STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435125	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Strand-Kjorsvig Community Rest Home	**801 S MAIN POST OFFICE BOX 195, ROSLYN, South Dakota, 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
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/11/26 through 8/13/26. Strand-Kjorsvig Community Rest Home was found not in compliance with the following requirements: F609, F610, F803, F812, and F883. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/11/26 through 8/13/26 . Areas surveyed included accident hazards related to a resident elopement, nursing services related to missing narcotics, environmental concerns, inappropriate resident discharge, and alleged staff-to-resident abuse. Strand-Kjorsvig Community Rest Home was found not in compliance with the following requirements: F600, F609, and F610.	F0000		
F0609 SS = E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F0609	F 609 Unable to correct prior non-compliance for not reporting and investigating incidents Current policies on reporting requirements reviewed by IDT and no changes needed All staff educated on reporting requirements and policy by 9/27/26 by DON or designee Administrator, DON and ADON reviewed regulation on reporting guildines by 9/27/26 DON or Designee will audit all incidents for proper reporting weekly for 4 weeks and monthly for 2 additional months and thereafter until otherwise determined by the QAPI Committee DON or Designee will present findings at monthly QAPI meetings for review and recommendations	9/27/26

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Samuel Van Voorst	Administrator	9/11/26

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F0609 SS = E	Continued from page 1 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, and policy review, the provider failed to report incidents to the SD DOH within the required time frame regarding one of one sampled residents (18) who experienced verbal abuse by a staff member and failed to report incidents regarding five of five sampled residents (3, 7, 11, 22, and 24) who experienced potential resident to resident physical and sexual abuse incidents that were required to be reported. Findings include: 1. Review of the 11/11/25 SD DOH FRI report revealed that on 11/11/25, director of nursing (DON) B was notified that resident 18 had a fall on 10/30/25. Contracted travel licensed practical nurse (LPN) K went to resident 18's room and called him an insulting name. Former certified nurse assistant (CNA) L was in the room and heard the interaction. The FRI report indicated that CNA L did not report this to the DON because she was afraid of retaliation from contracted travel LPN K. Registered nurse (RN) M reported the incident to DON B after she heard about the situation from CNA N on 11/11/25. DON B and assistant DON (ADON)/social service designee (SSD) C talked to resident 18 about the incident and verified he was called a derogatory name but did not want to repeat what contracted travel LPN K called him. DON B terminated contracted travel K and provided education to former CNA L about the importance of reporting incidents immediately. That FRI report indicated the incident occurred on 10/30/25 and was not reported to the SD DOH until 11/11/25, which was 12 days after the incident allegedly occurred. 2. Review of resident 3's electronic medical record (EMR) revealed that a progress note on 8/4/26 at	F0609		

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F0609 SS = E	Continued from page 2 4:51 p.m. by ADON/SSD C indicated that she responded to an incident in resident 3's room, where resident 11 went into resident 3's room and slapped him. Resident 3 then slapped resident 11 across the face "making her glasses fly into the hallway." Resident 3's sons were in the room during the event. On 8/4/26 at 5:29 p.m., a progress note by ADON/SSD C revealed that she notified DON B and resident 3's power of attorney (POA) of the incident that occurred in resident 3's room. Review of Resident 11's EMR revealed that her POA was notified of the incident as well on 8/4/26 at around 5:00 p.m. There was no evidence to support that this event was reported to the SD DOH. 3. Review of resident 24's EMR revealed that on 5/20/26 at 9:00 p.m., a progress note by LPN R indicated that resident 33 "stomped on her [resident 24] foot, grabbed the resident's chest, and shoved the resident. This action was unprovoked. Resident [24] did not fall to the floor. Staff intervened immediately and separated the residents." The progress note included that her vitals were within normal limits and she did not have any skin injuries. There was no evidence that resident 24's or resident 33's POAs or primary care providers (PCPs) had been notified of the incident, and no evidence that the SD DOH had been notified. 4. Review of resident 22's EMR revealed that on 3/31/26 at 7:44 p.m., a progress note by DON B revealed that an unidentified CNA reported to her that resident 22 had his hands on a female resident's breasts. The progress note stated that DON B told resident 22 that he was not supposed to touch anyone and he replied "okay." There was no evidence that this situation was reported as potential sexual abuse to the SD DOH. There was no evidence to support that this situation was reported to either resident's POAs or PCPs. 5. Review of resident 24's EMR revealed that on 1/18/26 at 2:16 p.m., a progress note by RN S indicated that resident 11 was standing in front of resident 24's room screaming at resident 24. Resident 24 was yelling for help. Resident 11 had ahold of resident 24's hand. Resident 11 had caused a skin tear to resident 24's left hand.	F0609		

