

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

PRINTED: 06/25/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/05/2025
NAME OF PROVIDER OR SUPPLIER SD HUMAN SERVICES CENTER - GERIATRIC PROGRAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3515 BROADWAY AVE YANKTON, SD 57078		
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F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/2/25 through 6/5/25. SD Human Services Center - Geriatric Program was found not in compliance with the following requirements: F609, F658, F732, F812, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/2/25 through 6/5/25. Areas surveyed included: nursing services related to a resident who fell and fractured his hip, a resident who had behavioral event that required the use of a manual hold, staff eating from a residents meal tray, potential staff to resident verbal and physical abuse, and staff acquiring and modifying of resident supplies without prior approval. SD Human Services Center - Geriatric Program was found not in compliance with the following requirements: F609 and F658.	F 000			
F 609 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	F 609	Resident 41 was assessed by nursing on 3/25/2025 when nursing became aware of the manual hold from 3/23/25. No injuries noted from that assessment. Reports alleging abuse or serious bodily injuries reported to the SD Department of Health from the facility starting January 1, 2025 to July 1, 2025 will be reviewed by the Acting Nursing Home Administrator or designee to ensure proper reporting time frames as defined in policy. The Geriatric Program policy PREVENTION OF MISTREATMENT, EXPLOITATION, NEGLECT AND ABUSE for Geriatric Units		

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

TITLE

(X6) DATE

[Signature]

Acting Administrator

7/2/2025

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

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F 609	Continued From page 1 the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §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 the South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, and policy review, the provider failed to follow their policy to file an initial report to the SD DOH within two hours of an incident that involved a sampled resident (41) who had a behavioral event that required her to be placed into a manual hold by staff members according to their policy. Findings include: 1. Review of the provider's 3/25/25 SD DOH FRI regarding resident 41 revealed: *On 3/23/25 at 6:50 p.m., resident 41 was by an exit door in the Spruce 1 unit. -She had placed her belongings in front of that door earlier that afternoon. *Resident 41 walked down the hall to the exit door where her belongings were with a mental health aide. *Resident 41 became upset and struck out at a mental health aide who was in the area.	F 609	will be amended by adding a clarifying language directing staff to the definitions in policy of abuse and serious bodily injury and timeframes for reporting to the SD Department of Health. Required reading will be assigned to all staff with updated policy and assessment via the facility's policy management system, Policy Tech with a required completion date of July 18, 2025. Supervisors will ensure staff have completed by July 18 or prior to their next shift working after July 18. Staff who are on leave will complete the required reading and assessment prior to first shift working. QAPI nurse will report completion of required reading to QAPI committee. The QAPI Nurse, or designee will complete audits of reports made to the SD Department of Health related to alleged violations. The audits will be conducted using an audit tool to review reports for timeliness in accordance with policy. All reports of alleged violations will be audited weekly until 4 weeks of 100% compliance is achieved. Following 100% compliance for 4 weeks, 80% of all alleged violation reports will be audited weekly for 8 weeks. When 8 weeks of 100% compliance is achieved the auditing frequency will be determined by the QAPI Committee. Reports of all audits will be submitted by the QAPI Nurse or designee monthly and reported to the QAPI Committee monthly.	7/18/2025	

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F 609	Continued From page 2 *A second mental health aide came to assist. *A low-level manual hold (physical restraint where staff physically hold a resident to prevent movement, but do not use any mechanical devices or equipment) was placed on resident 41 by the two mental health aides, and they assisted resident 41 with walking to the dining room of the day hall. Resident 41 struggled near the day hall, and the CNAs then transitioned the hold to a medium-level manual hold physical intervention used to safely manage medium to high-risk behaviors in individuals experiencing a mental health crisis when other de-escalation techniques are not effective), then back to a low-level manual hold, and continued to assist resident 41 with walking to the dining area. -The hold ended at 6:56 p.m. *Registered nurse (RN) F was the nurse on duty at the time of the incident. -She had not notified any of the required individuals of the use of the manual holds at that time. *The initial and final report was filed with the SD DOH on 3/25/25 at 10:15 a.m. Interview on 6/5/25 at 10:16 a.m. with mental health aide N revealed: *She worked for the provider for 31 years. *She had not had to use manual holds "very often." *There are three types of manual holds: low, medium, and high (a manual hold is temporary and focuses on stabilization and ensuring the safety of the resident). Interview on 6/5/25 at 10:34 a.m. with RN H regarding manual holds on residents revealed: *Manual holds were used when a staff member	F 609			

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F 609	Continued From page 3 needed to ensure their safety and/or a resident's safety, during forced cares (when a resident refuses care that their physician has ordered that they are required to receive, and the staff provides that care). *It was "super rare" that resident 41 required the use of a manual hold. *She received education on the approved manual holds every year and had completed the education "last week". *The process for when a manual hold was used was to: -Notify the charge nurse or the nurse manager. -Notify the house supervisor if the hold was completed after normal business hours. -Complete an incident report. -Complete a note in the resident's electronic medical record. -Notify the physician. -The social worker or charge nurse was responsible for reporting the incident to the SD DOH. Interview on 6/5/25 at 11:58 a.m. with geriatric program director of nursing (DON) B regarding the manual hold for resident 41 on 3/23/25 revealed: *RN F had not documented or reported the manual hold used for resident 41 to the charge nurse or house supervisor. -RN F had not assessed resident 41 after the use of the manual hold and did not perform any nursing duties associated with the use of a manual hold. *The process for when a manual hold was used was to complete a restraint (manual hold) note, complete an assessment of the resident, and notify the house supervisor for a face-to-face assessment of the resident.	F 609			

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F 609	Continued From page 4 -The house supervisor would document the face-to-face assessment in the resident's medical record. *DON B was not aware that the report of the incident was filed on 3/25/25 to the SD DOH. -She had thought the report was completed on 3/24/25. -She confirmed that a report should have been filed with the SD DOH within two hours of the incident that required manual hold use for resident 41 on 3/23/25. *She confirmed the provider's Abuse and Neglect Policy related to reporting to the SD DOH had not been followed by RN F. *She confirmed the provider's Prevention of Mistreatment, Exploitation, Neglect and Abuse policy had not been followed for the reporting of the use of manual holds for resident 41 on 3/23/25 to the SD DOH within two hours. Review of the provider's undated Prevention of Mistreatment, Exploitation, Neglect and Abuse policy revealed: **"An initial report shall be made within 2 hours of the event to the SD Department of Health." **Nurses shall assess, provide direction for care and monitor residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors ..." *"Reporting: Nurse in charge at the time, Abuse Prevention Coordinator, Nurse Manager, or Program Director shall, within 24 hours, report all allegations of abuse, mistreatment or neglect of residents and misappropriation of resident property ..."	F 609			
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658	Patient 41 was assessed on March 25th after learning of the restraint that had occurred on March 23, 2025. The		

