STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A103	A. BUILDING _____ B. WING _____	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KADOKA NURSING HOME	605 MAPLE ST W KADOKA, SD 57543

(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 4/14/25 through 4/16/25. Kadoka Nursing Home was found not in compliance with the following requirements: F658, F699, and F812.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to adhere to professional standards of care by not ensuring medications were taken by four of four observed residents (3, 9, 14, and 19) at the time those medications had been administered by one of one unlicensed medication aide (UMA) (I) and one of one licensed practical nurse (LPN) (J). Findings include: 1. Observation and interview on 4/14/25 with resident 14 in the dining room revealed: *At 5:30 p.m. a blue, oval-shaped pill, and a round salmon-colored pill were in a medication cup on the dining table in front of the resident. *Resident 14 sat between two female residents at that table. -The table was located near the entrance to the kitchen and around the corner from the medication cart. *At 5:45 p.m. the above medications remained in	F 658	Resident 9 order changed per provider to fiber gummy on 5/6/25 rather than powdered form. The Administration of Oral Medications policy (revision date 4/23/25), residents will be monitored by a UMA or nurse for the entire administration of medication whether the resident is in the dining room, hallway, resident room, or common areas to ensure that all the medication was properly taken. All nursing staff re-educated during in-service on 4/29/25 by DON/ADON on proper procedure of Medication Administration. Emphasis was placed on the importance of observing the residents to ensure all medications were completely ingested. Administration of Oral Medications policy was reviewed during nursing in-service on 4/29/25.	5/31/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maureen Cadwell
TITLE: CEO/Administrator
(X6) DATE: 05/08/2025

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.

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F 658	Continued From page 1 the medication cup. -Resident 14 stated she "wanted to eat something first" before she had taken those pills. *At 6:05 p.m. the medication cup was empty. 2. Continued observation in the dining room of resident 9 revealed: *At 5:35 p.m. UMA I placed a powdered substance in the resident's cup of thickened juice, and stirred it using a straw. -The powdered substance had not dissolved in the thickened juice and small clumps of the powder were seen inside the cup. *UMA I encouraged resident 9 to drink the contents of the cup, then walked back to her medication cart and continued with other residents' evening medication administrations. *At 6:15 p.m. the above juice glass was mostly empty. Small bits of clumped powder were seen along the inside and bottom of that cup. 3. Continued observation in the dining room and interview with resident 19 revealed: *At 5:50 p.m. resident 21 leaned over from her dining room chair and picked up a white pill from the floor. -She handed that pill to resident 19, who then placed it into her mouth and swallowed it. *Resident 19 stated that pill was "just a calcium pill." 4. Observation and interview on 4/15/25 at 7:35 a.m. with resident 3 in the dining room revealed: *She had picked up a medication cup on the table in front of her and drank the clear-colored substance inside that cup. -She had not known what she had drunk from that cup, but she thought it was "medicine."	F 658	Continued from previous page DON/ADON or designee will monitor and track medication passes starting 5/12/25 to ensure a UMA/Nurse is observing the entire administration of all medications randomly 5x per week for 1 month, then randomly 3x per week for 1 month, then randomly 1x per week for 1 month and report findings to Quality Assurance Process Improvement.	5/31/2025

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F 658	Continued From page 2 5. Review of residents 14, 9, 19, and 3's electronic medical records revealed: *Resident 14's 1/23/25 Basic Interview for Mental Status (BIMS) assessment score was a 9. That indicated she had moderate cognitive impairment. *Resident 9's 2/28/25 BIMS assessment score was 14. That indicated he was cognitively intact. *Resident 19's 1/25/25 BIMS assessment score was 15. That indicated she was cognitively intact. *Resident 3's 2/27/25 BIMS assessment score was 9. That indicated she had moderate cognitive impairment. *None of the above residents had a physician's order or an assessment completed that supported their ability to have self-administered their medications. Interview on 4/15/25 at 3:20 p.m. with UMA I and LPN J regarding the above medication administrations revealed: *UMA I confirmed having left residents 14 and 19's medication cups on their tables without having ensured that those residents had taken the prescribed medications in those cups. *The powder UMA I had added to resident 9's thickened juice was a physician-ordered fiber supplement. -The resident was unable to drink the entire cup of thickened juice at one time, so she observed the juice cup periodically during the meal service to ensure the contents had all been consumed by the resident by the end of the meal service. *UMA I and LPN J had known resident 9 took his fiber supplement in a gummy form in the past. They felt that allowed staff to confirm the supplement was taken at the time of its administration. *LPN J confirmed having left resident 3's fiber	F 658		

