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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **435043**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/01/2026**
NAME OF PROVIDER OR SUPPLIER **SPEARFISH CANYON HEALTHCARE**		STREET ADDRESS, CITY, STATE, ZIP CODE **1020 N 10TH STREET , SPEARFISH, South Dakota, 57783**	

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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 9/29/26 through 10/1/26. Spearfish Canyon Healthcare was found not in compliance with the following requirements: F554, F558, F698, F755, F760, F804, F812, and F880.	F0000		
F0760 SS = G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure staff administered resident medications according to the physician's order by one of one registered nurse (RN) (N) who administered Zosyn (a prescription antibiotic given through a vein to treat a broad range of bacterial infections) medication to one of one sampled resident (20) who had anxiety and an allergic reaction to that medication, and subsequently was transferred to the emergency room for evaluation and treatment. This citation is considered past noncompliance based on review of the corrective actions the provider implemented immediately following the incident. Findings include: 1. Interview on 9/29/26 at 11:55 a.m. with resident 20 in her room revealed that she recently was given the another resident's medication and had an allergic reaction to that medication. Resident 20 saw another resident's name on the intravenous (IV – medicine that goes through a catheter into a vein under the skin) medication label that was connected to her IV. Resident 20 clamped	F0760	"Past Noncompliance - no plan of correction required"	

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 [illegible]ays 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 [illegible]ays 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
Charlotte Pinchery	Administrator	10/26/26

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F0760 SS = G	Continued from page 1 the IV tubing (mechanism on the tubing to stop the flow of the medication or fluid into the vein), and called the staff for help. She was transferred to the hospital for treatment. She stated that she was worried about how something like that could happen and worried about other residents who were not able to read the prescription medication labels and call the staff for help. 2. Review of resident 20's electronic medical record (EMR) revealed that she admitted to the facility on 4/19/19. She had a 7/31/26 brief interview for mental status (BIMS) assessment score of 15, which indicated that her cognition was intact. Her provider added the medication Zosyn to her allergy list on 9/24/26, with the reaction severity documented as "severe," and the reaction manifestation documented as "anaphylaxis" (a severe, rapid, and potentially life-threatening allergic reaction that affects multiple body systems at once). The 9/15/26 nursing progress note written by RN N indicated that after she attached the IV Zosyn medication to resident 20's IV to be administered, the resident noticed that the name on the medication's prescription label was not hers. Resident 20 clamped the tubing on the IV to stop the medication administration and pressed her call light. Upon assessment, resident 20 was "flushed" and complained of being short of breath. RN N disconnected the medication from resident 20, and an ambulance was called to transfer resident 20 to the emergency room for evaluation. Resident 20's 9/15/26 progress note from the emergency room (ER) indicated that she was seen for an allergic reaction to Zosyn. She presented to the ER with "difficulty breathing" and "flushed skin." The "ER Course" section of her progress note indicated that her symptoms had subsided after 2 hours in the ER after she had received a steroid medication and a breathing treatment. She was prescribed Prednisone (a steroid that reduces inflammation and calms an overactive immune system) 40 milligrams (mg) once per day for the next three days. 3. Review of the provider's 9/15/26 Adverse Drug Reaction (ADR) Report revealed resident 20 received another resident's IV Zosyn instead of her	F0760		

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F0760 SS = G	Continued from page 2 physician-ordered IV Cefazolin (an antibiotic given to treat a more specific range of bacterial infections) at 1:00 p.m. on 9/15/26, Resident 20 had experienced "anxiety, tachycardia (rapid heart beat), and chest tightness." Her vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) included a heart rate of 140 beats per minute (bpm), and a respiratory rate of 26 breaths per minute. Resident 20 was sent to the emergency room for evaluation and returned in stable condition later that day. 4. Review of the undated signed statement from director of nursing (DON) B revealed that registered nurse (RN) N was immediately educated regarding the six rights of medication administration and IV medication administration. The provider educated all nursing staff on the 6 rights of medication administration and completed competency assessments of IV medication administration. 5. Review of the provider's 9/15/26 signed statement by RN N revealed that she had picked up the IV Zosyn from a cardboard box in the medication storage room. Since the thought that resident 20 was the only resident on IV medication, RN N did not check the resident's name and medication on that medication's prescription label before administering that medication to resident 20. 6. Interview on 10/1/26 at 1:20 p.m. with RN H revealed that she remembered the medication error involving resident 20 receiving the wrong IV medication. RN H stated that there were two residents on IV medication the day before that incident. IV medications came from an infusion center in a cardboard box. The box would have a plastic bag with the labeled medication on it, and another plastic bag with the tubing supplies that the nurses would use to administer that medication. RN H stated that one of the two residents who received IV medications had passed away the day before the medication error occurred. She stated that the nurse who administered the wrong medication likely assumed that the open box belonged to resident 20 because she was the only resident in the facility with orders to receive IV medication that day. RN H recalled having to perform a competency on IV medication administration as well as reviewing the provider's new policy that two nurses had to double-check and sign a resident's IV medication	F0760		

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F0760 SS = G	Continued from page 3 bag before administrating that medication to the resident. 7. Interview on 10/1/26 at 3:29 p.m. with director of nursing (DON) B revealed that she was aware of resident 20 receiving the wrong IV antibiotic medication on 9/15/26. DON B interviewed resident 20 regarding the medication error, and resident 20 reported that the allergic reaction was caused by anxiety regarding receiving another resident's medication. DON B stated that RN N was immediately educated on the six rights of medication administration and IV medication administration technique. A new facility policy regarding IV medication administration was introduced that required two nurses to verify an IV medication and sign their name on the prescription label that the two nurses had verified the correct medication for the correct resident. All nursing staff were educated on the new policy. All nursing staff had to complete IV therapy education and perform a competency on administration of IV medications. When a resident's IV medication was discontinued, the nursing staff was required to bring the leftover supplies, including the medication, to DON B's office for disposal. Audits of IV medication administration would be completed moving forward and this incident would be discussed at the next Quality Assurance and Performance Improvement (QAPI) meeting. 8. Review of the provider's June 2025 Adverse Consequences and Medication Errors Policy revealed that "an 'adverse consequence' refers to an unwanted, uncomfortable, or dangerous effect a drug may have, such as a decline in mental or physical condition, or functional or psychosocial status." A medication error was defined as "the preparation or administration of drugs or biologicals which is not in accordance with the provider's orders, manufacturer specifications, or accepted professional standards, and principles of the professional(s) providing services." The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed after record review revealed the facility had followed their quality assurance process, education was provided to all applicable staff regarding IV medication administration, observations and resident and staff interviews revealed staff understood the	F0760	F0812 Corrective Action: The Dietary Manager discarded the thawed ground beef and hamburger patties identified during the survey on September 30, 2026. The Dietary Manager/or designee will review food storage, preparation, handling, and service practices with dietary employees, including proper covering and protection of food, safe handling and storage of raw meat, proper use of food thermometers and sanitizing supplies, hand hygiene, glove changes, and appropriate food tasting procedures. Employees identified in the deficient practices will receive individualized reeducation and competency validation regarding safe food handling procedures. Identification of Others: All residents have the potential to be affected. Systematic Changes: The Dietary Manager/designee will provide education to all dietary staff on proper food handling and sanitation procedures including: •Ensuring all food items are appropriately covered and protected from contamination during storage, preparation, and service. •Proper cleaning and sanitizing of food thermometer probes between different food items, using a new single-use alcohol wipe when applicable.	November 15, 2026