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F0609 SS = E	Continued from page 3 There was no evidence that this event was reported to the SD DOH as potential resident to resident physical abuse. 6. Interview on 8/13/26 at 12:27 p.m. with ADON/SSD C revealed that DON B was responsible for reporting and investigating potential abuse incidents to the SD DOH. ADON/SSD C assisted with the investigations directed by DON B. 7. Interview on 8/13/26 at 1:41 p.m. with administrator A and DON B revealed that, in reference to the incident where resident 22 had his hands on another female residents' breasts, it was administrator A's expectation that all incidents of potential resident-to-resident sexual abuse should have been reported to the appropriate agencies and investigated. DON B confirmed that she was aware that, on 3/31/26, resident 22 had his hands on each of resident 7's. She said that the reason she did not report that interaction as potential sexual abuse is because resident 7 "initiates or invites that stuff." She confirmed that both resident 22 and resident 7 were cognitively impaired. DON B also indicated that the incidents involving resident 24 should have been reported to the SD DOH. Record review at that time revealed that resident 22 had a Brief Interview for Mental Status (BIMS) score of 4, and resident 7 had a BIMS score of 3, indicating their cognition was severely impaired. 8. Interview on 8/13/26 at 6:11 p.m. with DON B and ADON/SSD C revealed that DON B thought she had reported the 8/4/26 physical altercation between resident 3 and resident 11. When she logged in to the State Department of Health self-reporting system, she confirmed that event had not been reported. Regarding the allegation of staff-to-resident verbal abuse between LPN K and resident 18, the event happened on 10/30/25 but DON B was not informed about it until 11/11/25. CNA L was afraid of retaliation by LPN K, so she did not report it. CNA L no longer worked there. She expected all staff to report allegations of abuse and neglect to her or a charge nurse immediately. Since LPN K was the charge nurse on 10/30/25, she expected CNA L to report the event directly to her. She did not have documentation that former CNA L received education regarding abuse reporting after that incident. She had documentation that some of the staff received education about abuse, neglect, and mandatory	F0609		

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F0609 SS = E	Continued from page 4 reporting. 9. Interview on 8/13/26 at 6:45 p.m. with DON B revealed she was not aware that the incident between residents 11 and 24 had occurred. She expected staff to notify her of potential abuse incidents and accidents so she could report them to the SD DOH as needed. 10. Review of the provider's 1/23/18 Abuse, Neglect and Exploitation policy revealed that "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse…." "The facility will establish policies and procedures on abuse, neglect… pertaining to the following components:" "Investigation and staff identification of allegations;" "Training requirements for new and existing staff and in-service training for nurse-aides;" "reporting and response." "The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written." "When abuse, neglect or exploitation is suspected: Immediately report all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies…within specified timeframes;…Taking all necessary actions as a result of the investigation, which may include, but are not limited to, the following: Analyzing the occurrence(s) to determine why abuse, neglect,…and what changes are needed to prevent further occurrences; Defining how care provision will be changed and/or improved to protect residents receiving services; Training of staff on changes made and demonstration of staff competency after training is implemented; Identification of staff responsible for implementation of corrective actions; The expected date for implementation; and Identification of staff responsible for monitoring the implementation of the plan." "The Administrator should follow up with the government agencies, during business hours, to confirm the report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies." 11. Review of the provider's undated Incidents and Accidents policy revealed, "It is the policy of this facility for staff to report, investigate, and review any	F0609		

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F0609 SS = E	Continued from page 5 accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident." "The purpose of incident reporting can include: Assuring that the appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care. Conducting root cause analysis to ascertain causative/contributing factors as part of the Quality Assurance Performance Improvement (QAPI) to avoid further occurrences. Alert risk management and/or administration of occurrences that could result in claims or further reporting requirements. Meeting regulatory requirements for analysis and reporting of incidents and accidents." "Licensed staff will report incidents/accidents and assist with completion of any investigative information to identify root causes." "The following incidents/accidents require an incident/accident report but are not limited to: Alleged abuse,... Resident to resident altercations...." "If an incident/accident was witnessed by other people, the supervisor or designee will obtain written documentation of the event by those that witnessed it and submit that documentation to the Director of Nursing and/or Administrator."	F0609		
F0610 SS = E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F0610	F 610 Unable to correct prior non-compliance for not having sufficent investigation on incident on 11/11/25 Current policies regaurding investigations reviewed by IDT and neccessary revisions made as needed All staff educated on regulation on investigations and upated policy by 9/27/26 by DON or designee ADON or designee will audit thorough investigations on incidents completed weekly for 4 weeks and monthly for 2 additional months and thereafter until determined otherwise by QAPI Committee ADON or designee will present findings at monthly QAPI meetings for review and recommendations	9/27/26

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F0610 SS = E	Continued from page 6 This REQUIREMENT is NOT MET as evidenced by: A. Based on South Dakota Department of Health (SD DOH) Facility Reported Incident (FRI) report review, record review, interview, and policy review, the provider failed to investigate staff-reported incidents of potential resident abuse involving contracted travel licensed practical nurse (LPN) (K) when he allegedly called resident 18 an insulting name, and allegedly had been overly aggressive with resident 16 after the resident grabbed and twisted housekeeper Q's arm. Failure to investigate these allegations prevented the provider's ability to determine if abuse occurred and to mitigate the risk of future abuse to the residents who resided at the facility. Findings include: 1. Review of the SD DOH FRI dated 11/11/25 revealed the alleged abuse between LPN K and resident 16 occurred on 11/9/25 at 7:30 p.m. The report had been completed by director of nursing (DON) B. The report indicated that resident 16 was not capable of participating in the investigation. According to the report, LPN K had been overly aggressive with resident 16 on 11/9/25. DON B had become aware of that incident on 11/11/25. The DON stated that she interviewed housekeeper Q who was involved in that incident. Resident 16 grabbed, squeezed, and twisted housekeeper Q's arm. LPN K had intervened and forcibly removed resident 16 from housekeeper Q. The report indicated that housekeeper Q had stated LPN K had been more aggressive with resident 16 than he needed to be. The FRI indicated two residents had reported that same incident. One resident reported LPN K had resident 16 up against the wall, and the resident's feet were not touching the floor. The second resident had stated LPN K had hit resident 16 and shouted at him. The report indicated that LPN K had escorted resident 16 to his room and remained in resident 16's room with him for approximately 10 minutes. LPN K had stood in front of resident 16's recliner in an intimidating stance and if resident 16 attempted to stand LPN K would make him sit back down. The report indicated that LPN K's contract was terminated effective immediately on 11/11/25. Resident 16 did not show any signs of injury or bruising related to that incident on 11/9/25. There were no vital signs taken at the time of that incident.	F0610		