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F 658	Continued From page 5 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on the South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, and policy review, the provider failed to follow standard of nursing practices to ensure assessments, physician notification, house supervisor notification to ensure a face-to-face assessment of the resident was completed, and documentation was entered in the resident's medical record regarding the use of manual holds for one of one sampled resident (41) was completed. Findings include: 1. Review of the provider's 3/25/25 SD DOH FRI regarding resident 41 revealed: *On 3/23/25 at 6:50 p.m., resident 41 was by an exit door in the Spruce 1 unit. -She had placed her belongings in front of that door earlier that afternoon. *Resident 41 walked down the hall to the exit door where her belongings were with a mental health aide. *Resident 41 became upset and struck out at the mental health aide. *A second mental health aide came to assist. *A low-level manual hold (physical restraint where staff physically hold a resident to prevent movement, but do not use any mechanical devices or equipment) was placed on resident 41 by the two mental health aides, and they assisted resident 41 with walking to the dining room of the	F 658	assessment was was completed by nursing staff at 4:12 pm when resident was willing to be assessed. Resident 41 treatment plan was updated to address aggression and exit seeking behavior on 3/27/2025. To ensure other Geriatric Residents will not experience restraints without the appropriate assessments, notifications and orders in place, all Geriatric staff will be re-educated in process and procedure for manual holds and documentation including updates to treatment plan by completing required reading of the Physical Restraint - Manual Restraint Policy and an assessment to ensure understanding of the policy is being sent out through HSC document management system, Policy Tech with a required completion date of July 18, 2025. Supervisors will ensure staff have completed by July 18 or prior to their next shift working after July 18. Staff who are on leave will complete the required reading and assessment prior to first shift working. Summary of the required reading completion will be reported to QAPI committee meeting by QAPI nurse or designee.	7/18/2025	

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F 658	Continued From page 6 day hall. -Resident 41 struggled near the day hall, and the mental health aides then transitioned the hold to a medium-level manual hold (physical intervention used to safely manage medium to high-risk behaviors in individuals experiencing a mental health crisis when other de-escalation techniques are not effective), then back to a low-level manual hold, and continued to assist resident 41 with walking to the dining area. -The hold ended at 6:56 p.m. *Registered nurse (RN) F was the nurse on duty at the time of the incident. -RN F indicated she had not assessed resident 41 after the use of the manual hold and did not perform any nursing duties associated with the manual hold. Review of resident 41's medical record revealed: *Her admission date was 3/12/25. *Her diagnoses included: major neurocognitive disorder due to another medical condition with behavioral disturbance and chronic kidney disease. *Her 3/19/25 Brief Interview of Mental Status assessment score was a 1, which indicated she had severe cognitive impairment. Interview on 6/5/25 at 10:34 a.m. with RN H regarding manual holds on residents revealed: *Manual holds were used when a staff member needed to ensure their safety and/or a resident's safety, during forced cares (when a resident refuses care that their physician has ordered that they are required to receive, and the staff provides that care). *It was "super rare" that resident 41 required the use of a manual hold. *She received education on the approved manual	F 658			

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F 658	Continued From page 7 holds every year and had completed the education "last week". *The process for when a manual hold was used was to: -Notify the charge nurse or the nurse manager. -Notify the house supervisor if the hold was completed after normal business hours. -Complete an incident report. -Complete a note in the resident's electronic medical record. -Notify the physician. -The social worker or charge nurse was responsible for reporting the incident to the SD DOH. Interview on 6/5/25 at 11:58 a.m. with director of nursing (DON) B regarding resident 41's manual hold on 3/23/25 revealed: *RN F was the nurse on duty on 3/23/25 when resident 41 required the use of a manual hold by staff members. *RN F had not documented or reported the manual hold used for resident 41 to the charge nurse or house supervisor. -RN F had not assessed resident 41 after the use of the manual hold and did not perform any nursing duties associated with the use of a manual hold. *The process for when a manual hold was used was to complete a restraint (manual hold) note, complete an assessment of the resident, notify the house supervisor for a face-to-face assessment of the resident, and notify the resident's physician. -The house supervisor would document the face-to-face assessment in the resident's medical record. Review of the provider's undated Physical	F 658			

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F 658	Continued From page 8 Restraint Manual Restraint Policy revealed: ***It shall be the policy of the SDHSC that manual restraint only be used to ensure the immediate physical safety of a patient, a staff member, or others and must be discontinued at the earliest possible time." *Types of physical restraints used at HSC includes a manual restraint such as forced procedure holds, and physical intervention holds. ***Purpose" -To provide an intervention when a patient's behavior indicates that he/she is in immediate danger of harming him/herself or others." ***Manual Restraint: The use of one's hands and body to safely limit or restrict a patient's movement." ***The RN shall notify the patient's physician or designee giving a detailed description of the situation necessitating the use of manual hold." ***A face-to-face assessment shall be conducted by the physician or designee, or Face to Face RN within one (1) hour of initiation of physical restraint." ***Assessment includes: -The patient's immediate situation; -The patient's reaction to the intervention; -The patient's medical and behavioral condition; and -The need to continue or terminate the restraint." ***If a trained RN conducts the face-to-face evaluation following a Manual Hold and no further intervention or order for renewal is needed, the attending physician or designee will be notified of the hold and face to face evaluation the next working day." ***This consultation shall include, at a minimum, a discussion of the findings of the evaluation, the need for other interventions or treatment, and the need to continue or discontinue the use of	F 658			

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F 658	Continued From page 9 restraint." **"Restraint/Seclusion event assessment will be documented by the assessing physician or designee or trained Face-to-Face RN." **"The RN or designee shall notify the attending physician or designee of the use of manual restraint on the next working day ...This review shall be documented in the patient's electronic health record with appropriate recommendations or modifications." **"A RN shall document the patient's behaviors leading up to the restraint event and clinical assessment and rationale for use of a manual restraint." **"A RN shall document the physician or designee, or face-to-face RN that was notified to complete the face-to-face assessment." **"A RN shall document an assessment of the patient's mental and physical condition at least hourly or more frequently depending on patient need/condition or provider's orders." **"The RN shall document an assessment and decision to discontinue the manual restraint along with the patient's physical condition, including vitals upon release from a manual restraint." Review of the provider's Documentation policy revealed "All documentation shall be recorded as soon as possible after the occurrence."	F 658			
F 732 SS=F	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name.	F 732	All SD HSC Geriatric Residents and visitors have have access to nurse staffing information daily on the white board in the dayhall area of the units within each of the Geriatrics Program units. The nurse staffing posting has been revised to include facility name, current date, total number of hours worked by licensed and unlicensed nursing staff directly		

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F 732	Continued From page 10 (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, posted staffing review, and interview, the provider failed to ensure the posted nurse staffing information was accessible to residents and visitors at all times and that it included: *The facility's name. *The total number and the actual hours worked	F 732	responsible for nursing care per shift. The posting includes registered nurses and licensed practical nurses and certified nurses aides along with the unit resident census. At the beginning of the AM shift (6:00 am), the unit nurse or designee will post this document within the facility on the white board across from the nurses station on each unit. This area is fully accessible to visitors and residents. The QAPI Nurse or designee will audit this posting for completion daily on each unit and log the completion in an audit tool. The audits will be conducted using an audit tool with all required points identified, facility name, current date, total number of hours worked by licensed and unlicensed nursing staff directly responsible for nursing care per shift. the posting includes registered nurses and licensed practical nurses and certified nurses aides along with the unit resident census. Auditing will be done daily until 2 weeks of 100% Compliance. Following 100% compliance for 2 weeks, the posting will be audited 3 times weekly for 2 weeks. When 8 weeks of 100% compliance is achieved the auditing frequency will be determined by the QAPI Committee. Reports of all audits will be submitted by the QAPI Nurse or designee monthly and reported to the QAPI Committee.	7/18/2025	

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F 732	Continued From page 11 by registered nurses, licensed practical nurses, and certified nursing assistants per shift. 1. Observation on 6/3/25 at 8:00 a.m. revealed the staffing information titled Geriatrics AM Daily Staffing was posted on a central whiteboard near the Spruce 1 unit nurses' station, which was a locked senior care unit. It was not posted in the public area at the front entry of the facility to be accessible to visitors. The unit resident census was posted on a separate sheet of paper on the same whiteboard. 2. Review of the posted staffing data for 6/3/25 revealed: *The posting had the date on the top and "Geriatrics AM Daily Staffing" as a title. *There were three sections, one for each of the three geriatric units. *Location, worker, position, and shift columns were filled out for each unit. *Nurses were identified as "Charge Nurse" or "RN" (registered nurse). *All other staff were identified as "Staff". *The total number of nurse staffing hours was not included for each shift. *It did not include the facility's name. 3. Interview on 6/4/25 at 8:45 a.m. with geriatric program director of nursing (DON) B revealed: *The posting format was completed by someone in the administrative offices. *Nursing staff were responsible for filling in the correct staff names and shifts into that format. *Positions listed as staff referred to mental health technicians, who were all certified nurse assistants. *She was not aware the requirements for the posted nurse staffing data included the name of	F 732			