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F0760 SS = G	Continued from page 4 education provided regarding those topics and were following those processes, and a system for monitoring continued compliance was in place and ongoing. Based on the above information, noncompliance at F760 occurred on 9/15/26, and based on the provider's corrective action plans that were initiated on 9/16/26 and implemented for the deficient practice confirmed on 10/1/26, the noncompliance is considered past noncompliance.	F0760	(cont.) •Proper hand hygiene and glove changes between tasks, following contact with potentially contaminated surfaces, and before handling ready-to-eat foods. •Use of appropriate utensils to minimize direct hand contact with ready-to-eat foods. •Proper thawing, storage, labeling, dating, and temperature control of potentially hazardous foods, including raw meats. •Prohibiting eating or tasting food while actively preparing, plating, or serving resident meals. Food tasting will be performed in a designated area using sanitary procedures and clean utensils. The Dietary Manager will implement a standardized food safety observation checklist addressing food storage, hand hygiene, glove use, cross-contamination prevention, food temperatures, and meal service practices. All dietary staff will complete education and demonstrate competency in the identified food safety practices. Newly hired dietary staff will receive the same education during orientation. Monitoring: Beginning on or before November 15, 2026, the Dietary Manager/designee will conduct documented food safety observations during meal preparation and service daily for two weeks, three times weekly for two weeks, and weekly for eight weeks thereafter. Observations will include varying meal periods and dietary staff to ensure compliance across shifts. The monitoring checklist will include proper food covering, food storage and temperature control, food thermometer sanitation, hand hygiene, glove changes, utensil use, and safe food tasting practices.	November 15, 2025
F0812 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. (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 the staff followed standard food safety practices to prevent cross-contamination and food-borne illnesses regarding hand hygiene (handwashing), glove use, food temperatures, food storage, and food handling by one of one dietary director (DD) (K) during one of one observed meal service. Findings include:	F0812		November 15, 2026

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F0812 SS = F	Continued from page 5 1. Observation on 9/29/26 at 11:15 a.m. during the noon meal preparation revealed there were two uncovered metal containers on a counter next to the fryer and across from the steam table. There were dinner rolls inside those containers. Rolls from those containers were served to residents during the 9/29/26 noon meal service. At 11:45 a.m., fish sticks were cooking in the fryer next to the container of uncovered rolls. 2. Observation and interview on 9/29/26 at 12:04 p.m. with DD K in the kitchen revealed he was checking the food temperatures (temping) for the noon meal service. He temped the beets, then wiped the thermometer probe with an alcohol pad. He then temped the cooked chicken and used that same alcohol pad to clean the thermometer probe. DD K stated that alcohol pads should not be reused due to an increased risk for cross-contamination and a potential food allergy response. Continued observation and interview with DD K at the food preparation area across from the grill revealed that while wearing a pair of gloves, DD K mixed a chicken base paste with water to make a chicken broth, retrieved a metal pan from another area of the kitchen, and used potholders to remove a baking sheet of cooked chicken from the oven. With those same gloved hands, he picked up cooked chicken breasts from the baking sheet and placed them in a metal container, and then used tongs to handle some of the other cooked chicken breasts. He poured the prepared chicken broth over the chicken in the metal container. He picked up a dropped chicken breast from the floor and discarded it. DD K carried the metal container of chicken breasts to the other side of the kitchen. With those same gloved hands, he removed chicken breasts from the container and placed them onto a cutting board. He held the chicken breasts on the cutting board with his left gloved hand and used a knife in his right gloved hand to cut them into pieces. He placed the chicken pieces in a food processor with his gloved hands to puree them. He emptied the pureed chicken out of the processor into a serving bowl. DD K rearranged the pureed chicken in the bowl with his right gloved hand. DD K did not remove his unclean gloves, discard them, or wash his hands, and put on a pair of clean gloves during the observation. Regarding the above observation, DD K agreed that he had missed multiple opportunities to remove his unclean gloves, discard them, wash his hands, and put on a clean pair of gloves in between the various	F0812	(cont.) Any identified noncompliance will be corrected immediately, with additional employee education and competency validation as indicated. The Administrator will review monitoring results weekly to identify trends, verify corrective actions, and determine whether additional interventions are necessary. The Dietary Manager or designee will report on monitoring results monthly to the Quality Assurance and Performance Improvement (QAPI) Committee for three months. The QAPI Committee will review compliance trends and determine whether additional monitoring or corrective action is necessary to sustain compliance.	

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F0812 SS = F	Continued from page 6 tasks he performed during the noon meal preparation. He acknowledged that using kitchen tools, such as tongs, eliminated the need to handle the cooked chicken with his gloved hands. He agreed that the food-handling practices observed above increased the residents' risk for a food-borne illness. 3. Observation on 9/29/26 at 12:40 p.m. in the kitchen during the noon meal service revealed there was a wheeled cart across from the grill. There was a metal container on the second shelf of that cart. Inside that container was a thawed package of ground beef. One end of the package was opened, and there was pooled red blood and bits of raw hamburger at the opened end of the package. Beside the metal container on a baking sheet, there were two pre-made, thawed hamburger patties wrapped in plastic wrap. The plastic wrap was dated "9/28." 4. Observation and interview on 9/29/26 at 1:00 p.m. with DD K revealed one the above uncovered metal containers of dinner rolls was not used at the noon meal. DD K stated those rolls would be served at the 9/29/26 evening meal. 5. Observation at 1:17 p.m. in the kitchen revealed that cook G covered the metal container that contained the above thawed package of ground beef with plastic wrap and wrote 9/29 on it. At 1:21 p.m., cook G placed the metal container with the thawed package of ground beef and the baking sheet with the thawed hamburger patties inside the walk-in refrigerator. 6. Observation on 9/29/26 at 6:00 p.m. of cook E during the evening meal service revealed cook E stood in front of the steam table and was plating the residents' meals. He picked up cut pieces of a brat from the cutting board in front of the steam table and placed them in his mouth with his gloved hands. When he noticed that he was being observed, he removed and discarded his gloves in the trash can, washed his hands, put on a clean pair of gloves, returned to the steam table, and resumed serving the evening meal. 7. Interview on 9/30/26 at 2:45 p.m. with administrator A and DD K regarding the above food service observations revealed that the rolls served for the 9/29/26 noon meal should have been kept in their packaging or kept covered until they were used to preserve their quality and prevent potential cross-contamination. DD K discarded the thawed package of ground beef	F0812	F0558 Corrective Action: During the survey on September 29, 2026, the facility revised the meal ticket process and reinstated the ladder system to improve the organization and timeliness of resident meal service. The ladder system provides an organized method for compiling and prioritizing meal tickets at the steam table. The Dietary Manager and Dietary Supervisor monitor the compilation and progression of meal tickets to promote timely meal delivery and ensure residents are not inadvertently overlooked. Residents 2, 9, 11, and 20 will be interviewed regarding their dining experiences, meal service timeliness, and individual preferences. Identified concerns will be addressed through appropriate interventions. Identification of Others: All residents have the potential to be affected. Systematic Changes: The facility reinstated the ladder system for meal ticket organization during the survey on September 29, 2026, to improve the efficiency and coordination of resident meal service. The Dietary Manager and Dietary Supervisor will monitor meal ticket compilation and progression at the steam table to promote timely meal preparation and delivery. The facility's established meal service hours are lunch from 12:30 p.m. to 1:30 p.m. and dinner from 5:30 p.m. to 6:30 p.m.	November 15, 2026 November 15, 2026