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F 658	Continued From page 3 supplement on the table for the resident to have taken on her own. -She stated she was expected to have watched the resident take the medication at the time she administered it and she should not have walked away from the resident when the medication had not yet been taken. Interview on 4/16/25 at 7:46 a.m. with director of nursing (DON) B regarding the above observations revealed: *It was her expectation that UMAs and licensed nursing staff were to have observed and confirmed residents had taken their prescribed medications at the time they were administered. -A physician's order and a completed medication self-administration assessment were required for a resident to take their medications unsupervised. Review of the provider's revised 3/11/24 Administration of Medications policy on 4/16/25 at 7:46 a.m. with DON B revealed: *The policy had indicated: "14. No medications will be left in the resident's room unless a "Self-Administration of Medications Assessment has been documented by the medication nurse and a special order by the attending physician is in place." -DON B confirmed the above would have also applied to leaving medications on a dining room table.	F 658		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with	F 699	Social Services history completed on Resident 20 on date of admission indicated he was a supply clerk for the navy and did not see any combat.	5/31/2025

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F 699	Continued From page 4 professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility assessment review, the provider failed to ensure: *One of one sampled resident (20) had been screened for post-traumatic stress disorder (PTSD) upon being admitted to the facility. *The implementation of a trauma informed care program. Findings include: 1. Observation and interview on 4/15/25 at 10:00 a.m. with resident 20 in his room revealed he: *Was a well-groomed, heavy-set man who sat in his wheelchair during the interview. *Was never married, but he had a sister who was involved with his care. *Had lived in the facility for about 18 months. He wanted to live on his own again or in an assisted living facility. *Had a history of health conditions that included heart disease, a stroke that had affected his left side, and a fall that had caused a brain bleed. -Had a new diagnosis of leukemia, but he was not certain what his treatment course was. -Had breathing issues he attributed to the inhalation of jet fumes while he was in the military. *Had served during the Vietnam War on an aircraft carrier. -Had seen planes land on that carrier with visible signs of having been shot at by enemy fire. -Had not given his mother any details regarding his military assignment to protect her from	F 699	Continued from previous page TeleHealth admission and assessment note dated 12/21/2023 states Resident 20 denies having flashbacks or PTSD. Resident 20 served as a supply clerk in the Navy 1987-1988. Trauma Informed Care screen completed on Resident 20 on 5/6/25 by DON. Trauma Informed Care screens completed on all current residents before 05/31/25 by DON/ADON or designee. Per Trauma Informed Care Program policy effective 4/17/25, a Trauma Informed Care screen will be completed by DON/ADON or designee on all new admissions, then annually, and with any significant change, specifically a change in mental health status. Trauma Informed Care policy created and effective 4/17/25. All nursing staff were educated on new policy by DON on 4/29/25. DON/ADON or designee will monitor and track completion of Trauma Informed Care screens on current residents and new admissions and report to Quality Assurance Process Improvement.	5/31/2025

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F 699	Continued From page 5	F 699		

worrying about him.
-Was not recognized for his military service with "a parade or a celebration" when he was discharged from the service.
*Confirmed he had anxiety and depression mostly related to his loss of independence. He denied the need for counseling services, but he was taking medication for those conditions.

Review of resident 20's electronic medical record (EMR) revealed:
*He was admitted to the facility on 8/15/23.
*He was taking an anti-depressant medication once daily and an anti-anxiety medication twice daily.
*In addition to the above diagnoses reported by the resident, he also had a history of suicidal ideations diagnosed on 12/26/23.
*His 2/22/25 Brief Interview for Mental Status assessment score was 15. That indicated his cognition was intact.
*Social services designee (SSD)/registered nurse (RN) D's 2/24/25 progress note indicated: "he [resident 20] does have a history of being verbally abusive to staff and mocks other residents, this behavior has improved and this behavior is monitored. He has had occasional outbursts with staff when he becomes frustrated, none in this assessment period. [Resident 20] has been counseled and redirected with this negative behavior."
-Resident 20 had refused mental health services. There was no mention of his past military service or
potential trauma.