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F 732	Continued From page 12 the facility, the resident census and the total hours worked per nursing discipline. *She was not aware of a policy regarding the posting details but updating the whiteboard with the current staff information was on the day and night shift duties checklist.	F 732			
F 812 SS=F	4. Review of the daily and nightly duties checklist revealed that "white board" appears on those listed tasks for completion. 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, record review, and policy review the provider failed to follow food safety standards to ensure: *A process was in place to document sanitation	F 812	HSC Cleaning of Kitchen Appliances, Equipment, and Utensils Policy has been revised to add temperature requirement for hot water (110 to 120 degrees Fahrenheit). The revised policy reads, "Equipment and utensils must be thoroughly washed in the first compartment of the four-compartment sink with a hot (110-120 degrees Fahrenheit) detergent solution that is kept clean. The detergent must be used according to the manufacturer's label directions." To ensure required temperature of the hot wash water, thermometers have been ordered and are placed along with the sanitizer tablets and sanitizer test strips will be stored in a caddy near the sink, labeled with the "Dish washing Supplies". To ensure staff know which sink is for which task, sinks have been labeled with Hand washing sink, Dish washing sink, rinse basin, and sanitizing basin. The test strip inventory will be monitored by NOC Charge nurse or designee. This will ensure ongoing compliance with proper use and test strip availability.		

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F 812	Continued From page 13 levels in sanitation tubs and water temperatures in the wash tubs for three of three kitchenettes. *Refrigerator temperatures that were out of range had documented interventions for one of one refrigerator in one of three kitchenettes according to the provider's policy. *There was a designated hand washing sink in one of three kitchenettes. *Proper food and equipment handling processes were in place for three of three observed mental health aides (L, P, and X) and one of one therapeutic recreation specialist (R). Findings include: 1. Observation on 6/2/25 at 4:44 p.m. in the Willow 1 dining area revealed the drinks on the residents' tables were in Styrofoam cups. Interview on 6/3/25 at 10:20 a.m. with mental health assistant (MHA) O revealed: *Styrofoam cups were used for the residents because the glasses on the unit were small, and if those were used, the staff on the unit would have to wash them. *The staff washed the residents' dishes that did not come on the meal trays. *They washed those dishes with dish soap and then sanitized them. Interview on 6/3/25 at 10:52 A.M. with MHA Z revealed: *Adaptive cups that are used by the residents during meals, are hand washed by staff in the kitchenette sink, they do not go back to the kitchen to be washed. -She indicated the adaptive dishes that are used by the residents who live on Spruce two are washed in the kitchenette of the unit they live on. -Dirty dishes are first to be rinsed of any food	F 812	A new Monthly Kitchen Duties Documentation Log has been created to monitor and log time, water temperature, sanitizer levels, and staff completing the task of dish-washing. Each shift Certified Nursing Assistants will complete Log based upon duty assignment. Weekly tasks include Refrigerator cleaning and expiration date checking. Date task is done with the staff completing the task's initials, and any comments. Monthly tasks documented is refrigerator / Freezer defrosting. Date and staff initials are required. Monthly cupboard/pantry cleaning and expiration date checking has the date completed and staff initials. Required reading and assessment to ensure understanding of the Cleaning of Kitchen Appliances, Equipment and Utensils Policy has been sent to all Geriatric staff with a completion date of July 18. The required reading and assessment is sent through our document management software, Policy Tech. Supervisors will ensure staff have completed by July 18 or prior to their next shift working after July 18. Staff who are on leave will complete the required reading and assessment prior to first shift working. Summary of the required reading completion will be reported to QAPI committee meeting by QAPI nurse or designee. The QAPI nurse or designee will audit this log for completion 3 times a week and will note on Audit, the review. Specific items to look for include completion of the form, cleanliness and maintenance of kitchen and dishwashing supplies to ensure proper use		

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F 812	Continued From page 14 particles or beverages left in the cups in the first area of the compartment sink. -Clean water and Ajax soap are added to the first compartment of the sink and the dirty dishes are washed there. -Dishes are then rinsed with water in the second compartment of the sink. -The second compartment sink is then filled up with water and one to two Steramine tablets are added to the water. -Dishes are soaked in the water containing the Steramine tablets in the second compartment of the sink. -She had indicated that she was not sure of how the whole process of washing the dishes worked. -She did not state staff were to test the sanitizing solution level with the QAC test strips. *She had indicated that the QAC Fry Oil Saver test strips were for the air fryer. Observation on 6/3/25 at 12:52 of the Willow 1 kitchenette revealed: *Plastic glasses were stacked beside the sink on a towel and covered with another towel. *A two-compartment sink that had a dish strainer in one of its compartments. *A wet wadded paper towel was in the drain of the other sink. *Under the sink there were two brown tubs, a green and white scrub brush, dish soap, and a bottle of Steramine sanitizer tablets. -The tablets were blue. -The bottom of the brown tubs had an unknown sticky substance, flakes of a brown substance, and a black and white substance on them. *There were no test strips to measure the concentration of the sanitizer mixture. *In the upper cupboard to the left of the sink was a stack of clear glasses with handles.	F 812	and storage of equipment, dishes and food. QAPI nurse or designee will follow up with nurse manager any missed documentation or issues with compliance to policy. The QAPI Nurse or designee will complete this audit 3 times a week until 2 months of 100% compliance is reported to QAPI Committee monthly by the QAPI nurse or designee. At the end of 2 months of 3 times per week auditing with 100% compliance, auditing of the form will be done monthly and will be reported to QAPI committee monthly by the QAPI nurse or designee. To ensure proper food handling technique by all staff working with HSC Geriatric residents a required review of policies, Meal Service on Geriatric Units and Hand-washing Technique and Use of Hand Sanitizers with related assessments to ensure understanding of the policies is being sent out through HSC document management system, Policy Tech with a required completion date of July 18, 2025. Supervisors will ensure staff have completed by July 18 or prior to their next shift working after July 18. Staff who are on leave will complete the required reading and assessment prior to first shift working. Summary of the required reading completion will be reported to QAPI committee meeting by QAPI nurse or designee. SDHSC Geriatrics program will ensure refrigerator and freezer temperatures are within safe range by changing the Refrigerator / Freezer Temperature		

