South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	59168	A. BUILDING: _____ B. WING _____	R 10/15/2026

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME LC	801 SOUTH MAIN ST POST OF ICE BOX 195 ROSLYN, SD 57261

4) ID PREFIX TA	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TA	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	5) COMPLETE DATE
{S 000}	Compliance Statement A revisit survey was conducted on 10/15/26 for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for all previous deficiencies cited on 8/13/26. Strand-Kjorsvig Community Rest Home ALC was found not in compliance with the following requirements: S331, S450, and S477.	{S 000}		
{S 331}	44:70:04:10(1) Tuberculin Screening... Requirements Tuberculin screening requirements for healthcare personnel and residents are as follows: 1) Each healthcare personnel or resident shall receive an initial individual TB risk assessment that is documented 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. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of admission or employment are considered two-step. 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 this state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin or blood assay TB testing having been completed within the prior twelve months. Skin testing or TB blood assay tests are not necessary if documentation is provided by the transferring healthcare facility, healthcare personnel, or	{S 331}	S 331 Written education will be provided all nurses including LPN L and signed off on to confirm understanding by 11/14. ADON or designee will audit weekly for 4 weeks and monthly for two additional months and thereafter until determined otherwise by QAPI comittee for all new staff and new admits having Tb screening completed. ADON or deignee will report findings at monthly QAPI for review and recommendation.	11/25/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Samuel Van Voorst | TITLE: Adminstrator | (X6) DATE: 11/6/26

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{S 331}	Continued From page 1 resident, of a previous positive reaction to either test. Any healthcare personnel or resident who has a newly recognized positive reaction to the skin 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 review of the provider's accepted plan of correction (POC) for S236 with a completion date of 9/27/26, for the 8/13/26 licensure survey, record review, and interview, the provider failed to ensure the POC was followed for tuberculosis testing and documentation education and training for one of eight nurses (licensed practical nurse LPN) L). Findings include: 1. Review of the provider's accepted POC with a completion date of 9/27/26 revealed that, "All nurses trained on resident and staff TB [tuberculosis] testing and documenting requirements by 9/27/26 by DON [director of nursing] or designee." 2. Review of the POC documentation and revealed that there was no documentation that LPN L received or completed the POC training. 3. Review of the nurse's schedule revealed that LPN L had worked at least nine shifts since the POC's 9/27/26 completion date. 4. Phone interview on 10/15/26 at 8:58 a.m. with administrator A revealed that he expected the staff to complete the education prior to their next	{S 331}		

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{S 331}	Continued From page 2 working shift. 5. Email communication with additional documentation from DON B on 10/15/26 at 10:23 a.m. revealed that LPN L "did not attend the meeting on 8/24/26 as she is a night shift nurse. [LPN L] was given the same information as was discussed during the meeting. I did not have any of the nurses sign the education ..."	{S 331}		
{S 450}	44:70:06:01 Dietetic Services The facility shall have an organized dietetic service that meets the daily nutritional needs of residents and ensures that food is stored, prepared, distributed, and served in a manner that is safe, wholesome, and sanitary in accordance with the provisions of § 44:70:02:06. This Administrative Rule of South Dakota is not met as evidenced by: Based on review of the provider's accepted plan of correction (POC) with a completion date of 9/27/26, for the 8/13/26 licensure survey, record review, and interview, the provider failed to ensure the POC was followed as written regarding auditing for hand hygiene and glove use during meal service. Findings include: 1. Review of the provider's accepted POC with a completion date of 9/27/26 revealed that, "DON [Director of nursing] or designee will audit for proper hand hygiene and [glove] use being followed weekly for 4 weeks and monthly for 2 additional months and thereafter until determined otherwise by [the] QAPI [quality assurance and performance improvement] committee."	{S 450}	S 450 DM or designee will audit proper hand hygeine and glove use in the kitchen weekly for 4 weeks and monthly for two addional months and thereafter until determined otherwise by QAPI comittee DM or deisgnee will report findings at monthly QAPI meetings for review and recommendations	11/25/26