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F0812 SS = F	Continued from page 7 and hamburger patties that were observed on 9/29/26. Raw hamburger was a potentially hazardous food (PHF, food that requires temperature control to limit the growth of pathogens such as bacteria or viral organisms) and when left uncovered at room temperature for greater than 30 minutes, created the potential for a food-borne illness to occur if it was used or kept to be used later. DD K stated it was acceptable to taste-test food for palatability and temperature before a meal, but that was expected to occur away from the serving area. 8. Review of the provider's revised November 2022 Food Preparation and Service policy revealed: "2. Cross-contamination can occur when harmful substances, i.e., chemical or disease-causing microorganisms are transferred to food by hands (including gloved hands)..." "3. Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. 4. When verifying food temperatures, staff use a thermometer which is both clean, sanitized, and calibrated to ensure accuracy." "1. The 'danger zone' for food temperatures is above 41 degrees Fahrenheit and below 135 degrees Fahrenheit. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. 2. Potentially hazardous foods include meats..." "3. The longer foods remain in the 'danger zone' the greater the risk for growth of harmful pathogens." 9. Review of the provider's revised November 2022 Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices policy revealed: "9. Gloves are considered single-use items and must be discarded after completing the task for which they are used. Gloves are removed, hands are washed and gloves are replaced:" "14. Food service employees are trained in the proper use of utensils such as tongs, gloves, deli paper and spatulas as tools to prevent foodborne illness."	F0812	(cont.) The Dietary Manager, in collaboration with nursing leadership, will provide education to dietary and nursing staff regarding dignified dining and meal service expectations, including: •Proper utilization of the ladder system to organize and prioritize resident meal tickets. •Timely communication between dietary aides and cooks regarding resident arrivals, outstanding meal tickets, and meal service delays. •Serving residents seated at the same table at or near the same time whenever reasonably possible, while respecting individual preferences. •Monitoring residents who are waiting for meals to prevent excessive delays. •Ensuring meals are served at appropriate temperatures. •Offering alternative dining arrangements or meal service to residents who choose to leave the dining room before receiving their meals. •Accommodating individual resident preferences while maintaining organized and efficient meal service. The Dietary Manager or Dietary Supervisor will oversee the meal ticket process during meal service and address identified delays or service concerns as they occur. Monitoring: The Dietary Manager or Dietary Supervisor will conduct documented dining room observations during lunch and dinner meal service daily for two weeks, three times weekly for two weeks, and weekly for eight additional weeks beginning on or before November 15, 2026.	November 15, 2026
F0558 SS = E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, record review, and	F0558		

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F0558 SS = E	Continued from page 8 policy review, the provider failed to ensure the residents' needs and preferences were accommodated for five of five sampled residents (2, 9, 11, 20, and 41) who did not promptly receive their meals according to the residents' preferences during two of two observed meal services. Findings include: 1. Interview on 9/29/26 at 11:55 am. with resident 20 in her room revealed that the residents sometimes waited so long to get served a meal that they left the dining room without eating. 2. Review of resident 20's electronic medical record (EMR) revealed that she had a 7/31/26 Brief Interview for Mental Status (BIMS) assessment score of 15, which indicated that her cognition was intact. 3. Observation and interview on 9/29/26 at 1:04 p.m. with resident 9 in the dining room revealed she had been waiting 50 minutes to be served her lunch meal. The other resident who sat at her dining room table had eaten his lunch and left the dining room. Resident 9 stated that she wanted to go back to her room, but she was hungry and did not keep any snacks in her room. Resident 9 received her lunch meal at 1:16 p.m. and stated that the food was cold when it was served to her. 4. Review of resident 9's EMR revealed that she had a 9/12/26 BIMS assessment score of 13, which indicated that her cognition was intact. 5. Interview on 9/29/26 at 2:33 p.m. with resident 11 in his room revealed that he had to wait a long time for his meal to be served. He stated that sometimes he waited for "hours" to be served in the dining room. 6. Review of resident 11's EMR revealed he had a 7/20/26 BIMS assessment score of 5, which indicated his cognition was severely impaired. 7. Interview on 9/29/26 at 3:45 p.m. with resident 2 revealed that the facility's food service was inefficient. Sometimes he waited one hour for his meal to be served. Residents who arrived in the dining room later than he did were served their meals before he was served his. The 9/29/26 meal	F0558	(cont.) Monitoring will include: •Proper utilization of the ladder system and organization of meal tickets. •Timeliness of resident meal delivery within established meal service hours. •Length of time residents wait from arrival until meal service. •Coordination of meal delivery for residents seated at the same table. •Appropriate food temperatures at the time of service. •Resident satisfaction with meal service and dining experiences. Any identified delays or concerns will be addressed promptly through staff communication, additional education, or modification of meal service processes as indicated. The Administrator will review monitoring documentation weekly to evaluate compliance and identify trends. The Dietary Manager or designee will present meal service monitoring results and resident satisfaction feedback to the QAPI Committee monthly for three months. The QAPI Committee will evaluate the effectiveness of the ladder system and other implemented interventions to determine whether additional corrective actions or monitoring are necessary to sustain compliance.	

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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
F0558 SS = E	Continued from page 9 service began at about 12:00 noon. He was not served his meal until 1:15 p.m. By then, his tablemates had eaten and left the dining room. 8. Observation on 9/29/26 from 5:15 p.m. to 6:00 p.m. of the evening meal service revealed the meal service started at 5:15 p.m. At 5:22 p.m., resident 11 joined resident 41 at a dining room table. A staff member pushed resident 18's wheelchair to that same table. Resident 18 was served his evening meal at 5:30 p.m. Resident 18 drank his apple juice, moved his wheelchair away from the dining room table, and was assisted out of the dining room by a staff member. At 5:45 p.m., resident 11 placed his head on the dining table. Resident 11 and resident 41 continued to wait to be served. Resident 18's uneaten dinner meal remained on the table. At 5:50 p.m., resident 41 was served his meal. At that same time, resident 18 returned to the dining room table. Resident 18's uneaten meal was removed from the table, and at 5:55 p.m., resident 18 given another plated service of the evening meal. At 6:00 p.m., resident 11 was served his meal. 9. Interview on 9/29/26 at 6:05 p.m. with dietary aide P revealed that the residents' meals were served on a first-come, first-served basis. Upon arriving in the dining room, a paper menu (completed by the resident and/or staff on the previous day) that identified the resident's food selections for that meal, was taken by the staff to the kitchen and placed by the steam table for the server to plate those residents' meals. 10. Interview on 9/30/26 at 2:45 p.m. with administrator A and dietary director (DD) K revealed it was expected that the residents' meals were served "restaurant style." Residents seated at the same dining room table were expected to be served their meals at or near the same time. Administrator A and DD K were aware that some of the residents were unhappy with the food service and there were opportunities to improve that. 11. Review of the provider's February 2021 Dignity policy revealed, "5. When assisting with care, residents are supported in exercising their rights. For example, residents are..."e. provided with a dignified dining experience."	F0558	F0554 Corrective Action: Residents 6 and 71 were identified as being affected by the deficient practice. The Director of Nursing (DON)/designee will review Residents 6 and 71's current physician orders, medication self-administration assessments, and comprehensive care plans to ensure consistency and accuracy regarding their ability to safely self-administer medications. Medication self-administration practices will be reviewed to ensure that medications are not prepared and left at the bedside without appropriate assessment and authorization. On 10/1/2026 the DON/designee reviewed the self-administration assessment and physician orders specific to MiraLAX and Metamucil and updated the resident's care plan as indicated for resident 6. On 10/8/2026 the DON/designee reviewed the self-administration assessment and physician orders regarding oral medications and updated the resident's care plan as indicated for resident 71. Until appropriate assessments, physician orders, and care plan interventions are verified, nursing staff will administer medications in accordance with current physician orders and facility policy.	November 15, 2026

TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435043	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2026

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F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure residents were assessed for their ability to safely self-administer their medications for two of two sampled residents (6 and 71) observed with medications left at their bedside and did nothave a medication self-administration assessment completed. Findings include: 1. Observation and interview on 9/29/26 at 3:24 p.m. with resident 6 in her room revealed there was a plastic cup on her bedside table with a powdered substance in it. The resident stated that substance was Metamucil (a fiber supplement) and MiriLAX (a medication to relieve constipation). The nursing staff left a cup containing those medications on her table each morning. Resident 6 was responsible for mixing those medications with water and drinking that mixture. The nursing staff would leave a cup containing only MiriLAX powder for the resident to self-administer each evening. 2. Observation and interview on 9/30/26 at 3:30 p.m. with resident 6 in her room revealed a plastic cup on her table contained her MiriLAX and Metamucil powder. The nursing staff left those medications on her table earlier that morning for the resident to self-administer. The resident confirmed that on 9/29/26, she self-administered her morning Metamucil and MiriLAX observed in the cup on her table at 3:24 p.m. that day. 3. Review of resident 6's electronic medical record (EMR) revealed she admitted to the facility on 2/27/26. Her 7/20/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated she had no cognitive impairment. The resident's September 2026 physician's order summary included a 3/30/26 physician's order for 2 tsp. (teaspoons) of MiriLAX powder to be administered each morning for constipation. There was a 3/30/26 physician's order for 17 grams of Metamucil powder to be administered twice each day	F0554	(cont.) The DON/designee will complete a facility-wide audit of residents with medication self-administration orders and/or identified self-administration practices to verify that: •Current physician orders accurately identify medications authorized for self-administration. •Medication-specific self-administration assessments have been completed and support the resident's ability to safely self-administer the identified medications. •Comprehensive care plans accurately reflect the resident's assessed self-administration abilities and authorized medications. •Medication administration practices are consistent with physician orders, completed assessments, and care plan interventions. Any discrepancies identified during the audit will be addressed through appropriate reassessment, physician notification and order clarification as indicated, and care plan revisions. Residents without verified authorization and assessment will receive medications through nursing administration until the required documentation and clinical determinations are completed. Identification of Others: All residents have the potential to be affected.	November 15, 2026

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	435043	A. BUILDING B. WING	10/01/2026

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F0554 SS = D	Continued from page 12 she was assessed as able to safely self-administer Voltaren gel and artificial tears eye drops. Resident 71's physician order summary indicated that there was no physician's order for resident 71 to self-administer any oral medications. 7. Interview on 10/1/26 at 12:05 p.m. with DON B revealed that she expected the nursing staff to not leave medications with a resident for self-administration without a completed assessment and a physician's order. 8. Review of the provider's February 2021 self-administration of medications policy revealed that residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. "If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is reassessed periodically based on changes in the resident's medical and/or decision-making status."	F0554	Monitoring: Beginning on or before November 15, 2026, the DON/designee will conduct medication administration observations and medical record audits to ensure continued compliance with the facility's Self-Administration of Medications policy. Audits will include observations of medication administration practices on both the AM and PM shifts to verify that medications and treatments are not left at the bedside without appropriate authorization and completed assessments. Resident 6 and 71 (identified at survey) are approved for SAM. Medical record audits will verify that self-administration physician orders, medication-specific assessments, and care plans are accurate, current, and consistent with observed practices. Audits will be completed weekly for four weeks, then monthly for two months. Any identified discrepancies will be addressed promptly through resident reassessment, clarification of physician orders as indicated, care plan updates, and staff reeducation as appropriate. Audit findings and trends will be reviewed by the DON and reported to the Quality Assurance and Performance Improvement (QAPI) Committee for evaluation of sustained compliance and determination of any additional corrective actions. The facility's goal is 100% compliance with medication self-administration requirements.	November 15, 2026
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, record review, and policy review, the provider failed to ensure the staff assessed residents for potential complications or changes in condition after receiving dialysis (a treatment for kidney failure that removes waste and excess fluid from the blood when the kidneys are unable to) treatments by one of one licensed practical nurse (LPN) (I), who did not assess one of one sampled resident (68) after she received her dialysis treatment. Findings include: 1. Interview and observation on 9/29/26 at 11:15 a.m. with resident 68 in her room revealed that she received dialysis treatments on Mondays,	F0698		

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F0698 SS = D	Continued from page 13 Wednesdays, and Fridays. A dressing was present on her left forearm over her arteriovenous (AV) fistula (a surgically created connection between an artery and a vein designed to provide access to the bloodstream for dialysis) site. She stated that the dressing was applied to her arm by the staff at the dialysis center after her dialysis treatment on 9/28/26. 2. Interview and observation on 9/30/26 at 4:08 p.m. with resident 68 in the dining room revealed she received a dialysis treatment earlier that day. A dressing was present on her left forearm AV fistula site. She stated that the staff usually checked her vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) before she left for her dialysis treatment and "sometimes" checked them after she returned from receiving a dialysis treatment. She said that the staff did not check her vital signs, assess her dressing, or evaluate her fistula site after she returned from dialysis that day (9/30/26). She stated that she planned to leave the facility shortly for an outing with a family member and would not return to the facility until Friday (10/2/26) morning. 3. Review of resident 68's electronic medical record (EMR) revealed that she admitted to the facility on 12/3/25. Her diagnoses included essential hypertension (high blood pressure), end-stage renal disease (kidney failure), and type 2 diabetes (a condition involving disruptions in how the body regulates blood sugar). Her 9/9/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. She had a 12/8/25 physician's order to have dialysis treatments every Monday, Wednesday, and Friday. There was a 12/30/25 physician's order for the staff to "listen and document presence of bruit (swishing sound) and palpate thrill (buzzing sensation) at Left arterial fistula site on left forearm every day and evening shift" and to report any abnormal findings to the physician. Her care plan (personalized plan that addresses a resident's care needs, goals, and interventions) included a goal initiated on 12/8/25 that she "Will have no complications associated with impaired renal [kidney] function and dialysis" with interventions for the staff to check her fistula site daily to monitor for signs and symptoms of infection. No post-dialysis assessment was documented for the resident on 9/30/26.	F0698	F0698 Corrective Action: Resident 68 was identified as being affected by the deficient practice. The Director of Nursing (DON)/designee will review Resident 68's dialysis orders, post-dialysis assessment requirements, and comprehensive care plan to ensure appropriate monitoring and documentation following dialysis treatments. Resident 68 will receive a nursing assessment upon return from dialysis, including newly obtained vital signs, assessment of the AV fistula site for bruit and thrill, assessment of the access site dressing, and monitoring for signs and symptoms of post-dialysis complications. The DON or designee will review and update the resident's care plan and treatment administration record (TAR) to reflect post-dialysis monitoring requirements. The order to the TAR will read "complete assessment, new vitals, document in post dialysis assessment. The licensed nurse responsible for the resident's care will be educated regarding the requirement to independently assess the resident upon return from dialysis and document findings in the electronic medical record (EMR). Identification of Others: All residents receiving dialysis treatments have the potential to be affected.	November 15, 2026