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F 812	Continued From page 15 *Those glasses had drops of liquid in them. *On the shelf beneath those glasses was a ring of pink liquid. Observation and interview on 6/3/25 at 1:10 p.m. with MHA I in the Willow 1 kitchenette revealed: *There was no log of the sanitization mixture concentration levels in the kitchenette. *There was no log of wash water temperatures in the kitchenette. *MHA I stated dirty dishes were brought into the kitchenette and placed in one of the compartments of the two-compartment sink as they were dirtied. *Washing the dishes was an assigned task but any staff member could wash the dishes if they had time. *She washed the dishes with dish soap in one side of the two-compartment sink. *The other side of the two-compartment sink was filled half full of water and she would put one sanitizer tablet in that water. *The dishes were then to be placed to on the dish strainer to dry and then placed in the cupboards. *She agreed there was moisture in the glasses in the cupboard, and a liquid pink ring was under those glasses. *She would test the sanitizer concentration levels by dipping strips into the water that contained the sanitization tablet to determine if the concentration level was adequate to sanitize the residents' dishes. *She stated the last test strip was used after lunch, so more test strips needed to be ordered from supply. *She had not washed the dishes after the lunch meal to be able to verify the last test strip was used at that time. *She did not document the results of the sanitizer	F 812	Readings Log to be a monthly form instead of quarterly, requiring recheck of abnormal temperatures within 1 hour and adding abnormal temperature comment section to include documentation of abnormality and who was notified. Overnight Certified Nursing Assistants will complete Log based upon duty assignment. Staff will be educated on this revised Log by completing required reading that includes process and procedure for completing the updated form and who to notify and when of the abnormalities identified. Required reading and assessment to ensure understanding of the updated form and notification process change has been sent to all Geriatric staff with a completion date of July 18. The required reading and assessment is sent through our document management software, Policy Tech. Supervisors will ensure staff have completed by July 18 or prior to their next shift working after July 18. Staff who are on leave will complete the required reading and assessment prior to first shift working. Summary of the required reading completion will be reported to QAPI committee meeting by QAPI nurse or designee. The QAPI nurse or designee will monitor this Log for completion 3 times a week and will note on audit the review and outcome. Specific items documented to audit include completion of the Refrigerator/Freezer Temp Follow Up form and appropriate follow up. QAPI nurse or designee will follow up with nurse manager any missed documentation or		

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F 812	Continued From page 16 concentration levels when she completed the testing. Interview on 6/3/25 at 1:54 p.m. with MHA O in the Willow 1 kitchenette revealed: *The dishes were to be washed in the brown tubs that were stored under the sink. *She was not aware there were wet glasses in the cupboard and did not know what the liquid pink ring was under those glasses. *She stated there were no sanitization concentration test strips in the kitchenette because the last one was used by MHA I after breakfast. *The process for washing the dishes was to fill one tub with water and dish soap, and water with the sterilization tablet in it was to be in the second brown tub for rinsing the dishes. *The concentration of the sterilization mixture was one Steramine sanitizer tablet to one gallon of water. *There was no documentation of the sanitizer concentration test results. Interview on 6/4/25 at 11:06 a.m. with mental health aide Y revealed: *The two bags of Ore-Ida Golden Fries belonged to a resident who lived on Spruce 2. -She had indicated that staff at Human Services Center (HSC) had purchased the fries at the store for the resident, but the resident purchased them with his own money. *She had indicated that the red basin under the sink is used to put the dirty dishes in that have been picked up off the tables after the residents are finished eating. -Dirty dishes are first rinsed of any food particles or beverages left in the cups in the first area of the compartment sink.	F 812	issues with compliance to procedure. The QAPI Nurse or designee will complete this audit 3 times a week until 2 months of 100% Compliance is achieved. The summary of this audit will be reported to QAPI monthly by the QAPI nurse or designee. At the end of 2 months of 3 times per week auditing with 100% Compliance, auditing of the Log will be determined by the QAPI committee. To ensure all SDHSC Geriatric Program staff use proper hand hygiene and food handling techniques required reading and assessment will be sent to all HSC Geriatric staff. The required reading includes Meal Service for Geriatric Program Policy and Hand-washing Technique and use of Hand Sanitizer Policy and associated assessments with a completion date of July 18. The required reading and assessment is sent through our document management software, Policy Tech. Supervisors will ensure staff have completed by July 18 or prior to their next shift working after July 18. Staff who are on leave will complete the required reading and assessment prior to first shift working. Summary of the required reading completion will be reported to QAPI committee meeting by QAPI nurse or designee. To ensure understanding and compliance to procedure, audits will be completed with re-education and immediate correction as needed. A minimum of three meal time audits will be completed		

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F 812	Continued From page 17 -Clean water and Ajax soap are added to the first compartment of the sink and the dirty dishes are washed there. -Dishes are rinsed with water in the second compartment of the sink. -The second compartment sink is filled up with water and one to two Steramine tablets are added per one gallon of water. -The QAC test strips would then be used to test the solution. -Dishes are soaked in the water containing the Steramine tablets in the second compartment of the sink. Interview on 6/4/25 at 12:38 p.m. with geriatric program director of nursing (DON) B revealed: *Some resident dishes were to be washed by the staff in the kitchenettes. *Sanitization levels were to be tested each time residents' dishes were washed. *There were no logs kept of the tested sanitizer concentration levels. Interview on 6/5/25 at 8:19 a.m. with therapeutic recreational specialist R revealed: *She had washed the dishes after breakfast on 6/5/25. *Staff were to use a three-compartment sink method for washing the dishes. -The first tub was to be filled with soapy water. -The second tub was to be a clean water rinse. -The third tub was to be the sanitization tub where she used four Steramine sanitization tablets to three and one-half gallons of water. *The sanitization concentration was to be between 200 and 400 parts per million (PPM). *The results of the tested sanitizer concentration levels were not documented. *The temperature of the water was not taken	F 812	weekly to include one audit for each meal time. HSC Quality Compliance and Improvement Specialist or designee will complete audits and report results to QAPI nurse. Compliance goal is 90% compliance. Once 2 months of 3 audits per week at 90% compliance has been achieved, the auditing frequency will be determined by the QAPI Committee. Reports of all audits will be submitted by the QAPI Nurse or designee monthly and reported to the QAPI Committee.	7/18/2025	

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F 812	Continued From page 18 before or during the washing of the dishes. *All the dishes in the kitchenette were washed in the unit. *There was not a designated hand washing sink available for staff to wash their hands in the kitchenette, so staff used the two-compartment sink to wash their hands. *Staff had been provided education about two years ago when the policy for dishwashing in the kitchenettes was put into place. *She stated staff would be educated if there were any changes to the policy, and new staff were educated during the orientation process. 2. Observation on 6/5/25 at 8:33 a.m. of MHA J in the Willow 1 kitchenette revealed her entering the kitchenette and washing her hands in the sink that the dishes were to be washed. 3. Observation on 6/5/25 at 8:34 a.m. of therapeutic recreational specialist R in the Willow 1 kitchenette revealed: *She was putting dishes away in the cupboard. *She placed drinking glasses upside down with the drinking rims touching the palm of her hand. *She then placed those glasses in the cupboard. 4. Observation and interview on 6/5/25 at 9:06 a.m. of MHA P in the Willow 1 kitchenette revealed: *She washed her hands in the sink where the dishes were to be washed. *With her bare hands, she placed bread in the toaster, removed the toasted bread from the toaster, and then buttered the bread. *She stated she was making toast for resident 8. *She served the toast to resident 8, who was seated at the table, and resident 8 ate the toast. *MHA P stated she was a contracted traveling	F 812			

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F 812	Continued From page 19 MHA and had been assigned to work at the facility for two years. *The facility had provided her education. *She stated she was provided education on hand washing and glove use, but did not recall having had any food handling education. *She thought because she had washed her hands, she could handle ready to eat food with her bare hands. 5. Interview on 6/5/25 at 10:39 a.m. with geriatric program DON B revealed: *The MHA on each unit were responsible for washing the dishes in each unit's kitchenette. *Staff had been provided training on the washing and sanitization of the dishes in 2023 through a required reading session within the computerized training system. *Staff hired since that time had received training during their orientation process. *She expected the dishes to be dry prior to being placed in a cupboard. *Each unit was to have a three-compartment sink process in place using the sink and the brown tubs for washing and sanitizing the dishes. *After the wash, rinse, and sanitization process, the dishes were to be placed on the drying rack to dry, not on towels. *There was no separate handwashing sink available in the kitchenettes for staff to use. *She expected the water for the sanitization process would be tested to ensure the ratio of water to tablets was accurate for proper sanitization of the residents' dishes. *Staff did not take the temperature of the water used to wash dishes. *She expected the sanitization concentration level to be tested each time the residents' dishes were washed.	F 812			