On 4/15/25 at 1:50 p.m. a trauma-informed care assessment for resident 20 was requested from director of nursing (DON) B, assistant DON C,

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F 699	Continued From page 6 SSD/RN D, and Minimum Data Set (MDS) coordinator K. *They confirmed there was no such assessment completed for resident 20. They did not have a process to have assessed residents for trauma history. -They agreed resident 20 may have been at risk for trauma related to his military service. *The provider had no Trauma-Informed Care policy. Review of the provider's Facility Assessment last reviewed and updated in November 2024 revealed: *"Part 2: Services and Care We Offer Based on our Residents' Needs:" -Specific Care or Services had included: "Manage medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as trauma/post-traumatic stress disorder (PTSD)..."	F 699		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812	The Dishwasher Temperature Policy was reviewed on 4/15/2025. The dietary manager re-educated the dietary staff working on the process of monitoring the dishwasher. Signs were posted in the dish room on the process of monitoring the washing temperature, the minimal temperature, and the alternative sanitizing process if the dish washer temperature does not meet 120 degrees.	5/31/2025

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F 812	Continued From page 7 (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, record review, interview, and policy review, the provider failed to ensure: *One of one low-temperature dishwasher consistently met the required minimum wash and rinse temperatures for proper sanitation. *Temperature monitoring and documentation was completed consistently for one of one dishwasher temperature logs. Findings included: 1. Observation on 4/14/25 at 12:35 p.m. in the kitchen revealed: *The mechanical dishwashing machine had a label on it that read: -"Wash Temperature 120 degrees F [Fahrenheit] minimum." -"Rinse Temperature 120 degrees F minimum." *The logs for the dishwasher temperatures for April 2025 were on the counter and included: -Columns to record "Wash/Rinse Temp/IN [initials]" for each of the three mealtimes listed as "Breakfast", "Lunch', and "Supper". -Each column had only one recorded temperature. -Those temperatures ranged from 111 to 134 degrees F. --Fifteen of those recorded temperatures were not at the minimum wash/rinse temperature of 120 degrees F. *Review of additional dishwasher temperature logs revealed:	F 812	Continued from previous page A dietary staff meeting is scheduled for 5/9/2025 to educate on primary and secondary methods of food safety requirements related to dish washer temperatures and sanitizing methods. The dietary manager or designee will review and monitor the temperature log 5 times weekly for 1 month, 2 times weekly for 1 month, then weekly for 1 month and report to the quality assurance process improvement team monthly for further recommendation.	5/31/2025

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F 812	Continued From page 8 -For March 2025: - Columns to record "Wash/Rinse Temp/IN" for each of the three mealtimes "Breakfast", "Lunch', and "Supper". -Each column had only one recorded temperature. -Those temperatures ranged from 103.7 to 132.3 degrees F. --Twenty-four of those recorded temperatures were not at the minimum wash/rinse temperature of 120 degrees F. *For February 2025: -Columns to record "Wash/Rinse Temp/IN" for each of the three mealtimes "Breakfast", "Lunch', and "Supper". -Each column had only one recorded temperature. -Those temperatures ranged from 97 to 130.5 degrees F. --Eighteen of those recorded temperatures were not at the minimum wash/rinse temperatures of 120 degrees F. *For January 2025: -Columns to record "Wash/Rinse Temp/IN" for each of the three mealtimes "Breakfast", "Lunch', and "Supper". -Each column had only one recorded temperature. -Those temperatures ranged from 85 to 137.8 degrees F. --Twenty-five of those recorded temperatures were not at the minimum wash/rinse temperatures of 120 degrees F. 2. Observation and record review on 4/14/25 at 12:45 p.m. in the kitchen revealed: *The dishwasher temperature monitoring sheets had several unrecorded temperatures that included:	F 812		