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F0610 SS = E	Continued from page 7 Resident 16 had been up and walking around as his usual and did not show any adverse effects related to that incident. The incident on 11/9/25 was not reported to the police, and the SD DOH report had been rejected back to the facility's provided email, with additional questions about the report. The questions were not answered and a final report was not completed by the facility. 2. Interview on 8/13/26 at 11:11 a.m. with DON B revealed she had completed an investigation regarding the alleged abuse of resident 16 that occurred in November 2025. She did not have documentation to support the investigation she had done. She stated the investigation information would have been on the risk management form in the electronic medical record (EMR) system, but she could not find that documentation. She stated that she did substantiate the abuse and that LPN K was terminated. She could not remember who the residents were that had seen that incident take place. DON B was not able to provide the name of who had seen LPN K escort resident 16 back to his room and kept him in his recliner in an intimidating manner. She was not aware that her original FRI report had been rejected by the SD DOH due to unanswered questions regarding the alleged abuse. She acknowledged that she had received rejected reports in the past to her email address, and she would submit a different report when that happened. She stated she was "pretty sure [housekeeper Q]" had reported that information to her, but she did not have documentation from her investigation. She stated she did interview LPN K but she did not have the date of that inveterview and he had told her he had lost his temper. She did not have that interview documentation. She was not sure why staff had not reported that incident to her right way. DON B acknowledged that the police were not notified of that incident. DON B stated she directed her investigation toward abuse and she substantiated abuse and terminated LPN K. 3. Interview on 8/13/26 at 12:27 p.m. with assistant DON (ADON)/social services designee (SSD) C revealed that DON B was responsible for reporting potential abuse incidents to the SD DOH and for completing investigations. ADON/SSD C helped with the investigations as directed by DON B.	F0610		

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F0610 SS = E	Continued from page 8 4. Review of the 11/11/25 SD DOH FRI report revealed that on 11/11/25, director of nursing (DON) B was notified that resident 18 had a fall on 10/30/25. Contracted travel licensed practical nurse (LPN) K went to resident 18's room and called him an insulting name. Former certified nurse assistant (CNA) L was in the room and heard the interaction. The FRI report indicated that CNA L did not report this to the DON because she was afraid of retaliation from contracted travel LPN K. Registered nurse (RN) M reported the incident to DON B after she heard about the situation from CNA N. DON B and assistant DON (ADON)/social service designee (SSD) C talked to resident 18 about the incident and verified he was called a derogatory name but he did not want to repeat what contracted travel LPN K called him. DON B terminated contracted travel LPN K and provided education to former CNA L about the importance of reporting incidents immediately. The report did not indicate the dates that DON B and ADON/SSD C talked to resident 18, contracted travel LPN K was terminated, or the date CNA L was provided education occurred. 5. Interview on 8/13/26 at 1:41 p.m. with administrator A and DON B revealed that after the incidents between resident 16, resident 18, and LPN K, they did not interview any other residents or staff to gauge the extent of the alleged abuse by LPN K. Administrator A said that once they learned of the allegations, they suspended LPN K and then terminated his contract. He was not allowed to come back. Administrator A questioned why other residents and staff would need to be interviewed as part of an investigation into the alleged abuse, as they "eliminated all risk" from him because he was not allowed to return. He confirmed he was not involved in those investigations. 6. Interview on 8/13/26 at 6:11 p.m. with DON B and ADON/SSD C regarding the allegation of staff-to-resident verbal abuse between LPN K and resident 18 revealed that the event happened on 10/30/25 but DON B was not informed about it until 11/11/25. CNA L was afraid of retaliation by LPN K, so she did not report it to DON B right away. CNA L no longer worked there. She expected all staff to report allegations of abuse and neglect to her or a charge nurse immediately. Since LPN K was the charge nurse on 10/30/25, she expected the staff to report the event directly to her. She did not have documentation that former CNA L received education	F0610		

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F0610 SS = E	Continued from page 9 regarding reporting. She had documentation that some staff received abuse, neglect, and reporting education. 7. Review of the provider's 1/23/18 Abuse, Neglect and Exploitation policy revealed that "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse…." "The facility will establish policies and procedures on abuse, neglect… pertaining to the following components:" "Investigation and staff identification of allegations;" "Training requirements for new and existing staff and in-service training for nurse-aides;" "reporting and response." "The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written." "When suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur, an investigation is immediately warranted. Once the resident is cared for and initial reporting has occurred, an investigation should be conduction. Components of an investigation should include: Identifying staff responsible for the investigation;…Investigating different types of alleged violations; Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and Providing complete and thorough documentation of the investigation." "When abuse, neglect or exploitation is suspected: Immediately report all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies…within specified timeframes;…Taking all necessary actions as a result of the investigation, which may include, but are not limited to, the following: Analyzing the occurrence(s) to determine why abuse, neglect,…and what changes are needed to prevent further occurrences; Defining how care provision will be changed and/or improved to protect residents receiving services; Training of staff on changes made and demonstration of staff	F0610		