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/05/2025
NAME OF PROVIDER OR SUPPLIER SD HUMAN SERVICES CENTER - GERIATRIC PROGRAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3515 BROADWAY AVE YANKTON, SD 57078		
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F 812	Continued From page 20 *Staff had not been required to document the concentration levels of the sanitizer on a log. *She agreed there was no documentation process in place to verify staff were measuring the sanitization levels and that the PPM level was sufficient to sanitize the dishes. 6. Observation on 6/3/25 at 12:52 p.m. in the Willow 1 kitchenette revealed: *A refrigerator contained resident food items including a carton of eggs, a container of heavy whipping cream, a block of sliced cheese in a Ziploc bag dated 5/14/25, opened 16-ounce bottles of Diet Coke and Orange Fanta, and several bottles of condiments. *A "Refrigerator/Freezer Temperature Readings" log was located on the front of that refrigerator. 7. Review of the provider's April/May/June 2025 Willow 1 Kitchen Refrigerator/Freezer Temperature Readings log revealed: ***IF REFRIG [refrigerator] TEMP [temperature] [is] GREATER THAN 41[degrees] F [Fahrenheit] or FREEZER TEMP [is] GREATER THAN 0 F: 1. Adjust temperature: If Refrigerator temperature does not return to 41 [degrees F] or below immediately and/or if freezer temperature does not immediately return to 0 [degrees F] or below, move ALL food items to another refrigerator/freezer. 2. Notification: Notify Program Director/Nurse Manager, after hours leave phone message or email." *There were 25 days between 4/3/25 and 6/3/25 the refrigerator temperature reading was documented as 42 degrees or higher. *There were four days no refrigerator temperatures were documented, and three days no freezer temperatures were documented between 5/18/25 and 5/30/25. *The "COMMENTS" column was blank each day	F 812			

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F 812	Continued From page 21 for all three months. -Available comment codes included an up arrow to indicate "Temp setting increased," a down arrow to indicate "Temp setting decreased," "M=Contents moved to another refrigerator," and "D=Defrosted." 8. Observation on 6/5/25 at 8:55 a.m. of the Willow 1 refrigerator and freezer revealed: *The freezer temperature was -5 degrees F, and the refrigerator was 52 degrees F. *The refrigerator contained: -A tub of margarine dated "5/14." -A carton of eggs. -A container of heavy whipping cream dated "5/21." -A block of sliced cheese in a Ziploc bag dated 5/14/25. -A container of mayonnaise dated "4/20." -A gallon jug of milk. --An open container of "I can't believe it's not butter spray," dated "5/10," which indicated "refrigerate after opening." -An open container of coconut cream with almond milk dated "5/29" which indicated "refrigerate after opening." 9. Observations of the Willow 1 refrigerator on 6/5/25 revealed: *At 9:01 a.m. registered nurse (RN) G poured the milk from the refrigerator into a bowl of cereal and served it to a resident for breakfast. *At 9:13 a.m. the refrigerator temperature was 58 degrees F. 10. Observation and interview on 6/5/25 at 10:22 a.m. with RN G in the Willow 1 kitchenette revealed: *Staff members on the night shift monitored and	F 812			

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F 812	Continued From page 22 recorded the temperatures in that refrigerator, but all staff members were responsible for checking for outdated food. *She was the charge nurse on Willow 1 that day. *She confirmed the temperature of the refrigerator at that time was 50 degrees F. *She referred to the Kitchen Refrigerator/Freezer Temperature Readings log for instructions on whom to contact. *She confirmed that there were several times that the refrigerator temperature was over 42 degrees F in April, May, and June of 2025. *She was unaware that those temperatures had been over the required temperature because the staff had not reported them to her. *She expected that the staff members checking the refrigerator temperatures would have moved the food to another refrigerator and alerted their supervisor. *She stated that a documented comment code would have indicated if the food had been moved to another refrigerator during those months and confirmed that no codes had been documented. -She stated that some of the food in the refrigerator had potentially been in that refrigerator since April, since one of the opened dates indicated "4/20." 11. Interview on 6/5/25 at 10:39 a.m. with geriatric program DON B regarding the April, May and June 2025 Willow 1 refrigerator temperatures revealed: *She confirmed that there were many dates in April, May, and June when the documented temperature was over 41 degrees F. *She expected the staff member who documented the temperature to notify their supervisor and move the food to another refrigerator when the temperature was above 41	F 812			

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F 812	Continued From page 23 degrees. *Refrigerator/Freezer Temperature Readings logs were forwarded to her when they were completed every three months. 12. Observation on 6/2/25 at 4:56 p.m. during the meal service in Spruce 1 revealed: *Mental health assistant L put on a pair of disposable gloves, then she: -Delivered a meal tray to a resident at their dining room table. -Removed the lids that covered the dishes on the meal tray and returned to the kitchen. -Opened the refrigerator, took out a carton of milk, and returned to the resident's table. -Opened the carton of milk, poured it into a cup, and set the cup on the resident's meal tray. -Removed her disposable gloves and put on a new pair of disposable gloves without completing hand hygiene. *She picked up a chair with those gloved hands, and moved it to the table next to a resident. -With those potentially contaminated gloves, she picked up a sandwich from the resident's plate and gave her a bite of it. *She placed the sandwich back on the plate, then touched and cut the sandwich with those same gloved hands. *She gave the resident a large bite of the sandwich from a spoon. *She caught a piece of that sandwich that fell off the spoon in her same gloved hand, placed it on the resident's plate with the rest of her food, and continued assisting the resident with eating food from that plate. 13. Observation and interview on 6/2/25 at 5:20 p.m. of MHA X in the Spruce 2 dining area revealed:	F 812			

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F 812	Continued From page 24 *MHA X had on a pair of gloves and was assisting resident 28 eating the meal. *MHA X used his gloved hand to scoop egg salad with a fork onto a slice of bread. *With that same gloved hand, MHA X picked up the bread, and assisted resident 28 to eat the egg salad sandwich. *MHA X held a dish, scooped fruit out of that dish, and then handled the egg salad sandwich with that same gloved hand. *MHA X stated he was not sure if he was to wear gloves while assisting resident 28 with eating, but he wore gloves with all of resident 28's cares, so he wore them while he assisted resident 28 at the table. *He stated he was provided education on how to assist residents with eating, but that was a "long time ago". -He was not able to give a time range when that education had occurred. 14. Observation on 6/2/25 at 5:20 p.m. of MHA L revealed: *After assisting a resident, she removed her gloves, carried dirty dishes to the kitchenette, and returned with clean gloves tucked between her body and bare arm. *She completed hand hygiene, then put those gloves on. *With those gloved hands, she touched the back and side of a resident's chair, lifted the top slice of bread on a sandwich, looked at the open sandwich, lowered the bread back down, and then continued assisted a resident with eating other meal items. 15. Interview on 6/2/25 at 5:40 p.m. with MHA L in the dining room revealed: *She didn't think about the gloves no longer being clean after she placed them against her clothing	F 812			