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F 812	Continued From page 9 -April 2025 had 7 unrecorded temperatures out of 40 opportunities. -March 2025 had 15 unrecorded temperatures out of 93 opportunities. -February 2025 had 36 unrecorded temperatures out of 84 opportunities. -January 2025 had 32 unrecorded temperatures out of 93 opportunities. 3. Interview on 4/14/25 at 12:53 p.m. with dietary manager (DM) E revealed: *She had been employed with the facility as the DM since 7/29/24. *She knew about the low temperatures of the dishwasher since she had started as the dietary manager. *She had called the service department from whom they leased the dishwasher, he came to the facility four times to service the dishwasher and was able to get the rinse and wash temperatures to a minimum of 120 degrees F. -He had been coming to the facility to service the dishwasher and had told the facility they needed a holding tank. -She was unsure of when maintenance had installed the holding tank. *She agreed there were several unrecorded temperatures on the dishwasher temperature logs. *She had tried to check the dishwasher temperature logs monthly but had gotten busy and forgotten to check them. 4. Observation and interview on 4/15/25 at 8:13 a.m. in the kitchen with dietary staff G revealed: *She stated she was running the dishwasher to see what the thermometer read. -It had read 117 degrees F for the wash temperature, she did not wait for the thermometer	F 812		

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F 812	Continued From page 10	F 812		

to read the rinse temperature.
*She stated she had to run the dishwasher again to get the thermometer to read 120 degrees F or above.
*On the second cycle, the wash temperature was 123 degrees F, and the rinse temperature was 127 degrees F.

5. Interview on 4/15/25 at 8:25 a.m. with maintenance manager F revealed he had installed the holding tank on 1/7/25.

6. Interview on 4/15/25 at 9:20 a.m. with chief operating officer (COO) A regarding the low dishwasher temperature readings revealed:
*She thought the holding tank that was installed on 1/7/25 had fixed the problem.
*She expected the kitchen staff to have notified the DM of the dishwasher low temperature readings.
*She had talked to the service department that they leased the dishwasher from, and they discussed options if the temperature problem did not resolve.
*She confirmed there had been no gastrointestinal outbreak in the facility.

7. Interview on 4/15/25 at 4:45 p.m. with dietary staff H regarding the low dishwasher temperature readings revealed she:
*Had written temperatures on the dishwasher temperature log below 120 degrees F.
*Stated she knew the dishwasher temperature needed to be 120 degrees F or above.
*Did not notify the dietary manager of the low dishwasher temperature readings.

8. Review of the provider's 11/1/23 Dish Machine Temperature Log policy revealed:

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F 812	Continued From page 11 "OBJECTIVE: Dishwashing staff will monitor and record dish machine temperatures to ensure proper sanitizing of dishes." Procedure: *"1. The dishwashing staff will be provided a log for daily temperature tracking." *"2. The food service manager will train dishwashing staff to monitor [the] dish machine temperature throughout the dishwashing process." *"3. Staff will be trained to record dish machine temperatures." *"4. Dishwashing staff will be trained to report any problem with the dish machine to the food service manager as soon as they occur. *"5. The food service manager will assess any dish machine problems and take action to assure sanitation of dishes."	F 812		

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 4/14/25. Kadoka Nursing Home was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at E004 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	E 000		
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:	E 004	The Chief Operating Officer reviewed the organizational flow chart on 4/15/2025. The Director of Nursing was updated to the new Director of Nursing within 6 months of role position. The administrator remains current. The Chief Operating Officer will monitor the organizational flow chart monthly for 3 months and report to the quality assurance process improvement team for further recommendations.	5/31/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maureen Cadwell
TITLE: CEO/Administrator
(X6) DATE: 05/08/2025

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
	43A103	A. BUILDING _____ B. WING _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KADOKA NURSING HOME	605 MAPLE ST W KADOKA, SD 57543

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 004	Continued From page 1 * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to update the emergency preparedness plan organizational flow chart for 2025. Findings include: Record review on 4/14/25 at 3:15 p.m. revealed no documentation that the provider's current emergency preparedness plan organizational flow chart had been updated. A former administrator and former nurse listed on the chart were no longer employed with the provider. Interview with the chief operating officer on 4/14/25 at 5:00 p.m. confirmed those findings.	E 004		

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	43A103	A. BUILDING _____ B. WING _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KADOKA NURSING HOME	605 MAPLE ST W KADOKA, SD 57543

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A103	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KADOKA NURSING HOME	**605 MAPLE ST W** **KADOKA, SD 57543**

