days of hire. Policy will be completed by 1/13/2025. Winner Regional Health is implementing a new program called MedTrainer. MedTrainer will be where all education will be completed. The education will be deployed at the beginning of each year. A LTC CNA bundle is being developed for deployment of all state required education. Due to this being a new program, the required education will be deployed to all employees on February 1st, 2025. Human resources will conduct audits to maintain compliance of new employees. New employees of the Winner Long Term Care, will be discussed with DON or designee and shared at LTC QAPI for 6 months, to maintain compliance. The LTC QAPI committee will be responsible for the decision to continue the audit after 6 months, if errors continue to occur.	1/13/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Brian Williams TITLE CEO (X6) DATE 01/14/2025

CEO 01/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10713	A. BUILDING: ______ B. WING ______	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNER REGIONAL HEALTHCARE CENTER	**805 EAST 8TH ST WINNER, SD 57580**

(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 facility identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure training was completed for fire prevention/response, emergency procedures/preparedness, infection control & prevention, accident prevention safety procedures, proper restraint use, resident rights, confidentiality of resident information, care of residents with unique needs, dining assistance, nutritional risks, hydration, abuse, neglect, misappropriation, and mistreatment, for two of seven sampled employees (K and I). Findings include: 1.Review of employee personnel records revealed: *Employee K was hired on 1/15/08. *Employee I was hired on 12/19/23. *There was no documentation they had completed the following education within the last year: -Fire prevention/response. -Emergency procedures/preparedness. -Infection control & prevention. -Accident prevention safety procedures. -Proper restraint use. -Resident rights. -Confidentiality of resident information. -Care of residents with unique needs. -Dining assistance, nutritional risks, and hydration. -Abuse, neglect, misappropriation, and mistreatment. Interview and review of employee training records on 12/19/2024 at 9:01 a.m. with director of	S 206	Employee K has completed all	

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
	10713	A. BUILDING: ____ B. WING ____	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNER REGIONAL HEALTHCARE CENTER	805 EAST 8TH ST WINNER, SD 57580

(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 nursing B revealed: *All staff are required to complete training annually. *They used an online training program. *The managers of the departments were responsible for ensuring their staff had completed their annual training. *She confirmed there was no documentation to support that employee K and I had completed their annual training. *She confirmed the facility did not have a policy regarding personnel training.	S 206		
S 296	44:73:07:11 Director of Dietetic Services A full time dietary manager who is responsible to the administrator shall direct the dietetic services. Any dietary manager that has not completed a Dietary Manager's course, approved by the Association of Nutrition & Foodservice Professionals, shall enroll in a course within 90 days of the hire date and complete the course within 18 months. The dietary manager and at least one cook must shall successfully complete and possess a current certificate from a ServSafe Food Protection Program offered by various retailers or the Certified Food Protection Professional's Sanitation Course offered by the Association of Nutrition & Foodservice Professionals, or successfully completed equivalent training as determined by the department. Individuals seeking ServSafe recertification are only required to take the national examination. The dietary manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each resident are met. If the dietary manager is not a dietitian, the facility shall schedule dietitian consultations onsite at least monthly. The dietitian	S 296	Dietary Manager (employee D) immediately began the ServSafe Manager certificate. On 1/10/2025 employee D takes the final exam. Winner Regional Health will have two certified employees. MedTrainer is a new program that Winner Regional Health is in the process of implementing. This program will notify the employees within 90 days of lapse of certification.	1/10/2025

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
	10713	A. BUILDING: ___ B. WING ___	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNER REGIONAL HEALTHCARE CENTER	805 EAST 8TH ST WINNER, SD 57580

(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 296	Continued From page 3	S 296		

shall approve all menus, assess the nutritional status of residents with problems identified in the assessment, and review and revise dietetic policies and procedures during scheduled visits. Adequate staff whose working hours are scheduled to meet the dietetic needs of the residents shall be on duty daily over a period of 12 or more hours in facilities.

This Administrative Rule of South Dakota is not met as evidenced by:
Based on interview and certificate review, the provider failed to ensure the dining services manager and one cook possessed a current ServSafe Food Protection Program certificate.
Findings include:

1. Interview on 12/17/24 at 8:40 a.m. with food services supervisor (FSS) D revealed:
*She had been the FSS since June of 2023.
*She was completing her certified dietary managers (CDM) courses.
*Her ServSafe Food Protection Program certificate expired in September 2024.
*She had not renewed her ServSafe certificate.
*A cook she had recently hired possessed a current ServSafe certificate.
*No other employees were ServSafe certified.

2. Interview on 12/17/24 at 3:36 p.m. with consultant dietitian E regarding ServSafe requirements revealed:
*She was aware of the regulations for two staff to be ServSafe certified in the dietary department.
*Her expectation was the provider would meet the requirements.
*She would work with FSS D to get her ServSafe certificate up to date.

3. Interview on 12/19/24 at 9:00 a.m. with chief

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
	10713	A. BUILDING: ______ B. WING ______	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNER REGIONAL HEALTHCARE CENTER	**805 EAST 8TH ST WINNER, SD 57580**

(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 296	Continued From page 4 executive officer (CEO) A revealed: *He thought two dietary staff had their ServSafe certificates. *He was not aware FSS D's ServSafe certificate had expired. *It was his expectation that staff would meet the regulations. 4. Review of the ServSafe Food Protection Program certificates revealed. *FSS D's certificate expired 9/6/24. *Cook M's certificate was still current.	S 296		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 12/17/24 through 12/19/24. Winner Regional Healthcare Center was found in compliance.	S 000		