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F0610 SS = E	Continued from page 10 competency after training is implemented; Identification of staff responsible for implementation of corrective actions; The expected date for implementation; and Identification of staff responsible for monitoring the implementation of the plan." "The Administrator should follow up with the government agencies, during business hours, to confirm the report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies." B. Based on record review, interview, and policy review, the provider failed to investigate potential incidents of resident abuse for two separate resident altercations reviewed involving residents 15 and 24, and residents 7 and 22. Findings include: 1. Review of resident 22's EMR revealed that his 7/1/26 BIMS assessment score was 4, indicating his cognition was severely impaired. On 3/31/26 at 7:44 p.m., a progress note by DON B revealed that an unidentified CNA reported to her that resident 22 had his hands on an unidentified female resident's breasts. The progress note stated that DON B told resident 22 that he was not supposed to touch anyone and he replied "okay." Interview on 8/13/26 at 6:11 p.m. with DON B regarding the above progress note revealed that she confirmed there was no investigation or change in resident care plans after the incident where resident 22 was witnessed by staff to be grabbing resident 7's breasts. Review of resident 7's EMR revealed that there was no progress note made about the above incident. There was no evidence to support that her POA or PCP were made aware of the potential resident to resident sexual abuse that occurred on 3/31/26. Her 5/31/26 BIMS assessment score was 3, indicating her cognition was severely impaired. 2. Review of resident 24's EMR revealed that a 6/17/26 at 4:40 p.m. progress note by ADON/SSD C indicated that resident 24 squeezed another resident's arm and caused a skin tear.	F0610		

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F0610 SS = E	Continued from page 11 Review of the 6/17/26 SD DOH FRI report indicated that resident 15 notified ADON/SSD C that resident 24 squeezed her arm and caused a skin tear. Resident 15's arm wound was treated, her vital signs were assessed, and resident 24's psychiatric provider was notified. A staff member was assigned to be with resident 24 one-on-one for additional supervision and safety. Resident 15 and 24's care plans were reviewed. Review of resident 24's EMR revealed that her 8/18/26 BIMS assessment score was 99, indicating she could not complete that assessment. Review of resident 15's EMR revealed that her 5/31/26 BIMS assessment score was 4, indicating her cognition was severely impaired. Email communication with the SD DOH on 8/13/26 at 10:11 a.m. revealed that the provider submitted an initial FRI report regarding the 6/17/26 incident between residents 15 and 24, but no final report or investigation conclusion was submitted to support a thorough investigation was completed. Interview on 8/13/26 at 7:02 p.m. with DON B revealed that she typically submitted the final report to the SD DOH along with the information requested by the SD DOH for the initial report. She confirmed that she did not further investigate the incident involving resident 24 causing a skin tear to resident 15. 3. Review of the provider's 1/23/18 Abuse, Neglect and Exploitation policy revealed that "The facility will establish policies and procedures on abuse, neglect… pertaining to the following components:" "Investigation and staff identification of allegations;" "Training requirements for new and existing staff and in-service training for nurse-aides;" "reporting and response." "The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written." "When suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur, an	F0610		

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F0610 SS = E	Continued from page 12 investigation is immediately warranted. Once the resident is cared for and initial reporting has occurred, an investigation should be conduction. Components of an investigation should include: Identifying staff responsible for the investigation;...Investigating different types of alleged violations; Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and Providing complete and thorough documentation of the investigation." "When abuse, neglect or exploitation is suspected: Immediately report all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies...within specified timeframes;...Taking all necessary actions as a result of the investigation, which may include, but are not limited to, the following: Analyzing the occurrence(s) to determine why abuse, neglect,...and what changes are needed to prevent further occurrences; Defining how care provision will be changed and/or improved to protect residents receiving services." "The Administrator should follow up with the government agencies, during business hours, to confirm the report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies."	F0610		
F0812 SS = E	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	F0812	F 812 Cook J and all other dietary staff educated on standard safe food practices including hand hygenie and glove use and updated policies by 9/27/26 by dieticain or designee Current safe food practice policies reviewed by IDT and necessary revions made as needed DON is serve safe certified DON or designee will audit for proper hand hygiene and govle use being followed weeekly for 4 weeks and monthly for 2 additional months and thereafter until determinded otherwise by QAPI committee DON or designee present findings at monthly QAPI meetings for review and recommendations	9/27/26

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F0812 SS = E	Continued from page 13 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 review, the provider failed to ensure that the staff followed standard safe food service practices regarding handwashing and glove use when serving food by one of one cook (J) during one of two meals observed. Findings include: 1. Observation on 8/13/26 at 11:27 a.m. in the kitchen revealed that cook J brought some dirty dishes to the dishwashing area and used the water sprayer to spray down a sheet pan. She did not wash her hands afterwards. She then went over to the clean silverware and picked up a spoon. She went over to the microwave, pulled out the bowl of green beans that had been reheating, stirred the green beans with the spoon, and placed the bowl of green beans back in the microwave. She set the spoon on the counter in front of the microwave. After that, she washed her hands. 2. Continued observation on 8/13/26 at 11:41 a.m. in the kitchen revealed that cook J was wearing a pair of gloves on her hands. She picked up a rag from the sanitizer bucket and wiped up some spilled food on the counter. She did not change her gloves or wash her hands before starting to serve the resident's food. She picked up the clean plates by placing four of her fingers on top of the plate (touching the surface of the plate that the resident's food would touch), with her thumb supporting the bottom of the plate. This had the potential to transfer germs from her gloved hands onto the clean plates. Several times throughout the observation, cook J would touch her face, push up her glasses, and wipe her forehead with the back of her gloved hand. She changed gloves a few times throughout the observation, but did not wash her hands before putting on a new pair of gloves. 3. Interview on 8/13/26 at 2:18 p.m. with cook J revealed that the training and orientation she	F0812		