(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 4/14/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Kadoka Nursing Home was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K341 and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 341 SS=C	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to maintain the fire alarm system	K 341	The fire alarm system was reviewed on 4/17/2025. The Chief Operating Officer contacted the contracting fire alarm system supplier on 4/17/2025. The dialer and automatic third party notification system is scheduled to be installed on 5/13/2025. The Chief Operating Officer or designee will monitor the operation of the dialer on the fire alarm system monthly for 3 months and report to the quality assurance process improvement team for further recommendations.	5/31/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Maureen Cadwell	CEO/Administrator	05/08/2025

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
	43A103	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/14/2025**

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KADOKA NURSING HOME	**605 MAPLE ST W** **KADOKA, SD 57543**

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K 341	Continued From page 1 as required (no signal dialer and no monitoring of the fire alarm). Findings include: 1. Record review on 4/14/25 at 2:25 p.m. revealed there was an annual fire alarm inspection and testing performed on 1/27/25. There was no documentation the fire alarm signal was transmitted to a monitoring agency. The fire drill reports did not document that a signal had been received by a monitoring agency. The fire alarm panel did not have a dialer to transmit a signal to a monitoring location. 2. Interview with the plant operations supervisor at the time of the review confirmed that finding. He stated the fire alarm signal was not transmitted to any location. Failure to test the fire alarm system as required increases the risk of death or injury due to fire. The deficiency had the potential to affect 100% of the building occupants. Ref: 2012 NFPA 101 Section 19.3.4.1, 9.6.1.5; 2010 NFPA 72 Section 14.6.2.4, Figure 14.6.2.4 Section 7.12-7.14 and page 11 of 11)	K 341		
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted	K 712	The Chief Operating Officer reviewed the monthly Fire Drill Policy on 4/28/2025. The Chief Operating Officer will educate the maintenance director and all staff on the monthly and quarterly fire drill process by 5/31/2025.	5/31/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A103	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KADOKA NURSING HOME	**605 MAPLE ST W** **KADOKA, SD 57543**

(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 712	Continued From page 2 between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to: *Conduct fire drills for a minimum of one per shift per quarter for April 2024 through March 2025 for all three shifts. A total of eleven fire drills were documented. No fire drills were held for the first shift during the first quarter (January, February, and March) of 2025. *Hold fire drills at varying times for each shift. *Document transmission of the fire alarm signal during the fire drills. Findings include: 1. Record review on 4/14/25 at 4:15 p.m. revealed the nursing home had three scheduled staff shifts: First shift: from 6:00 a.m. to 2:30 p.m.; Second shift: from 2:00 p.m. to 10:30 p.m.; Third shift: from 10:00 p.m. to 6:30 a.m. The fire drills held for April 2024 through March 2025 were documented as follows: *4/1/24: 10:00 a.m. *5/8/24: 3:10 p.m. *6/13/24: 11:30 p.m. *7/9/24: silent, 1:00 a.m. *8/8/24: 9:20 a.m. *9/17/24: 4:30 p.m. *10/22/24: 10:30 a.m. *11/21/24: silent, 12:45 a.m. *12/9/24: 4:15 p.m. *2/27/25: silent, 1:00 a.m. *3/24/25: 2:45 p.m. 2. Interview with the plant operations supervisor	K 712	Continued from previous page The Chief Operating Officer or designee will monitor the monthly fire drill process and operation x 3 months then quarterly x 3 months and report to quality assurance process improvement for further recommendations.	5/31/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A103	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/14/2025**

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KADOKA NURSING HOME	**605 MAPLE ST W** **KADOKA, SD 57543**

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K 712	Continued From page 3 on 4/14/25 at 4:45 p.m. confirmed those findings. The deficiency had the potential to affect 100% of the building occupants.	K 712		

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
	10637	A. BUILDING: _____ B. WING _____	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KADOKA NURSING HOME	605 MAPLE ST W POST OFFICE BOX 310 KADOKA, SD 57543