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F 812	Continued From page 25 and her bare skin. *She agreed those gloves would not be considered clean and that she touched the sandwich and continued to assist the resident with eating with those unclean gloves. 16. Observation on 6/5/25 at 8:23 a.m. of the refrigerator in the Spruce kitchenette revealed unenclosed flats (a tray used for transporting eggs in bulk) of raw eggs on the middle shelf above ready-to-eat Jello, applesauce, and juice cups. The bottom drawer of the refrigerator had a sign stating "Per CANS [Child and Adult Nutrition Services], eggs can't be stored above ready to eat foods. Store eggs in bottom drawer." 17. Interview with geriatric program DON B on 6/4/25 regarding glove use while assisting residents with dining revealed she felt staff usually wore gloves only when touching food. 18. Observation on 06/03/25 at 10:49 A.M. of the kitchenette on Spruce two revealed: *There were eight unopened 4-packs of Jello Snack Pack cups in a cabinet available for the residents as a snack. -One pack with a expiration date of 9/10/24. -One pack with a expiration date of 9/27/24. -One pack with a expiration date of 10/23/24. -Two packs with a expiration date of 10/25/24. -One pack with a expiration date of 12/3/24. -Two packs with a expiration date of 1/27/25. 19. Observation on 6/04/25 at 10:51 A.M. of the refrigerator and freezer compartment on Spruce two in the kitchenette revealed: *Two unopened Yoplait light vanilla yogurts with a expiration date of 6/2/25. *One unopened garlic butter spray with a expiration date of 9/8/24.	F 812			

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F 812	Continued From page 26 20. Interview on 6/4/25 at 11:06 AM. with MHA Y revealed: *The two bags of Ore-Ida Golden Fries belonged to a resident who lived on Spruce two. -She had indicated that staff at Human Services Center (HSC) had purchased the fries at the store for the resident, but the resident purchased them with his own money. *She had indicated that the red basin under the sink is used to put the dirty dishes in that have been picked up off the tables after the residents are finished eating. -Dirty dishes are first rinsed of any food particles or beverages left in the cups in the first area of the compartment sink. -Clean water and Ajax soap are added to the first compartment of the sink and the dirty dishes are washed there. -Dishes are rinsed with water in the second compartment of the sink. -The second compartment sink is filled up with water and one to two Steramine tablets are added per one gallon of water. -The QAC test strips would then be used to test the solution. -Dishes are soaked in the water containing the Steramine tablets in the second compartment of the sink. 21. Interview on 6/4/25 at 11:23 A.M. with Geriatric Program DON B revealed: *She was not aware there were outdated food items in the kitchenette. *Her expectation is staff should be monitoring the expiration date of all food items in the kitchenette. -Inspections of the kitchenette are to be done by staff every week and by a charge nurse every month.	F 812			

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F 812	Continued From page 27 -The MHAs are to be putting all new food items received from the kitchen behind or underneath any previous items that were already in the kitchenette. 22. Interview on 6/5/25 at 11:02 A.M. with Food Service Supervisor BB revealed: *Food is distributed from the main kitchen and then to each unit with issued dates and expiration dates. *Dietary staff do not monitor the kitchenettes in the units. *Unit staff on the units monitor the issue and expiration dates of food in their kitchenettes. 23. Review of the provider's October 2022 Manual Warewashing policy revealed: **"All cookware, dishware, and serviceware that is not processed through the dish machine will be manually washed and sanitized." **"Wash temperature at no less than 100 [degrees] F [Fahrenheit]". **"Appropriate test strips will be utilized to measure the concentration of the sanitizer solution. Results will be recorded on the Three-Compartment Sink Log." Review of the provider's undated Cleaning of Kitchen Appliances, Equipment, and Utensils policy revealed: **"Storage and handling of kitchen equipment and utensils: -Clean cups, glasses, plates, and bowls shall be handled by their bases, so as to prevent fingers and thumbs from contacting inside surfaces or lip contact surfaces. -Clean equipment and utensils shall be stored above the floor in a clean dry location in an area which protects them from splash, dust, and other	F 812			

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F 812	Continued From page 28 contaminations. -Clean equipment and utensils shall be thoroughly dry prior to storing." *"Daily cleaning/sanitization of soiled kitchen equipment, utensils, and assistive eating devices: -A three-compartment sink (one permanent compartment and two portable compartments) must be provided for manually washing, rinsing, and sanitizing equipment and utensils. Sink compartments must be large enough to accommodate immersion of the largest equipment and utensils. Note: One permanent sink compartment shall be designated for handwashing and may not be used for washing, rinsing, or sanitizing equipment and utensils." -"Drain boards and racks must be provided for holding washed, rinsed, and sanitized equipment and utensils to air dry." -"Manual washing, rinsing, and sanitizing must be done in the following manner: a) Obtain needed supplies from designated storage area: --Portable Sink (2) --Drain board and Rack --Dishwashing Detergent --Quaternary sanitizing tablet(s) b) Sinks must be thoroughly cleaned before each use. c) Equipment and utensils must be thoroughly washed in the first compartment of the three-compartment sink with a hot detergent solution that is kept clean. The detergent must be used according to the manufacturer's label directions. d) Equipment and utensils must be rinsed free from detergent with clean water in the second compartment of the sink. e) Equipment and utensils must be sanitized in	F 812			

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F 812	Continued From page 29 the third compartment of the sink by immersing them in warm water (1 gallon) and one quaternary sanitizing tablet(s) (use one tablet per 1 gallon of water- allow several minutes for tablet(s) to dissolve prior to immersing). Immerse items for at least one (1) minute. f) Equipment and utensils must be air-dried after sanitization using a rack and drain board." Review of the provider's 9/30/24 New Employee Orientation Checklist revealed: *"Dishwashing -Dishes washed on the unit are required to be washed using the 3-compartment sink method. -Additional tubs should be located under the kitchen sink. -Sanitizer and testing strips should be utilized". *"Food Handling -Wear gloves when preparing or serving patient food". *"Fridge [refrigerator] Temps [temperatures] -Complete daily fridge temp log -Ensure the temperature is safe for food storage -Immediately report concerns to [the] nurse". *"Food Storage -Date and label with date items are received and opened. -Food should be rotated and disposed of in accordance with safe storage, expiration dates and handling guidelines." Review of the provider's May and June 2025 Willow Shift Duties Checklist revealed "Check fridge temp" was marked completed each day starting on 5/1/25 through 6/4/25. Review of the provider's undated Food Storage policy revealed: *"All refrigerators and freezer temperatures are to	F 812			

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F 812	Continued From page 30 be monitored and logged on a DAILY basis. Completed forms are forwarded to Nurse Managers." ** Temperatures recommended by our dietitian and the state health department: Refrigerator: 36 degrees F to 41 degrees F. Freezers: 0 degrees F or lower. If outside range, temperature should be adjusted and if temperature continues to be outside of range report to Physical Plant Department." **Sealed Unopened Food: Discard on : Expiration date." **Until sealed foods are opened, go by expiration date." Review of the provider's undated Geriatric Program Inspection and Storage of Foods and Beverages Brought in for Residents policy revealed: "Policy: It is the policy of the SDHSC-Geriatric Program to inspect and properly store all foods and beverages brought in by visitors for resident consumption." "Storage of Food and Beverages: All foods and beverages will be labeled with the resident's initials and date it was received."	F 812			
F 880 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	F 880	To reduce risk of infection and mishandling of catheter supplies, Resident 39 catheter supplies have been replaced with new supplies and have been dated and initialed and stored in labeled cupboard. Patient 39 has been placed on enhanced barrier precautions to reduce the risk of infection related to an indwelling device. To ensure all SDHSC Geriatric patients are not at risk for having their specific supplies mishandled and appropriate precautions overlooked, policies and procedures have		

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F 880	Continued From page 31 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 prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct	F 880	been reviewed and revised as follows: A reference for Geriatric Program to refer to Enhanced Barrier Precaution Policy has been added to the following policies for indwelling devices: •Suprapubic catheter replacement and care •Catheterization – insertion, care, and removal of indwelling urethral catheter •Tracheostomy Care •PICC Lines and Midlines •Gastrostomy and Jejunostomy Feeding Tube – Formula, Water, Medication Administration •Gastrostomy and Jejunostomy Tube – Removal and Insertion •Wound Care •Multi Drug Resistant Organisms To ensure all Geriatric Staff understand policy and procedure for standard precautions and when additional precautions are required, Enhanced Barrier Precautions Policy and a review of Standard, Transmission Based, and Enhanced Barrier Precaution powerpoint education with related assessments is being sent out through HSC document management system, Policy Tech with a required completion date of July 18, 2025. Supervisors will ensure staff have completed by July 18 or prior to their next shift working after July 18. Staff who are on leave will complete the required reading and assessment prior to first shift working. Summary of the required reading completion will be reported to QAPI committee meeting by QAPI nurse or designee.		