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F0812 SS = E	Continued from page 14 received when she started working at the facility was online training videos. She knew that she was supposed to have washed her hands and changed gloves after touching her face, and when her hands were visibly soiled. She was not aware of the potential to transfer germs from her hands onto the clean plates with the way she was picking up the plates. 4. Interview on 8/13/26 at 4:54 p.m. with administrator A revealed that dietary manager E was no longer at the facility for an interview. He confirmed that the above observations were breaks in hand hygiene. 5. Review of the provider's 2026 Handwashing Guidelines for Dietary Employees policy revealed that "dietary employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single service and single use articles and also in the following situations: ...After hands have touched anything unsanitary i.e., garbage, soiled utensils/equipment, dirty dishes, etc.; After hands have touched bare human body parts other than clean hands (such as face, nose, hair etc.); After handling chemicals and before beginning to work with food; While preparing food, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; ...Before donning [putting on] gloves for working with food; ...After engaging in any activity that may contaminate the hands."	F0812		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary	F0600	F 600 Cannot correct prior non-compliance for actions of LPN K LPN K is no longer employeed by facility All staff educated on abuse and neglect by 9/27/26 by DON or deignee Policies on abuse and neglectreviewed by IDT no changes made ADON or designee will audit for any alleged incidents of abuse and neglect weekly for 4 weeks and monthly for 2 additional months and thereafter until determinied otherwise by QAPI committee ADON or deignee will present findings at monthly QAPI meeting for review and recommendations	9/27/26

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F0600 SS = D	Continued from page 15 seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, and policy review, the provider failed to protect the residents' right to be free from verbal abuse for one of one sampled resident (18) who was called an insulting name by one of one contracted travel licensed practical nurse (LPN) (K). Findings include: 1. Review of the 11/11/25 SD DOH FRI report revealed that on 11/11/25, director of nursing (DON) B was notified that resident 18 had a fall on 10/30/25. Contracted travel licensed practical nurse (LPN) K went to resident 18's room and called him an insulting name. Former certified nurse assistant (CNA) L was in the room and heard the interaction. The FRI report indicated that CNA L did not report this to the DON because she was afraid of retaliation from contracted travel LPN K. Registered nurse (RN) M reported the incident to DON B after she heard about the situation from CNA N. DON B and assistant DON (ADON)/social service designee (SSD) C talked to resident 18 about the incident and verified he was called a derogatory name but did not want to repeat what contracted travel LPN K called him. DON B terminated contracted travel LPN K and provided education to former CNA L about the importance of reporting incidents immediately. The report did not indicate the dates that DON B and ADON/SSD C talked to resident 18, contracted travel LPN K was terminated, or the date CNA L was provided education occurred. 2. Review of resident 18's electronic medical record (EMR) revealed that he admitted to the facility on 10/9/25. His 4/25/26 Brief Interview for Mental Status (BIMS) assessment score was 13, which indicated that he was cognitively intact. He had a diagnosis of mild cognitive impairment (a slight decrease in memory and thinking skills that is worse than normal aging). He had psychiatric services started on 11/6/25. 3. Interview on 8/11/26 at 4:14 p.m. with resident 18 revealed that he hardly remembered the November 2025 incident where the male nurse called him an insulting name, he was not bothered by it, and he felt safe in the facility. 4. Interview on 8/12/26 at 8:45 a.m. with certified	F0600		

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F0600 SS = D	Continued from page 16 medication aide (CMA) O revealed that she had not heard any staff talk meanly to the residents. If she did, she would report it to the nurse or DON B. She recalled receiving education about abuse, neglect, and mandatory reporting. 5. Interview on 8/12/26 at 8:54 a.m. with RN P revealed that she was not aware of any staff member being verbally abusive towards residents. She would report allegations of abuse to DON B. She recalled completing education about abuse, neglect, and reporting. 6. Interview on 8/13/26 at 12:27 p.m. with ADON/SSD C revealed that she went with DON B to interview resident 18 regarding the verbal abuse incident that occurred on 10/30/25 by contracted travel LPN K. Resident 18 reported that a male nurse called him some names. DON B was responsible for reporting all potential abuse incidents to the SD DOH and for completing investigations. ADON/SSD C helped with the investigations directed by DON B. 7. Interview on 8/13/26 at 1:41 p.m. with administrator A and DON B revealed that after the incidents between resident 16, resident 18, and LPN K, they did not interview any other residents or staff to gauge the extent of the alleged abuse by LPN K. Administrator A said that once they learned of the allegations, they suspended LPN K and then terminated his contract. He was not allowed to come back. Administrator A questioned why other residents and staff would need to be interviewed as part of an investigation into the alleged abuse, as they "eliminated all risk" from him because he was not allowed to return. He confirmed he was not involved in those investigations. 8. Interview on 8/13/26 at 6:11 p.m. with DON B and ADON C regarding the allegation of staff-to-resident verbal abuse between LPN K and resident 18, the event happened on 10/30/25, but she was not informed about it until 11/11/25. The staff person that reported it to her (CNA L) was afraid of retaliation by LPN K, so CNA L did not report it to DON B. The staff member who reported the event to DON B no longer worked there. She expected all staff to report allegations of abuse and neglect to her or a charge nurse immediately. Since LPN K was the charge nurse on 10/30/25, she expected former CNA L to report the event directly to her. She did not have documentation that former CNA L received education regarding abuse reporting after that incident. She had documentation that some of the	F0600		