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F0698 SS = D	Continued from page 14 4. Interview on 9/30/26 at 4:50 p.m. with LPN I revealed that she did not yet document resident 68's post-dialysis assessment, but she planned to document it before the end of the day. She stated that she usually documented her assessment "from the dialysis communication form." She looked for the communication form (the facility's form used by the facility staff and the dialysis center's staff to communicate information about and any care received by a resident before, during, and after dialysis treatments) at the nurses' station, located it, and stated that the facility's nursing staff did not usually check resident 68's vital signs when she returned from her dialysis treatments. She stated, "We see her come in, she hands us the dialysis communication form, and there is a set of post-dialysis vitals [vital signs] from the dialysis center on it." 5. Further review of resident 68's EMR revealed her 9/30/26 Post-Hemodialysis Assessment was completed on 9/30/26 at 5:07 p.m. by LPN I, who documented the resident's dialysis access assessment, her vital signs, and a Resident General Condition assessment. The dialysis access assessment documented a positive bruit and thrill. "NA" was documented in the box labeled "Arrival Time Post Dialysis." 6. Interview on 10/1/26 at 12:05 p.m. with director of nursing (DON) B revealed that she expected the nurses to assess residents when they returned from dialysis treatments, which included checking their vital signs, assessing for post-dialysis complications, assessing their fistula site, and completing the post-dialysis assessment in the resident's EMR. She did not expect the nurses to document the vital signs from the dialysis communication form as the Post-Hemodialysis Assessment. 7. Review of the provider's 2025 "Hemodialysis Catheters - Access and Care of" policy revealed that to prevent infection or clotting, the staff should check for signs of infection such as warmth, redness, tenderness, or edema at the access site when performing routine care and at regular intervals. The staff should also check the color and temperature of the fingers and the radial pulse of the access arm during routine care and at regular intervals. Staff should also check patency of the site at regular intervals and should palpate the site to feel the "thrill," or use a stethoscope to hear the "whoosh" or "bruit" of blood flow through the access.	F0698	Systematic Changes: The DON/designee will provide education to all licensed nursing staff regarding the facility's dialysis policies and procedures, with emphasis on post-dialysis assessment, monitoring, and documentation requirements. Education will include: •Completing an independent nursing assessment promptly upon the resident's return from dialysis. •Obtaining and documenting a new set of vital signs upon return rather than relying solely on vital signs provided by the dialysis center. •Assessing the dialysis access site for bruit and thrill, as applicable, and monitoring for redness, warmth, swelling, tenderness, bleeding, and other signs of complications. •Assessing the condition of the dialysis access dressing and identifying any concerns requiring follow-up. •Monitoring for post-dialysis complications, including hypotension, dizziness, weakness, bleeding, changes in condition, and other symptoms requiring nursing intervention. •Documenting the resident's actual return time and completing the post-dialysis assessment in the EMR promptly following the assessment. •Reviewing the dialysis communication form for relevant treatment information while ensuring facility nursing assessments are independently completed and documented. •Notifying the physician and/or dialysis center of abnormal findings as indicated. The DON or designee will implement TAR orders for residents receiving dialysis to prompt nursing staff to obtain and document a new set of vital signs upon return from each dialysis treatment. The DON or designee will ensure dialysis-related physician orders, care plans, and TAR interventions are reviewed and updated as indicated.	November 15, 2026

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F0698 SS = D	Continued from page 15 Care immediately following dialysis treatment includes monitoring the dressing and changing the dressing, if needed. "Mild bleeding from site (post-dialysis) can be expected. Apply pressure to insertion site and contact dialysis center for instructions." The nurse should document the following in the resident's medical record every shift: location of the access, condition of the dressing, whether dialysis was done during the shift, and post-dialysis observations. 8. Review of the provider's 2010 "End-Stage Renal Disease, Care of a Resident with" policy revealed that "Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care." Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of those residents. Education and training of staff includes, specifically: the nature and clinical management of ESRD, including infection prevention and nutritional needs; the type of assessment data that is to be gathered about the resident's condition on a daily or per-shift basis; signs and symptoms of worsening condition or complications of ESRD; how to recognize and intervene in medical emergencies such as hemorrhages and septic infections; and the care of grafts and fistulas.	F0698	(cont.) Newly hired licensed nursing staff will receive education regarding post-dialysis assessment and documentation requirements during orientation. Monitoring: Beginning on or before November 15, 2026, the DON/designee will conduct audits of post-dialysis assessments and TAR documentation to ensure nursing staff complete and document the required assessments following dialysis treatments. Audits will verify: •New vital signs were obtained and documented upon return from dialysis. •The resident's actual return time was documented. •The dialysis access site and dressing were assessed and documented. •The resident was assessed for post-dialysis complications. •The post-dialysis assessment was completed in the EMR. •Abnormal findings were appropriately addressed and reported. Audits will be completed weekly for four weeks, followed by monthly audits for two months. Any discrepancies identified will be addressed promptly through resident assessment, staff reeducation, and additional corrective action as indicated. Audit results and identified trends will be reviewed by the DON and reported to the Quality Assurance and Performance Improvement (QAPI) Committee for evaluation of sustained compliance and determination of additional interventions as necessary.	November 15, 2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F0755		

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F0755 SS = D	Continued from page 16 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the staff followed standards of practice for medication administration when one of one registered medication aide (RMA) (L) documented the administration of one of one sampled resident's (6) medications without confirming the resident had taken those medications. Findings include: 1. Observation and interview on 9/29/26 at 3:24 p.m. with resident 6 in her room revealed there was a plastic cup on her bedside table that contained her Metamucil (a fiber supplement) and MiriLAX (a medication used to relieve constipation). The nursing staff left a cup containing those medications on her table each morning. Resident 6 was responsible for mixing the medications with water and then drinking the contents of the cup. 2. Observation and interview on 9/30/26 at 3:30 p.m. with resident 6 in her room revealed that there was a plastic cup on her table that contained her MiriLAX and Metamucil powder. The nursing staff left those medications on her table earlier that morning for the resident to self-administer. 3. Review of resident 6's electronic medical record (EMR) revealed she admitted to the facility on 2/27/26. Her 7/20/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated she had no cognitive impairment. The resident's September 2026 medication administration record (MAR) indicated a 3/30/26 physician's order for 2 tsp. (teaspoons) of MiriLAX powder to be administered daily at 8:00 a.m. for constipation. There was a 3/30/26 physician's order	F0755	F0755 Corrective Action: Resident 6 was identified as being affected by the deficient practice. The Director of Nursing (DON)/designee will review Resident 6's medication administration practices to ensure medications are administered and documented in accordance with physician orders and facility policy. The DON/designee will review Resident 6's medication administration record (MAR) and assess for any potential adverse effects related to medications documented as administered without verification of ingestion. The attending physician will be notified as clinically indicated. Direct education will be provided to the medication administration staff members involved regarding proper medication administration procedures, the six rights of medication administration, and accurate and timely MAR documentation. Education will emphasize that medications must not be documented as administered until administration has been completed and verified in accordance with facility policy. Identification of Others: All residents have the potential to be affected.	November 15, 2026