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F 880	Continued From page 32 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 record review, observation, interview, and policy review, the provider failed to ensure infection control practices were maintained for: *The storage of suprapubic catheter (a tube surgically placed through the abdomen into the bladder to drain urine) supplies for one of one sampled resident (39). *The use of personal protective equipment (PPE) while caring for one of one sampled resident (39) who had a suprapubic catheter and required the use of enhanced barrier precautions (EBP) (a set of infection control practices to reduce the spread of infection) per their policy. *For appropriate glove use for one of one housekeeper (custodial crew leader) (S) while cleaning resident rooms. Findings include: 1. Review of resident 39's electronic medical record revealed: *He was admitted on 1/27/25.	F 880	To ensure continued compliance a review of Catheterization - Insertion, Care and Removal of Indwelling Urethral Catheter Policy and Suprapubic Catheter Replacement and Care and updates were made to reflect proper PPE required and site cleaning. Required reading and assessments for these policies are being sent out through HSC document management system, Policy Tech with a required completion date of July 18, 2025. Supervisors will ensure staff have completed by July 18 or prior to their next shift working after July 18. Staff who are on leave will complete the required reading and assessment prior to first shift working. Summary of the required reading completion will be reported to QAPI committee meeting by QAPI nurse or designee. To ensure complete understanding and execution of proper procedures for catheter cares, competencies will be completed with all nursing and direct care Geriatric staff. Competencies include knowledge and use of enhanced barrier precautions and standard precautions; catheter site care; care and storage of drainage bags and catheter tubing. Competencies will be completed by Infection Control RN, QAPI nurse, Director of Nursing, or designees. Competencies will be completed by July 18. Staff who are on leave will complete competency prior to their next working shift. Summary of the competency completion will be reported to QAPI committee meeting by QAPI nurse or designee.		

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F 880	Continued From page 33 *His 4/24/25 Brief Interview of Mental Status (BIMS) assessment score was 8, which indicated he was moderately cognitively impaired. *His diagnoses included prostate enlargement and obstructive uropathy (a blockage in the urinary tract, preventing urine from draining properly). *A 3/25/25 physician's order, to "Cleanse suprapubic area with soap and water. Pat dry and change split sponge gauze PRN [as needed]." *A 4/23/25 physician's order, for a "New leg bag every month." *A 6/3/25 physician's order, for "May place leg [drainage] bag on suprapubic catheter in am [morning] and remove at HS [bedtime], large urine collection [drainage] bag on at HS." *A 6/3/25 physician's order, to "Clean catheter leg bag every night and urine collection bag every am with 1:10 ratio bleach/water-use funnel to flush diluted bleach solution through tubing, wipe outside of bag with soap and water to clean; allow bag to air dry and keep in basin with paper towel in bottom of basin; change paper towel daily." 2. Observation and interview on 6/2/25 at 1:36 p.m. of resident 39's room revealed: *He was uncertain if his catheter had been removed. *Staff members did not wear a gown when they provided his care. *There was no signage on the door or near the entrance of his door indicating that resident 39 was on EBP. 3. Observation on 6/2/25 at 4:44 p.m. in resident 39's room and shared bathroom revealed: *The bathroom was shared by the two residents who resided in rooms on either side of the bathroom.	F 880	To ensure ongoing compliance with procedures audits will be completed by Charge Nurses or designees. Audits include proper use of standard and enhanced barrier precautions and catheter site care, care and storage of catheter supplies. Three audits will be completed per week for any unit with resident requiring catheter cares until 2 months of 100% Compliance. The summary of this audit will be reported to QAPI monthly by the QAPI nurse or designee. At the end of 2 months of 3 times per week auditing, auditing of the form will be done monthly and will be reported to QAPI committee monthly by the QAPI nurse or designee. To ensure all Housekeeping Staff understand policy and procedure for hand hygiene, Handwashing Technique and Use of Hand Sanitizers Policy and related assessment is being sent out through HSC document management system, Policy Tech with a required completion date of July 18, 2025. Infection Control RN and Housekeeping Supervisors will ensure staff have completed by July 18 or prior to their next shift working after July 18. Staff who are on leave will complete the required reading and assessment prior to first shift working. Summary of the required reading completion will be reported to QAPI committee meeting by QAPI nurse or designee. To ensure ongoing compliance with handwashing techniques, Infection Control		

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F 880	Continued From page 34 *There was a cabinet with four doors inside the bathroom. The cabinet was not labeled with the residents' names. *Two stacked gray basins were together inside the bathroom cabinet. -A paper towel and a catheter urine drainage bag with an attached drainage tube were inside the top basin. --There was no protective cap on the end of that drainage tube. --The date "5/22" was marked in the corner of that drainage bag, but it was not marked with the resident's name or initials to identify which resident it was used for. -The bottom basin was labeled "Dirty 5/22." *A graduated measurement container was on a washcloth on the shelf inside the cabinet, and was not labeled or dated. *There were no gowns or eye protection in resident 39's room or shared bathroom. 4. Interview on 6/3/25 at 9:20 a.m. with mental health aide (MHA) AA and resident 39 revealed: *She confirmed she had assisted resident 39 to get dressed that day. *Resident 39 used an "overnight bag" at night and wore a "leg bag" during the day. *She wore gloves when she cared for resident 39's catheter, but did not need to wear a gown. *Resident 39 walked "hand-held" with two staff members assisting him, each holding one of his hands. *She did not need to wear gloves or a gown when she assisted resident 39 with walking. 5. Observation and interview on 6/3/25 at 9:35 a.m. of the W1 soiled utility room and resident 39's room with MHA AA revealed: *The soiled utility room was used to clean	F 880	RN or designee will audit hand hygiene by housekeeping staff minimum of 2 audits per week until 2 months of 90% Compliance. The summary of this audit will be reported to QAPI monthly by the QAPI nurse or designee. At the end of 2 months of 2 times per week with 90% compliance, QAPI Committee will determine frequency of continued audits. Willow 1 Soiled Utility Room had a handwashing sink that was not working. That sink has been repaired and is functioning with adequate flow with both hot and cold water for staff to effectively wash their hands. The repairs to the sink was completed prior to end of day 6/5/2025. The metal sink basin had rust build up that has been removed on July 1, 2025. To ensure continued functioning of the hand washing sink and ensure metal sink basin remains clean and free from rust and film, the catheter cares audit will monitor hand washing sinks and basin sinks cleanliness and condition. Three audits will be completed per week for any unit with resident requiring catheter cares until 2 months of 100% Compliance. The summary of this audit will be reported to QAPI monthly by the QAPI nurse or designee. At the end of 2 months of 3 times per week auditing, auditing of the form will be done monthly and will be reported to QAPI committee monthly by the QAPI nurse or designee.		