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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 4/14/25 through 4/16/25. Kadoka Nursing Home was found in compliance.	S 000		
S 000	Compliance/noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities was conducted from 4/14/25 through 4/16/25. Kadoka Nursing Home was found not in compliance with the following requirement: S290.	S 000		
S 290	44:73:07:05 Food Supply The facility shall maintain an on-site supply of perishable and nonperishable foods to meet planned menus for three days. A facility shall maintain an additional supply of nonperishable foods as part of the facility's emergency preparedness plan. A facility may use military meals ready to eat and dried milk in an emergency event according to the facility's emergency response plan. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure an emergency planned menu had been developed and enough nonperishable foods were supplied to provide those meals for three days in an emergency. Findings include: 1. Observation on 4/14/25 at 5:25 p.m. in the food	S 290	The dietary manager reviewed the three day emergency food supply policy. The three day emergency menu was created by the dietician and implemented by the dietary manager on 4/15/2025. The necessary food items were acquired on 4/15/2025 to complete the three day emergency menu. A dietary education meeting is scheduled for 5/9/2025. The dietary manager or designee will monitor to ensure the items of the three day emergency menu are inventoried and available monthly. The dietary manager or designee will report to the quality assurance process improvement team monthly for three months for further recommendations.	5/31/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maureen Cadwell — TITLE: CEO/Administrator — (X6) DATE: 05/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10637	A. BUILDING: _____ B. WING _____	04/16/2025

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S 290	Continued From page 1 storage room revealed the following foods were present: *Six boxes of 36-ounce (oz) rice pilaf. *Eleven 42-oz containers of Quaker Oats. *A three-quarters full box of 500/ 2-count club crackers. *A half box of 500/2-count Zesta original saltine crackers. *Seven 28-oz packages of one-step chicken flavor stuffing mix. *Nineteen packages of creamy classic mashed potato mix. *Six 5 pound (lb) packages of cornbread muffin mix. *Seven 6 lb 10 oz cans of whole kernel corn. *Three 6 lb 9 oz cans of medium sliced carrots. *One 14.5 oz can of sliced carrots. *Three 6 lb 10 oz cans of cream-style corn. *Two 5 lb 13 oz cans of chopped spinach. *Two 6 lb 8 oz cans of spaghetti sauce with tomato bits. *Three 102 oz cans of diced tomatoes in juice. *Two 6 lb 5 oz cans of green beans. *Two 14.5 oz cans of cut green beans. *Three 6 lb 5 oz cans of cut wax beans. *Twelve 3 lb 2 oz cans of cream of celery soup. *Four 6 oz cans of tomato paste. *Eight 12 oz cans of tomato paste. *Thirty-three 10.5 oz cans of tomato soup. *Twenty 7.25 oz cans of chicken noodle soup. *Twenty-seven 15 oz cans of Roma tomato sauce. *Four 10.5 oz cans of cream of mushroom sauce. *Nine 50 oz cans of cream of mushroom sauce. *Six 16 oz cans of mushrooms. *One 14.4 oz can of sauerkraut. *Four 116 oz cans of cherry pie filling. *Two 112 oz cans of apple pie filling. *Seven 6 lb 10 oz cans of applesauce. *Five 6 lb 9 oz cans of sliced pears.	S 290		

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	10637	A. BUILDING: _____ B. WING _____	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 290	Continued From page 2 *Four 6 lb 9 oz cans of sliced peaches. *Two 6 lb 8 oz cans of fruit cocktail. *Seven 6 lb 8 oz cans of sliced apples. *Five 6 lb 10 oz cans of mandarin oranges. *Three 20 oz cans of pineapple. *Twelve 16 oz cans of navy beans. *Six 6 lb 12 oz chili-style pinto beans. *Two 7 lb 3 oz cans of baked beans. *Six 50 oz cans of tomato soup. *Five 35 oz bags of cereal. *Three 12 oz bags of cereal. *Four large bags of pasta. *Four 108 oz cut sweet potatoes *One 4 lb 2.5 oz can of tuna. Interview on 4/14/25 at 5:30 pm with dietary manager (DM) E revealed she: *Had been employed with the facility as DM since 7/29/24. *Stated the facility's resident census was 30. *Was unaware that an additional supply of nonperishable emergency food items was needed according to state regulation. *Did not have an emergency menu to reference for what food items were needed.. Review of the provider's effective date 4/15/25 Emergency Meal Plan policy revealed: *Procedure: "The following will be available during an emergency or disaster:" *"1. Emergency food and supplies for the planned menu pattern for 3 to 7 days.*. The menu should be palatable even if repetitious. Food that can be transported in case of an evacuation should be available. Foods of similar nutritional value may be substituted."	S 290		