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F0755 SS = D	Continued from page 17 for 17 grams of Metamucil powder to be administered twice each day at 8:00 a.m. and 6:00 p.m. for constipation. RMA L documented on resident 6's September 2026 MAR that on 9/29/26 and 9/30/26, she administered the resident's 8:00 a.m. doses of MiriLAX and Metamucil, but those medications were still in a plastic cup on the resident's bedside table as stated in the 9/29/26 3:24 p.m. and 9/30/26 3:30 p.m. observations above. 4. Interview on 10/1/26 at 9:00 a.m. with RMA L regarding resident 6 revealed that she prepared the resident's 9/30/26 8:00 a.m. MiriLAX and Metamucil powders, and placed the cup of prepared medications on the resident's bedside table. She did not observe resident 6 self-administer those medications, and she did not know that on 9/29/26 at 3:24 p.m. and on 9/30/26 at 3:30 p.m. those medications were not taken by the resident and remained on the resident's bedside table. RMA L stated she knew she should not have left the prepared medications in resident 6's room on the mornings of 9/29/26 and 9/30/26, and she should have returned to the resident's room to verify that the medications were taken by the resident before she documented those medications were administered in the resident's EMR. 5. Interview on 10/1/26 at 9:15 a.m. with director of nursing (DON) B revealed that RMA L was responsible for ensuring resident 6 had taken her Metamucil and Mirilax before she documented those medications were administered. 6. Review of the provider's revised November 2022 Documentation of Medication Administration policy revealed, "2. Administration of medication is documented immediately after it is given."	F0755	Systematic Changes: The DON/designee will provide education to all licensed nurses and registered medication aides regarding the facility's Medication Administration and Documentation of Medication Administration policies. Education will include: •The six rights of medication administration: right resident, right medication, right dose, right route, right time, and right documentation. •Ensuring medications are administered in accordance with physician orders. •Verification that medications have been taken or otherwise administered appropriately before documenting administration. •Prohibition of documenting medications as administered before actual administration has occurred. •Accurate and timely documentation in the electronic medication administration record (eMAR). •Appropriate documentation and follow-up when a resident refuses, delays, or does not receive a scheduled medication. •Notification of the licensed nurse or DON when medication administration discrepancies are identified. Newly hired licensed nurses and medication aides will receive education regarding medication administration and documentation requirements during orientation.	November 15, 2026
F0804 SS = D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable,	F0804		

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F0804 SS = D	Continued from page 18 attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the provider failed to ensure the nutritive value was maintained for a modified pureed diet texture prepared by one of one dietary director (DD) (K) and one of one cook (G) during one of one observed meal service. Findings include: 1. Observation on 9/29/26 at 11:55 a.m. of dietary director (DD) K in the kitchen during the noon meal service revealed that he added hot water to the diced beets in a food processor to puree them for the residents who required a pureed diet texture. 2. Observation on 9/29/26 at 1:00 p.m. of cook G in the kitchen during the noon meal service revealed that she added hot water from the coffee dispenser to the cooked chicken in a food processor to puree them for the residents who required a pureed diet texture. 3. Interview on 9/30/26 at 4:15 p.m. with DD K regarding pureed food preparation revealed that liquids such as chicken or vegetable broth, or milk were used to thin food to a pureed consistency. That practice maintained the taste and nutritional value of the pureed food. Neither he nor cook G followed that expectation when they pureed the cooked beets and chicken for the noon meal on 9/29/26. 4. On 10/1/26 at 11:17 a.m., a Pureed Food Preparation policy was requested from administrator A. On 10/1/26 at 1:30 p.m., administrator A indicated the provider did not have that policy. A therapeutic diet manual (a standardized clinical reference used to plan, prepare, and serve modified meals) was requested from administrator A at that same time. She stated the kitchen did not have a therapeutic diet manual. 5. Interview on 10/1/26 at 4:15 p.m. with registered dietician (RD) consultant F regarding pureed food preparation revealed that he recommended the use of milk, vegetable, beef, or chicken broth to puree a food item. Those additions fortified the food. Water diluted the nutritive value and taste of pureed food.	F0804	Monitoring: The DON/ designee will conduct medication administration observations and MAR documentation audits to verify that medications are administered and documented in accordance with physician orders and facility policy beginning on or before November 15, 2026. Audits will include observation of medication administration practices on both AM and PM shifts, with emphasis on ensuring medications are not documented as administered before actual administration has been verified. Audits will be conducted weekly for four weeks, followed by monthly audits for two months. Any discrepancies identified will be addressed promptly through staff reeducation, resident assessment, and corrective action as indicated. Audit results and identified trends will be reviewed by the DON and reported to the Quality Assurance and Performance Improvement (QAPI) Committee for evaluation of sustained compliance and determination of any additional interventions. The facility's goal is 100% compliance with medication administration and documentation requirements. F0804 Corrective Action: The facility's established recipes for preparing modified-texture diets, including pureed foods, were provided to the surveyor during the annual survey. The Administrator/Dietary Manager will review the preparation of pureed foods with all dietary employees to ensure established recipes are consistently followed and the nutritional value, flavor, and appropriate texture of foods are maintained.	November 15, 2026 November 15, 2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435043	A. BUILDING B. WING	10/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET , SPEARFISH, South Dakota, 57783

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F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program, The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must	F0880	(cont.) A therapeutic diet manual was ordered on October 23, 2026, to provide additional standardized guidance for the preparation and service of therapeutic and mechanically altered diets. The Dietary Manager, in collaboration with the consulting Registered Dietitian, will review the facility's pureed food preparation procedures and provide education to dietary employees regarding the appropriate use of approved liquids and ingredients when preparing modified-texture foods. Identification of Others: All residents receiving pureed or other modified-texture diets have the potential to be affected. Systematic Changes: The Dietary Manager, in collaboration with the consulting Registered Dietitian, will develop and implement a written Pureed Food Preparation Policy to establish consistent procedures for preparing nutritionally appropriate, palatable, and visually appealing modified-texture meals. The policy will address: •Consistent use of standardized recipes for modified-texture diets. •Appropriate use of milk, broth, or other recipe-approved liquids to achieve the prescribed food consistency while maintaining nutritional value and palatability. •Avoidance of unnecessary dilution of pureed foods with water when it would compromise nutritional value or flavor. •Appropriate food consistency and texture according to resident diet orders and applicable swallowing safety requirements. •Maintaining appropriate food temperatures, presentation, and portion sizes.	November 15, 2026

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F0880 SS = D	Continued from page 20 prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the staff followed infection prevention and control practices to ensure one of one sampled resident's (49) humidifier was routinely cleaned and kept free from potential mold and bacterial growth; that resident's personal care items and bathing supplies were labeled, stored, and used in a manner to prevent potential spread of infection in two of two observed bathtub rooms (Century hallway bathtub room and Therapy bathtub room); and maintain a cleanable surface for one of one grab bar (a securely mounted safety fixture designed to provide a stable handhold for maintaining balance, supporting body weight, and preventing fall) in a bathroom shared by 3 of 3 sampled residents (64, 14, and 31). Findings include: 1. Observation on 9/29/26 at 9:39 a.m. in resident 49's room revealed the resident wore oxygen delivered through a nasal cannula (flexible tubing with prongs that delivers oxygen through the nose). There was a nebulizer (a device that converts liquid medication into an inhalable mist) and CPAP (continuous positive air pressure) machine (delivers air through a face mask to keep the airway open during sleep) on her bedside stand. There was a humidifier on a counter between two storage cabinets that was on, but there was no humidified air coming out of it.	F0880	(cont.) Upon receipt, the therapeutic diet manual will be reviewed by the Dietary Manager and consulting Registered Dietitian and incorporated into the dietary department's reference materials and procedures as appropriate. The Dietary Manager /designee will provide education to all dietary employees responsible for preparing modified-texture diets regarding the Pureed Food Preparation Policy, standardized recipes, and appropriate food preparation techniques. Dietary employees responsible for modified-texture meal preparation will demonstrate competency through direct observation. The Dietary Manager will ensure that standardized recipes and applicable therapeutic diet references are readily accessible to dietary employees during food preparation. Monitoring: The Dietary Manager/designee will conduct documented observations of modified-texture food preparation daily for two weeks, three times weekly for two weeks, and weekly for eight additional weeks beginning on or before November 15, 2026. Monitoring will include: •Compliance with standardized recipes and the Pureed Food Preparation Policy. •Appropriate selection and use of liquids when preparing pureed foods. •Appropriate consistency and texture of modified-texture foods. •Maintenance of nutritional value, appearance, and palatability. •Appropriate food temperatures and portion sizes.	November 15, 2026