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{S 450}	Continued From page 3 2. Review of the POC documentation revealed that assistant director of nursing (ADON) C completed the weekly audits on 9/14/26, 9/24/26, and 10/7/26. There were no audits for the week of 9/28/26. 3. Email communication with additional documentation from ADON C on 10/14/26 at 2:16 p.m. revealed that she was assigned to complete the audit during the week of 9/28/26 but was out of the facility from 9/29/26 to 10/1/26, and the audit was not completed. No one else was assigned to complete the audit in her absence. 4. Phone interview on 10/14/26 at 4:53 p.m. with administrator A revealed that someone else should have completed the audits during ADON C's absence.	{S 450}		
{S 477}	44:70:06:09 ritten Menus Any regular or therapeutic menu, including therapeutic diet menu extensions for all diets served in the facility, must be written, prepared, and served as prescribed by each resident's physician, physician assistant, nurse practitioner, or dietician. Each menu must be written at least one week in advance. This Administrative Rule of South Dakota is not met as evidenced by: Based on review of the provider's accepted plan of correction (POC) with a completion date of 9/27/26, for the 8/13/26 licensure survey, record review, and interview, the provider failed to ensure the POC was followed as written regarding auditing meal portion sizes.	{S 477}	S 477 DM or desingee will audit for proper portion sizes weekly for 4 weeks and monthly for 2 additonal months and thereafter until determined otherwise by QAPI committee DM or Designee will report findings at monthly QAPI meetings for review and recommendations	11/25/26

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{S 477}	Continued From page 4 Findings include: 1. Review of the provider's accepted POC with a completion date of 9/27/26 revealed that, "DON [Director of nursing] or [designee] will audit portion sizes being followed weekly for 4 weeks and monthly for two additional months and thereafter until determined otherwise by [the] QAPI [quality assurance and performance improvement] committee." 2. Review of the POC documentation revealed that assistant director of nursing (ADON) C completed the weekly audits on 9/15/26, 9/21/26, and 10/7/26. There were no audits for the week of 9/28/26. 3. Email communication with additional documentation from ADON C on 10/14/26 at 2:16 p.m. revealed that she was assigned to complete the audit during the week of 9/28/26 but was out of the facility from 9/29/26 to 10/1/26, and the audit was not completed. No one else was assigned to complete the audit in her absence. 4. Phone interview on 10/14/26 at 4:53 p.m. with administrator A revealed that someone else should have completed the audits during ADON C's absence.	{S 477}		

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F0000	INITIAL COMMENTS A revisit survey was conducted on 10/15/26 for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities for all previous deficiencies cited on 8/13/26. Strand-Kjorsvig Community Rest Home was found not in compliance with the following requirements: F600, F609, F610, F803, and F812.	F0000		
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 seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on review of the provider's accepted plan of correction (POC) with a completion date of 9/27/26, for the 8/13/26 standard recertification and complaint survey, record review, and interview, the provider failed to provide evidence that the POC for the previously cited noncompliance at F600 was followed as written regarding 7 of 42 staff members' (E, F, G, H, I, J, and K) education and training on abuse and neglect. Findings include: 1. Review of the provider's accepted POC for F600	F0600	F 600 Empoloyee's E, F, G, H, I, J, K will receive education on abuse and neglect by 11/13/26 DON or designee will audit for completed abuse and neglect training weekly for 4 weeks and monthly for two additional months and thereafter until determined otherwise by QAPI committee. DON or designee will report findings at monthly QAPI meetings for review and recommendations	11/13/26