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F0600 SS = D	Continued from page 17 staff received education about abuse, neglect, and mandatory reporting. They confirmed that not all staff received the education at the in-service, and there was no monitoring system in place to ensure staff and resident interactions remained free from verbal abuse. 9. Review of the provider's 1/23/18 Abuse, Neglect and Exploitation policy revealed that "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse…." "'verbal abuse' means the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability." "The facility will establish policies and procedures on abuse, neglect… pertaining to the following components:" "Investigation and staff identification of allegations;" "Training requirements for new and existing staff and in-service training for nurse-aides;" "reporting and response." "The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written."	F0600		
F0803 SS = D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;	F0803	F 803 All dietary staff, DON and ADON trained on following menus including portion sizes and substitutions by 9/27/26 by Dietician or designee Dietary Manager E no longer employed New dietary manager hired and kitchen will be covered by DON and ADON until dietary manager starts, also temp cook hired to fill any open shifts Policies regarding serving sizes and substitutions created by IDT DON or deisngee will audit portion sizes and substitutions being followed weekly for 4 weeks and monthly for two additional months and thereafter until determined otherwise by QAPI committee DON or deignee will report findings at monthly QAPI meeting for review and recommendations	9/27/26

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F0803 SS = D	Continued from page 18 §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is NOT MET as evidenced by: Based on menu review, observation, and interview, the provider failed to ensure one of two dietary staff (cook J) followed the menu serving sizes for each diet offered which had the potential to affect all residents within the facility, and failed to substitute a nutritionally adequate replacement for the pureed garlic bread for three of three residents (6, 11, and 17) who required a pureed diet. Findings Include: 1. Review of the provider's lunch menu for 8/16/26 showed that the planned meal included lasagna, a layered lettuce salad, garlic bread, chocolate-vanilla swirl pudding, and milk. For the regular diet, serving sizes consisted of a two-inch by two-inch piece of lasagna (approximately three-quarters of a cup), one cup of layered lettuce salad, one slice of garlic bread, one-half cup of pudding, and eight ounces of milk. The mechanical soft diet used the same serving size for the lasagna and substituted green beans for the layered lettuce salad; however, the menu did not indicate a serving size for the green beans. The pureed diet included the same meal items and serving sizes as the regular diet, with each item served in pureed form. For the cardiac diet, the serving sizes for the lasagna and garlic bread matched the regular diet. In place of the layered lettuce salad, the menu listed "lettuce salad" without a serving size. Instead of pudding, individuals on the cardiac diet received a "fruit of choice," along with skim milk. The diabetic diet followed the same serving sizes for the lasagna and layered lettuce salad but provided half a slice of garlic bread and substituted a "fruit of choice" for the pudding; skim milk was also provided.	F0803		

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F0803 SS = D	Continued from page 19 The small portions diet kept the same serving sizes for the lasagna and milk but reduced the lettuce salad to one-quarter cup, the garlic bread to half a slice, and the pudding to one-quarter cup. 2. Observation on 8/13/26 at 11:41 a.m. revealed that cook J was using tongs for the lettuce salad, and a blue-handled one-quarter cup scoop for the pudding, the pureed green beans, and pureed lasagna. For the residents on a pureed diet, she used one scoop (about a quarter cup) for the pudding, two full scoops (about a half cup) for the pureed lasagna, and two full scoops (about a half cup) for the pureed green beans. There was no pureed garlic bread prepared, and she did not replace that menu item with a nutritionally adequate substitute. There were three residents who received the pureed diet: residents 6, 11, and 17. For the other meals, cook J used the tongs to portion about one-half cup of lettuce salad onto the plates. She did not use a measuring tool to accurately portion one cup of lettuce salad onto the plates. Cook J used the blue handled scoop to portion one scoop (about a quarter cup) of pudding rather than the one-half cup listed on the menu. 3. Interview on 8/13/26 at 2:18 p.m. with cook J revealed that the training and orientation she received when she started working at the facility was online training videos. She confirmed she did not look at the lunch menu for the serving sizes because she was running late. She "eyeballed it" when estimating the amount of salad that she placed on the resident's plate and thought she had served about one cup. 4. Interview on 8/13/26 at 4:54 p.m. with administrator A revealed that he expected staff to follow the facility menu serving sizes.	F0803		
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives	F0883	Resident 9 provided risk and benefit forms on pnemo vaccine information and signed declination form by 9/27/26 by DON or designee All other residents audit for completed vaccines and completed if not by DON or designee by 9/27/26 Policy on vaccine risk and benfit requirements created by IDT All nurses educated on risk and benefit requirements and vaccine requirements and documentation by 9/27/26 by DON or designee	9/27/26