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F0880 SS = D	Continued from page 21 The water tank lifted off the humidifier base. The base contained a shallow reservoir of water. There were scattered black areas around the inside perimeter of the base, and the area beneath the standing water. The underside of the water tank was covered with scattered black areas. 2. Observation and interview on 9/29/26 at 9:39 a.m. and on 9/30/26 at 11:50 a.m. in resident 49's room revealed the above humidifier was on, but there was no humidified air coming out of it. The resident said that the staff filled the humidifier with water and cleaned it because she was physically unable to do that herself. She was not sure when the humidifier was last cleaned. She used the humidifier because the oxygen she wore dried out the inside of her nose. The water tank lifted off the humidifier base. The base contained a shallow reservoir of water. There were scattered black areas around the inside perimeter of the base, and the area beneath the standing water. The underside of the water tank was covered with scattered black areas. 3. Review of resident 49's electronic medical record (EMR) revealed her diagnoses included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), asthma, and chronic respiratory failure. Her allergy list included mold. The resident's 8/27/26 Brief Interview for Mental Status Assessment score was 15, which indicated she had no cognitive impairment. There was a 3/12/25 physician's order, "Humidifier air turned on as needed. Every day and night shift for humidity. Check water level." The resident's September 2026 treatment administration record (TAR) revealed that the nursing staff documented two times daily that the water level of the humidifier was checked. The resident's revised 8/18/26 care plan indicated that resident 49 was at risk for altered respiratory function and she required the use of supplemental oxygen and a CPAP. There was no mention that the resident used a humidifier. 4. Interview on 10/1/26 at 3:25 p.m. with licensed practical nurse (LPN) I regarding resident 49's humidifier revealed that she ensured the humidifier was turned on as needed and as the resident requested, and verified that there was water in the water tank. She visualized the water level without lifting the water tank off the humidifier base. LPN I	F0880	(cont.) Any identified concerns will be corrected promptly, with additional staff education and competency validation as indicated. The Administrator will review monitoring documentation weekly to identify trends and verify corrective actions. The Dietary Manager or designee will report monitoring results monthly to the QAPI Committee for three months. The QAPI Committee will evaluate the effectiveness of corrective interventions and determine whether additional monitoring or systemic changes are necessary to sustain compliance. F0880 Corrective Action: Resident 49's humidifier was identified as not being maintained in accordance with infection prevention practices. A cleaning order was entered into the treatment administration record (TAR) on 10/1/26 to establish a routine cleaning schedule. The DON/designee will ensure the humidifier is cleaned and maintained according to manufacturer recommendations and facility policy. The resident's care plan will be reviewed and updated to reflect humidifier use and maintenance requirements. The resident will be assessed for any potential adverse effects, with physician notification as clinically indicated. The personal care items identified in the Century hallway and Therapy bathtub rooms will be reviewed, and items that cannot be verified as belonging to a specific resident or safely maintained for shared use will be placed in a designation storage area free from contamination.	November 15, 2026

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F0880 SS = D	Continued from page 22 did not know who was responsible for cleaning the humidifier or how often it was cleaned. She thought resident 49 used the humidifier mostly at night, but the humidifier ran "quite a bit this summer, almost daily." 5. Observation and interview on 10/1/26 at 8:50 a.m. with director of nursing (DON) B regarding resident 49's humidifier revealed there was no cleaning schedule for the resident's humidifier. She was not sure when the humidifier was last cleaned. The black discoloration on the underside of the water tank and around and inside of the humidifier base suggested it had not been cleaned for some time. She stated the black discolorations looked like "mold." DON B acknowledged that failing to clean the resident's humidifier increased the resident's risk for lung inflammation and/or an allergy flare-up. 6. Review of the provider's 7/31/26 Personal Fan, Air Conditioners, Small Appliances Use in Resident Rooms policy revealed, "The facility will support resident choice while ensuring that fans, air conditioners, and small appliances are maintained, cleaned, inspected, and used in a manner consistent with CMS [Centers for Medicare and Medicaid Services] regulations, fire safety standards, infection prevention practices, and facility policies." 8. Observation on 9/29/26 at 11:43 a.m. in the bathroom shared by residents 14, 31, and 64 revealed a grab bar attached to the wall directly in front of the toilet. A plastic-like material was wrapped around the grab bar and secured to the grab bar with tape. The plastic material and tape were torn, cracked, and broken which created an uncleanable surface. 9. Observation on 9/29/26 at 5:10 p.m. in the Century hallway bathtub room revealed multiple personal care items and bathing supplies were stored on top of the gray cabinet near the bathtub room door. The items included one bottle of Nivea sensitive body wash, two bottles of VO5 scalp conditioner, one bottle of Dove Deep Moisture body wash, one bottle of Suave conditioner, one bottle of Suave shampoo, and one bottle of Olay Moisture Rich lotion. None of those items were labeled with a resident's names or initials. 10. Observation and interview on 10/1/26 at 11:42 a.m. in the Therapy bathtub room with certified nursing assistant (CNA) D revealed a large cabinet with personal care supplies stored in it. The items on the top shelf in the cabinet included one bottle of	F0880	(cont.) When approved multi use items are needed to be utilized, staff will be educated regarding placement, storage, and handling of items to prevent cross contamination. Resident-specific bathing supplies will be labeled and stored separately to prevent cross-contamination. The damaged plastic-like material and tape on the grab bar in the bathroom shared by Residents 14, 31, and 64 will be removed. The grab bar will be assessed to ensure the underlying surface is intact, cleanable, and capable of being effectively disinfected. Any damaged or uncleanable materials will be replaced as indicated. Identification of Others: All residents utilizing humidifiers, shared bathing areas, personal care products, or grab bars with applied grip materials have the potential to be affected Systematic Changes: The DON/ designee will provide education to nursing staff regarding the facility's Personal Fans, Air Conditioners, and Small Appliances Use in Resident Rooms policy. Education will include identifying humidifiers and other small appliances in resident rooms, notifying nursing management when these items are identified, and ensuring appropriate cleaning schedules and maintenance requirements are established. Humidifiers requiring staff assistance with cleaning will have cleaning schedules established in the TAR according to manufacturer recommendations and facility policy.	November 15, 2026