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	Adminstrator	11/13/26

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F0600 SS = D	Continued from page 1 with a completion date of 9/27/26 revealed that, “All staff [will be] educated on abuse and neglect by 9/27/26 by [the] DON [director of nursing] or [designee].” 2. Review of the POC documentation and staff schedules revealed that transportation/certified nursing assistant (CNA) E, CNA F, waitress G, waitress H, CNA I, waitress J, and waitress/cook K did not receive the required education by the POC completion date of 9/27/26, and worked or were scheduled to work shifts after that completion date. 3. Phone interview on 10/15/26 at 8:58 a.m. with administrator A, DON B, assistant DON (ADON) C, and business manager D revealed that the online abuse and neglect education was assigned to all staff to be completed. Administrator A confirmed he expected the staff to complete the education prior to working their next shift. 4. Email communication on 10/15/26 at 10:23 a.m. with DON B revealed that transportation/CNA E and CNA F were scheduled to work as needed (PRN) mostly to transport residents to and from appointments. She did not assign the online abuse education to those staff members for that reason. 5. Email communication on 10/15/26 at 1:16 p.m. with business manager D revealed that transportation/CNA E and CNA F worked shifts after the POC completion date of 9/27/26.	F0600		
F0609 SS = D	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	F0609	F 609 Empoloyee's E, F, G, H, I, J, K will receive education on reporting requirements by 11/13/26 DON or designee will audit for completed reporting reuirements training weekly for 4 weeks and monthly for two additional months and thereafter until determined otherwise by QAPI committee. DON or designee will report findings at monthly QAPI meetings for review and recommendations	11/13/26

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F0609 SS = D	Continued from page 2 accordance with State law through established procedures. §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 review of the provider's accepted plan of correction (POC) with a completion date of 9/27/26, for the 8/13/26 standard recertification and complaint survey, record review, and interview, the provider failed to provide evidence that the POC for the previously cited noncompliance at F609 was followed as written regarding 7 of 42 staff members' (E, F, G, H, I, J, and K) education and training on reporting requirements. Findings include: 1. Review of the provider's accepted POC for F609 with a completion date of 9/27/26 revealed that, "All staff [will be] educated on reporting requirements and policy by 9/27/26 by [the] DON [director of nursing] or designee." 2. Review of the POC documentation and staff schedules revealed that transportation/certified nursing assistant (CNA) E, CNA F, waitress G, waitress H, CNA I, waitress J, and waitress/cook K did not receive the required education by the POC completion date of 9/27/26, and worked or were scheduled to work shifts after that completion date. 3. Phone interview on 10/15/26 at 8:58 a.m. with administrator A, DON B, assistant DON (ADON) C, and business manager D revealed that the abuse and neglect education, that included reporting requirements, was assigned online to all staff to be completed. Administrator A confirmed he expected the staff to complete the education prior to their next working shift. 4. Email communication on 10/15/26 at 10:23 a.m. with DON B revealed that transportation/CNA E and CNA F were scheduled to work as needed (PRN) mostly to transport residents to and from appointments. She did not assign the online abuse and neglect education, that included reporting requirements, to those staff members for that	F0609		

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F0609 SS = D	Continued from page 3 reason. 5. Email communication on 10/15/26 at 1:16 p.m. with business manager D revealed that transportation/CNA E and CNA F worked shifts after the POC completion date of 9/27/26.	F0609		
F0610 SS = D	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. This REQUIREMENT is NOT MET as evidenced by: Based on review of the provider's accepted plan of correction (POC) with a completion date of 9/27/26, for the 8/13/26 standard recertification and complaint survey, record review, and interview, the provider failed to provide evidence that the POC for the previously cited noncompliance at F610 was followed as written regarding 7 of 42 staff members' (E, F, G, H, I, J, and K) education and training on abuse and neglect incident investigation requirements. Findings include: 1. Review of the provider's accepted POC for F610 with a completion date of 9/27/26 revealed that, "All staff [will be] educated on regulation on investigations and [updated] policy by 9/27/26 by DON [director of nursing] or designee." 2. Review of the POC documentation and staff schedules revealed that transportation/certified	F0610	F 610 Empoloyee's E, F, G, H, I, J, K will receive education on abuse and neglect invesigation requirements by 11/13/26 DON or designee will audit for completed training on abuse and neglect investigation requirements weekly for 4 weeks and monthly for two additional months and thereafter until determined otherwise by QAPI committee. DON or designee will report findings at monthly QAPI meetings for review and recommendations	11/13/26