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F0883 SS = D	Continued from page 20 education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.	F0883	ADON or designee will audit risk and benfits being completed and all vaccines alng with documentation completed on newly admitted reisdents weekly for 4 week and monthly for two additional months and thereafter until QAPI committee determines otherwise ADON or designee will present findings at monthly QAPI meetings for review and recommendations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435125	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0883 SS = D	Continued from page 21 This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure that the risks and benefits information of receiving the pneumococcal vaccines were documented as provided in the resident's electronic record (EMR) to one of one sampled resident (9) who refused pneumococcal vaccination. Findings include: 1. Review of resident 9's EMR revealed he admitted to the facility on 6/23/26. He received an unspecified formulation of the pneumococcal conjugate vaccine (PCV) on 12/1/15 and 1/30/17. According to the PnuemoRecs Vax Advisor App (resource for the Centers for Disease Control and Prevention's current adult vaccine recommendations), resident 9 needed one dose of either PCV15, PCV20, or PCV21 to have his pneumococcal vaccines up to date. There was no documentation that he was offered and refused the pneumococcal vaccine. 2. Interview on 8/13/26 at 5:33 p.m. with director of nursing (DON) B and assistant DON (ADON)/social service designee (SSD) C revealed that resident 9 did not want vaccinations at the facility. They confirmed they did not have documentation that he was provided education regarding the risks and benefits of receiving the pneumococcal vaccines. Typically, the facility received a form that was sent by the pharmacy to indicate which vaccines the resident wanted or did not want. They did not have this for resident 9. 3. Review of the provider's 7/27/26 RSV, Influenza, Covid-19 and Pneumococcal Vaccination policy revealed that "In order to reduce the disease-morbidity and mortality associated with RSV, influenza and pneumococcal disease, RSV, influenza and pneumococcal vaccines are offered to all residents per the CDC guidelines found on the CDC website." "The resident's medical record includes: Documentation that the resident and/or resident's legal representative was provided education regarding the benefits and potential side effects of the influenza and/or pneumococcal immunization."	F0883		

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F0883 SS = D	Continued from page 22 "Documentation of any refusals to be vaccinated."	F0883		

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 _____	08/13/2026

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STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN POST OFFICE BOX 195 ROSLYN, SD 57261

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/11/26 through 8/13/26. Strand-Kjorsvig Community Rest Home was found not in compliance with the following requirements: S206, S236, S240, 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. The facility shall provide additional personnel	S 206	S 206 Employee orientation and annual training completed for employee's W and R through relias Employee V no longer employed Business Office Manager audited all other staff for completed orientation and annual training by 9/27/26 New hire and training requirements reviewed by IDT no changes made Business Office Manager was educated on education requirements by administrator by 9/27/26 Business Office Manager or designee will audit employee oreintation and annual training completion weekly for 4 weeks and monthly for two additional months and thereafter until determined otherwise by QAPI Comittee BOM or designee will present findings at monthly QAPI meetings for review and recommendations	9/27/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Samuel Van Voorst — TITLE: Administrator — (X6) DATE: 9/11/26

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S 206	Continued From page 1 education based on the facility's identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee record review and interview, the provider failed to ensure that the required orientation training was completed within 30 days of hire for two of three sampled employees (V and W) and the annual training was completed for one of three sampled employees (R). Findings include: 1. Review of cook V's employee file revealed she was hired 6/1/26 and she had not completed the required orientation training topics of fire prevention and response, emergency preparedness and procedures, infection prevention and control, accident prevention safety procedures, proper restraint use, resident rights, mandatory reporting of incidents and diseases, care of residents with unique needs, dining assistance, nutritional risks, hydration, and advanced directives within 30 days of hire. 2. Review of certified nursing assistant (CNA) W's employee file revealed she was hired on 6/25/26 and she had not completed the required orientation training topics of mandatory reporting of incidents and diseases, and advanced directives within 30 days of hire. 3. Review of licensed practical nurse (LPN) R's employee file revealed she was hired on 10/31/24 and she had not completed the required annual training topics of mandatory reporting of incidents and disease. 4. Interview on 8/13/26 at 5:00 p.m. with business manager G revealed that employees R, V, and W	S 206		

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S 206	Continued From page 2 did not have the required training completed. She was responsible for assigning that education. 5. Interview on 8/13/26 at 5:22 p.m. with director of nursing (DON) B revealed that cook V did not complete her required new hire training within the required time frame and when it was discussed this with her, she gave her two-week notice to leave her employment. DON B expected all new hire training to be completed prior to an employee starting their shift. Dietary manager (DM) E was responsible for ensuring dietary staff had their required education completed. DON B was responsible for ensuring that all staff's education was completed in the required time frame. DON B acknowledged that employees R, V, and W did not have their required training completed. 6. Interview on 8/13/26 at 7:30 p.m. with DM E revealed that cook V did not complete her required new hire training and should have. When it was discussed with cook V, she gave her two-week notice, so they did not have her finish it. Cook V still worked at the facility. DM E was responsible for ensuring that dietary staff completed all their education. Business manager G assigned the education to the dietary staff and would notify DM E if it was not completed because DM E was not able to see that information.	S 206		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare personnel or residents are as follows: (1) Each new healthcare personnel or resident	S 236	S 236 TB test completed on residents 12, 22 and 9 by 9/27/26 by ADON or designee TB test completed on employee O by 9/27/26 by ADON or designee All other staff and residents audited for completed TB test by 9/27/26 by ADON or desingee	9/27/26

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S 236	Continued From page 3 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 record review, interview, and policy review, the provider failed to ensure two of five sampled residents (12 and 22) received a two-step tuberculin (TB) skin test or a QuantiFERON Gold lab test within twenty-one	S 236	S 236 All nurses trained on resident and staff TB testing and documenting requirements by 9/27/26 by DON or designee Policy reviewed by IDT with no changes needed ADON or designee will audit completion of TB test for residents and staff weekly for 4 weeks and monthly for two additional months and thereafter until determined otherwise by QAPI committee ADON or deisgnee will present findings at monthly QAPI for review and reccomendations	