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F0880 SS = D	Continued from page 23 Remedy treat antifungal powder, one tube of Thera antifungal body powder, one bottle of Malibu hemp moisturizer, one bottle of Speed Stick antiperspirant, one bottle of Remedy no rinse cleanser, a tube of Remedy prevent silicone cream with zinc oxide, a tube of Remedy essentials treat antifungal cream, and a tube of Remedy specialized prevent silicone cream. None of those items were labeled with a resident's name or initials, and they were not stored in an area designated for a specific resident. CNA D stated that the personal care items in the cabinet in the Therapy bathtub room were handled and used during the residents' baths. She confirmed that the above items were not labeled with a resident's name or initials and that each of the bottles appeared to have been used. She stated that she was unable to determine if the personal care items belonged to a specific resident or if they were used by multiple residents. CNA D stated that some items were supplied by the facility and were used by multiple residents. She was unsure which items were supplied by the facility. CNA D stated that all personal care items should be labeled with a resident's name or initials and only used for one resident because they are not cleaned between residents' baths. 11. Interview on 10/1/26 at 2:15 p.m. with the infection preventionist (IP) M revealed that she expected all personal care items in the bathtub rooms to be labeled with the resident's name or initials and the items should be stored in an area designated for each specific resident. She explained that the facility supplied some personal care items or "community" items that were used on multiple residents and were not labeled with a resident's name or initials. She stated these "community" items were not cleaned between uses or stored in an area designated to a specific resident. She stated that personal care items that are handled by the resident or bath aide during the residents' bath could become contaminated through contact with a resident's skin, bathwater, or bodily secretions before the personal care items are returned to the shelf. She confirmed that using personal care items for multiple residents' baths and not disinfecting personal care items between resident's baths increased the risk of infection spread. IP M stated that residents 14, 31, and 64 used the same grab bar for assistance in their shared bathroom. She confirmed that the torn, cracked, and exposed materials on the grab bar could harbor moisture and/or bacteria and could not be effectively cleaned or disinfected. IP M expected	F0880	(cont.) The IP/ designee will provide education to nursing and direct care staff regarding proper labeling, storage, and use of resident personal care items. Resident-specific bathing supplies will be maintained in individually labeled shower caddies or designated storage areas to prevent cross-contamination. Shared personal care products will be managed according to manufacturer instructions and infection prevention practices. Products that cannot be safely used between residents without risk of contamination will be designated for individual resident use. The Therapy and Maintenance departments, in collaboration with the IP, will implement a tracking spreadsheet identifying locations where Dycem, grip strips, or similar materials are applied to grab bars or other surfaces. The tracking spreadsheet will include the location, date of application, responsible department, and inspection findings. Weekly inspections will be conducted to ensure materials remain intact, cleanable, and free from damage. Damaged or uncleanable materials will be removed and replaced with appropriate cleanable alternatives. Monitoring: The DON/ IP/ designee will conduct weekly audits beginning on or before November 15, 2026, for four weeks, followed by monthly audits for two months, to ensure continued compliance with infection prevention practices.	November 15, 2026

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F0880 SS = D	Continued from page 24 surfaces to be monitored routinely to prevent torn, cracked, or damaged surfaces that would create an uncleanable surface. She confirmed that there was no process in place to monitor uncleanable surfaces. 12. Review of the provider's August 2019 Cleaning and Disinfection of Environmental Services Policy revealed that environmental surfaces wound be "cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities." The policy also indicated that any items that may come in contact with intact skin were to be disinfected according to the manufacturer's label instructions for use.	F0880	(cont.) Audits will include: •Verification that humidifiers have appropriate cleaning schedules and that cleaning is documented in the TAR. •Observation of humidifiers to ensure they are clean and maintained according to manufacturer recommendations. •Inspection of shared bathing areas to verify that personal care items are labeled, appropriately stored, and not shared in a manner that increases the risk of cross-contamination. •Review of the Dycem and grip strip tracking spreadsheet to verify weekly inspections are completed. •Observation of grab bars and other surfaces to ensure they remain intact, cleanable, and free from torn, cracked, or damaged materials. Any identified concerns will be addressed promptly through cleaning, replacement of materials, staff reeducation, or additional corrective action as indicated. Audit findings and trends will be reviewed by the DON and IP and reported to the Quality Assurance and Performance Improvement (QAPI) Committee to evaluate sustained compliance and determine whether additional interventions are necessary. The facility's goal is 100% compliance with infection prevention and control practices.	

South Dakota Department of Health

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	10686	A. BUILDING: _____ B. WING _____	10/01/2026

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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 9/29/26 through 10/1/26. Spearfish Canyon Healthcare was found not in compliance with the following requirement: S296.	S 000		
S 296	44:73:07:11 Director of Dietetic Services A facility shall have a full-time dietary manager who is responsible to the administrator and who shall direct the dietetic services. The dietary manager must: (1) Be a certified dietary manager; (2) Be a certified food service manager; (3) Have a similar national certification for food service management and safety from a national certifying body; or (4) Have an associate's or higher degree in food service management or hospitality from an accredited institution of higher learning that has a course of study in food service or restaurant management. Any dietary manager who does not must enroll, within ninety days of the dietary manager's hire date, in programming necessary to achieve one of the qualifications, and achieve the qualifications within eighteen months of hire. The dietary manager and at least one cook shall possess a current certificate from a ServSafe Manager Food Protection Program offered by various retailers, the Certified Food Protection Professional's Sanitation Course offered by the Association of Nutrition and Foodservice Professionals, or an equivalent training program as determined by the department. Individuals	S 296	Corrective Action: The facility's Dietary Manager enrolled in a Certified Dietary Manager (CDM) training program on September 29, 2026, during the annual survey. The Administrator has verified the Dietary Manager's enrollment, documented the anticipated completion date, and established a written education and competency development plan. The facility has an established consulting Registered Dietitian who provides onsite consultation monthly and remote professional oversight between visits. The Administrator will review and document the consulting Registered Dietitian's responsibilities to ensure qualified oversight of dietary operations during the Dietary Manager's educational program. Identification of Others: All residents have the potential to be affected.	November 15, 2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charlotte Rothery — TITLE: Administrator — (X6) DATE: 10/16/26

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S 296	Continued From page 1 seeking ServSafe recertification are only required to take the national examination. The dietary manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each resident are met. If the dietary manager is not a dietitian, the facility must schedule dietitian consultations onsite at least monthly. The dietitian shall approve each menu, assess the nutritional status of each resident with problems identified in the assessment, and review and revise dietetic policies and procedures during scheduled visits. The facility shall have sufficient personnel to meet the dietetic needs of the residents and provide dietetic services for a minimum of twelve hours each day. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and job description review, the provider failed to ensure the dietary department had a certified dietary manager regarding one of one dietary director (DD) (K) who failed to enroll, within 90 days of his hire date, in a program necessary to achieve the qualifications of a certified dietary manager (CDM). Findings include: 1. Interview on 9/29/26 at 11:05 a.m. with DD K revealed that he possessed a current ServSafe Food Protection Manager certification. He was not enrolled in a program to achieve one of the qualifications required to become a CDM. 2. Interview on 9/30/26 at 10:30 a.m. with administrator A revealed she knew DD K was not	S 296	Systematic Changes: The Dietary Manager will complete the CDM training program within four months of enrollment with a targeted completion date of January 29, 2027. The Administrator will establish a written professional development plan on or before November 15, 2026, outlining educational milestones, expected progress, and completion requirements. The consulting Registered Dietitian will continue monthly onsite visits and remote consultation between visits, providing professional oversight of dietary services consistent with the established consulting agreement. The Administrator will review the facility's dietary management qualifications and oversight arrangements to ensure continued compliance with applicable state and federal requirements. Upon completion of the educational program, the Dietary Manager will provide documentation and, if required, successfully complete the certification examination and obtain applicable credential.	November 15, 2026

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SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET SPEARFISH, SD 57783

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 296	Continued From page 2 enrolled in a CDM program. She expected that to have occurred within 90 days of his 1/1/26 hire date, but it had "slipped my mind." 3. Review of DD K's 12/10/25 signed job description revealed that he, "Must be a certified dietary manager or willing to become certified within four months of employment."	S 296	Monitoring: Beginning on or before November 15, 2026, the Dietary Manager will submit weekly written educational progress reports to the Administrator for four months or until all required qualifications have been obtained. The Administrator will review educational progress weekly, including coursework completion, established milestones, and barriers to completion. The consulting Registered Dietitian's monthly onsite visits and remote consultation activities will be documented and reviewed by the Administrator. The Administrator will present educational progress and dietary oversight findings to the QAPI Committee monthly until regulatory compliance has been achieved and sustained.	November 15, 2026