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F0610 SS = D	Continued from page 4 nursing assistant (CNA) E, CNA F, waitress G, waitress H, CNA I, waitress J, and waitress/cook K did not receive the required education by the POC completion date of 9/27/26, and worked or were scheduled to work shifts after that completion date. 3. Phone interview on 10/15/26 at 8:58 a.m. with administrator A, DON B, assistant DON (ADON) C, and business manager D revealed that the abuse and neglect education, that included incident investigation requirements, was assigned online to all staff to be completed. Administrator A confirmed he expected the staff to complete the education prior to their next working shift. 4. Email communication on 10/15/26 at 10:23 a.m. with DON B revealed that transportation/CNA E and CNA F were scheduled as needed (PRN) mostly to transport residents to and from appointments. She did not assign the online abuse education, that included incident investigation requirements, to those staff members for that reason. 5. Email communication on 10/15/26 at 1:16 p.m. with business manager D revealed that transportation/CNA E and CNA F worked shifts after the POC completion date of 9/27/26.	F0610		
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; §483.60(c)(5) Be updated periodically;	F0803	F 803 DON, ADON, and DM educated on backup/designee to complete audit if primary is absent DM or designee will audit proper hand hygeine and glove use in the kitchen weekly for 4 weeks and monthly for two addional months and thereafter until determined otherwise by QAPI comittee DM or deisgnee will report findings at monthly QAPI meetings for review and recommendations	11/13/26

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F0803 SS = D	Continued from page 5 §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 review of the provider's accepted plan of correction (POC) with a completion date of 9/27/26, for the 8/13/26 standard recertification and complaint survey, record review, and interview, the provider failed to ensure the POC was followed as written regarding auditing menu portion sizes and substitutions being followed. Findings include: 1. Review of the provider's accepted POC for F803 with a completion date of 9/27/26 revealed that, "DON [director of nursing] or [designee] 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 [quality assurance and performance improvement] committee." 2. Review of the POC documentation revealed that assistant director of nursing (ADON) C completed the weekly audits on 9/15/26, 9/21/26, and 10/7/26. There were no documented audits for the week of 9/28/26. 3. Email communication with additional documentation from ADON C on 10/14/26 at 2:16 p.m. revealed that she was assigned to complete the audit during the week of 9/28/26 but was out of the facility from 9/29/26 to 10/1/26, and the audit was not completed. No one else was assigned to complete the audit in her absence. 4. Phone interview on 10/14/26 at 4:53 p.m. with administrator A revealed that someone else should have completed the audits during ADON C's absence.	F0803		
F0812 SS = D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F0812		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0812 SS = D	Continued from page 6 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on review of the provider's accepted plan of correction (POC) with a completion date of 9/27/26, for the 8/13/26 standard recertification and complaint survey, record review, and interview, the provider failed to ensure the POC was followed as written regarding auditing for proper hand hygiene and glove by the staff during meals. Findings include: 1. Review of the provider's accepted POC for F812 with a completion date of 9/27/26 revealed that, "DON [director of nursing] or designee will audit for proper hand hygiene and [glove] use being followed [weekly] for 4 weeks and monthly for 2 additional months and thereafter until [determined] otherwise by [the] QAPI [quality assurance and performance improvement] committee." 2. Review of the POC documentation revealed that assistant director of nursing (ADON) C completed the weekly audits on 9/14/26, 9/24/26, and 10/7/26. There were no documented audits for the week of 9/28/26. 3. Email communication with additional documentation from ADON C on 10/14/26 at 2:16 p.m. revealed that she was assigned to complete the audit during the week of 9/28/26 but was out of the facility from 9/29/26 to 10/1/26, and the audit was not completed. No one else was assigned to	F0812	F812 DON, ADON, and DM educated on backup/designee to complete audit if primary is absent DM or desingee will audit for proper portion sizes weekly for 4 weeks and monthly for 2 additonal months and thereafter until determined otherwise by QAPI committee DM or Designee will report findings at monthly QAPI meetings for review and recommendations	11/13/26

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 10/15/2026

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F0812 SS = D	Continued from page 7 complete the audit in her absence. 4. Phone interview on 10/14/26 at 4:53 p.m. with administrator A revealed that someone else should have completed the audits during ADON C's absence.	F0812		