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S 236	Continued From page 4 days of their admission to the facility, one of five sampled resident (9), who did not have documentation from the previous facility's TB test result, received a TB skin test or a QuantiFERON Gold lab test within twenty-one days of their admission to the facility, and one of three employees reviewed (O) received a two-step TB skin test or a QuantiFERON Gold lab test within twenty-one days of their hire date. Findings include: 1. Review of resident 9's electronic medical record (EMR) revealed he admitted to the facility on 6/23/26. His first TB test was completed on 3/6/26 and was negative. His second step TB test was completed on 3/25/26 and there was no result documented. 2. Review of resident 12's EMR revealed he admitted to the facility on 4/27/26. His first TB test was completed on 4/27/26 and was negative. His second TB test was completed on 5/7/26 and there was no result documented. 3. Review of resident 22's EMR revealed he admitted to the facility on 10/15/25 and he did not have documentation that he received a two-step TB skin test or a QuantiFERON Gold lab test. 4. Review of Certified medication aide (CMA) O employee record revealed she was hired on 6/27/25 and had her first TB test on 6/27/25 that was negative. She had her second TB test on 7/7/25 and the result was not documented. 5. Interview and EMR review on 8/13/26 at 5:22 p.m. with director of nursing (DON) B revealed she expected the residents' and staff's TB test results to be documented by the nurse who read	S 236		

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S 236	Continued From page 5 them. She confirmed that residents 9 and 12 did not have their second TB test results documented. She confirmed that resident 22 did not have a TB test or QuantiFERON Gold lab test completed because his family member refused it. She did not complete any further TB symptom monitoring for resident 22 after he admitted to the facility. She was not sure what , needed to be done if a resident refused and their policy did not include that information. She confirmed CMA O did not have her second TB test results documented. 6. Review of the provider's 6/10/25 Employee TB Testing-2 step policy revealed it indicated that all healthcare workers were to receive a TB test within 14 days of employment. The DON or assistant DON would complete the TB screening. The business office staff would monitor that the staffs TB tests were completed within the required time frame and notify the DON if they were not. 7. On 8/13/26 at 3:45 p.m., a resident TB testing policy was requested from DON B and was not received before exiting the facility.	S 236		
S 240	44:73:04:12.01 Tuberculosis Education-Healthcare Personnel A facility shall provide yearly education to all healthcare personnel on TB risk factors, the signs and symptoms of TB, and the TB infection control policies and procedures of the facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee personnel training record	S 240	S 240 All staff includung staff O, R,and U educated on TB by 9/27/26 by DON or designee IDT team reviewed and revised employee training requirements to include TB education Business Office Manager or designee will audit TB training completion weekly for 4 weeks and monthly for two additional months and thereafter until determined otherwise by QAPI committee BOM or designee will present finding at monthly QAPI for review and recommendations	9/27/26

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S 240	Continued From page 6 review, and interview, the provider failed to ensure personnel had completed the required annual tuberculosis (TB) (a serious infection that primarily affects the lungs that is spread through the air by coughs and sneezes) training for three of three sampled employees who worked at the facility for a year or more (O, R, and U). Findings include: 1. Review of employee personnel records revealed that employee O was hired on 6/27/25, employee R was hired on 10/31/24, and employee U was hired on 4/4/24. 2. Review of employee training records revealed, there was no documentation that employees O, R, and U had received annual training on TB signs and symptoms, risk factors, and TB infection control policies and procedures. 3. Interview on 8/13/26 at 5:00 p.m. with business manager G revealed that she was not aware staff were required to complete annual TB education. She was responsible for assigning staff education. 4. Interview on 8/13/26 at 5:22 p.m. with director of nursing (DON) B revealed that she acknowledged that staff did not receive the required annual TB education.	S 240		
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	S 301	S 301 Employee V no longer employed All other dietary staff audited for completed dietary training through relias by Business Office Manager or deisgnee Dietary training requirements reviewed by IDT with no changes made	9/27/26

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S 301	Continued From page 7 personnel. The training must include the following subjects: (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee training review and interview, the provider failed to ensure one of one newly hired cook (V) was trained on six of nine required dietary in-service training topics within 30 days of hire. Findings include: 1. Review of cook V's employee record revealed that she was hired on 6/1/26. Her file did not contain any documentation that she had been trained on the required dietary in-service training topics of handwashing, food handling and preparation, foodborne illness, serving and distribution, nutrition and hydration, and sanitation within 30 days of hire. 2. Interview on 8/13/26 at 5:22 p.m. with director of nursing (DON) B revealed that cook V did not complete her required new hire training within the required time frame and it was discussed this with her, she gave her two-week notice to leave her employment.	S 301	S 301 Business Office Manager or designee will audit new hire and annual dietary training being completed timely weekly for 4 weeks and monthly for two additional months and thereafter until determined otherwise by the QAPI Committee BOM or designee will present findings at monthly QAPI meetings for review and recommendations	

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S 301	Continued From page 8 She expected all new hire training to be completed prior to an employee starting their shift. Dietary manger (DM) E was responsible for ensuring dietary staff had their required education completed. DON B was responsible for ensuring that all staff's education was completed in the required time frame. 3. Interview on 8/13/26 at 7:30 p.m. with DM E revealed that cook V did not complete her required new hire training and should have. When it was discussed with cook V, she gave her two-week notice, so they did not have her finish it. Cook V still worked at the facility. DM E was responsible for ensuring that dietary staff completed all their education. Business manager G assigned the education to the dietary staff and would notify DM E if it was not completed because DM E was not able to see that information.	S 301		