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F 880	Continued From page 35 resident 39's catheter equipment. *The room contained a two-part metal sink, a separate hand washing sink, and a hopper (a specialized sink flushing device used to rinse soiled items and linens of body fluids). *On the right-side counter of the metal sink, there was a graduated measurement container that contained two syringes, a bottle of hand sanitizer, and two one-gallon jugs of bleach used to clean resident 39's catheter equipment. -The graduated container and syringes were stored in the soiled utility room. --That container was not labeled with resident 39's name or dated. --The syringes were not labeled with resident 39's name. One syringe was dated "4/23." *The left-side counter of the metal sink contained vacuum cleaner parts. *She stated that the urinary drainage catheter bag was to be transported to the soiled utility room in the "dirty" basin, and after it was cleaned, the catheter was placed in the "clean" basin and was to be returned to resident 39's bathroom. She called that process the "two-bin system." *She stated she used "200 cc [cubic centimeters]" of bleach to clean the catheter bag. The bleach was measured in the graduated container and drawn into the syringe. She would "shake it around" to coat the inside of the catheter bag, then drain the bleach into the sink. -She stated no water was needed to dilute the bleach to clean or rinse resident 39's catheter bag or tubing. -She confirmed that she used the sink and did not use the hopper when she drained the bleach out of resident 39's catheter bag. *She stated she did not need to wear a gown when she cleaned of resident 39's catheter bag. *She confirmed that the basins and the catheter	F 880	To ensure readily accessible PPE, resident will be assessed if storing PPE in resident room is appropriate. If not appropriate to store PPE in resident room, there is a supply of PPE at nurses station.	7/18/2025	

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F 880	Continued From page 36 bag were stored stacked inside each other in the left side of resident 39's unlabeled shared bathroom cabinet. 6. Observation on 6/3/25 at 9:45 a.m. of the W1 soiled utility room revealed: *The metal sink basin used to clean resident 39's catheter bag contained a black film and rust. *The right-side counter of the metal sink, where the items used to clean resident 39's catheter bag were stored, contained spots of a white film. *The hot and cold water of the hand-washing sink produced a small trickle of water that decreased to drips when turned on, which did not provide a sufficient flow of water for staff to effectively wash and clean their hands. 7. Observation on 6/3/25 at 3:24 p.m. revealed: *MHAs Q and M entered resident 39's room. -They did not complete hand hygiene (hand washing or the use of hand sanitizer) and did not put on gowns or gloves. *No signage on the door or near the entrance of his door indicated that resident 39 was on EBP. *MHA Q knelt on the floor beside resident 39's bed and assisted him to put on his shoes. *MHA M had a gait belt (a waist strap gripped as a support for safe mobility and transfers) removed the gait belt from her waist and placed it around resident 39's waist. *MHAs Q and M assisted resident 39 to stand and walk while holding the gait belt and his hands, to the whirlpool room. *MHA M assisted resident 39 to remove his shirt while seated on the whirlpool tub seat and into the whirlpool tub. *MHA Q exited the whirlpool room, entered resident 39's room, then returned to the whirlpool room carrying an uncovered gray basin with a	F 880			

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F 880	Continued From page 37 graduated measurement container, an alcohol wipe, and a box of gloves. He did not wear a gown or gloves. *Resident 39 was observed partially undressed, seated on the whirlpool tub seat. *MHA M wore gloves but did not wear a gown. Continued observation and interview on 6/3/25 at 3:36 p.m. with MHA Q revealed: *He carried resident 39's gray basin labeled "dirty" with the empty graduated urine collection container, and a box of gloves uncovered under his left arm and against his clothes from the whirlpool room to the W1 soiled utility room and set them on the right-side counter of the metal double sink. -The dirty basin was stacked inside another basin that was labeled "clean." -There was no barrier between the "clean" basin and the sink counter. *He stated he only needed to wear gloves when cleaning resident 39's catheter equipment and did not know of any other PPE that would be required to use when cleaning those items. *He confirmed resident 39 wore a "leg bag during the day," as a fall prevention intervention. *Once in the soiled utility room, MHA Q used hand sanitizer and put on a pair of gloves. He did not put on a gown or eye protection. *With those gloved hands, he: -Poured bleach into the container that he had used to empty urine from resident 39's catheter bag. -Added water to that container and rinsed it. -Removed those gloves, cleansed his hands with hand sanitizer, and put on a new pair of gloves. -Then placed a paper towel and the cleaned container into the basin marked "clean." -Placed a second paper towel and the "clean"	F 880			

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F 880	Continued From page 38 basin into the "dirty" basin. *He stated he used a "Ten to one ratio" (ten parts water to one part bleach) to clean all of resident 39's catheter equipment. *The graduated measurement container that was stored in the soiled utility room was marked with the date "6/3/25," resident 39's name, and had two marked lines on it, one labeled "bleach" and the other "H2O." *MHA Q removed his gloves, did not perform hand hygiene, placed the box of gloves on top of the graduated measurement container that was inside the two stacked basins, held them under his arm, against his shirt, and opened the door with his opposite hand. *When asked about the hand-washing sink, he stated he was unaware that the hand-washing sink did not work and confirmed that it did not produce a stream of water when turned on and off. *MHA Q then carried those above items uncovered to resident 39's room and placed them into the unlabeled cabinet in the shared resident's bathroom. 8. Observation on 6/4/25 at 8:39 a.m. of MHA CC and MHA J revealed: *MHA J had a gait belt, removed that gait belt from her waist, and placed it around resident 39's waist. *MHA J and MHA CC assisted resident 39 to stand and walk while holding the gait belt and his hands, to his room and into his shared bathroom. *Without performing hand hygiene, MHA J put on gloves and assisted resident 39 to sit on the toilet. *Without performing hand hygiene or putting on gloves, MHA CC assisted resident 39 to lower his pants and to sit on the toilet. Once resident 39	F 880			

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F 880	Continued From page 39 was seated, MHA CC put on a pair of gloves. *After resident 39 was finished, he assisted the staff in readjusting his undergarments. *With those same gloved hands, MHAs J and CC assisted resident 39 from the bathroom to his bed. *Resident 39 was not offered an opportunity to wash his hands after having used the toilet. Observation on 6/4/25 at 8:45 a.m. in resident 39's room revealed: *MHA CC without completing hand hygiene, put on a pair of gloves. *MHA J completed hand hygiene and put on gloves. With those gloved hands, she: -Placed two open plastic bags on the recliner. -Placed four wash cloths in the bottom of resident 39's hand washing sink in his room. -Ran water on those four wash cloths. -Placed soap on two of those washcloths. -Placed those washcloths into the plastic bags on the recliner, and then removed her gloves. *Without performing hand hygiene, mental health aide J put on a pair of gloves, and with those gloved hands, she lowered the front waistband of resident 39's pants to expose his suprapubic catheter. *MHA CC used a soapy washcloth to wash the skin around the suprapubic catheter insertion site, then washed down the catheter tubing, back up the tubing, and then washed around the suprapubic catheter insertion site a second time. She repeated those steps with another wet washcloth that did not contain soap, then pulled resident 39's pants back up to cover the suprapubic catheter site. -There was no split sponge gauze observed at the suprapubic insertion site. *MHA CC and J then removed their gloves. MHA	F 880			

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F 880	Continued From page 40 CC completed hand hygiene. *MHA J did not complete hand hygiene and placed the gait belt that was worn by resident 39 around her waist and exited resident 39's room carrying the bags of soiled linen. *MHA J and CC did not wear gowns when they completed resident 39's catheter care. 9. Observation and interview on 6/4/25 at 1:17 p.m. with registered nurse (RN)/nurse manager E in resident 39's room revealed: *She confirmed: *There were no signs that indicated resident 39 was EBP. *The bathroom was shared by the two residents who resided in rooms on either side of the bathroom. *The cabinet in that bathroom was not labeled with the residents' names. *Two stacked gray basins were together inside the bathroom cabinet. A paper towel and a catheter urine drainage bag with an attached drainage tube were inside the top basin. --There was no protective cap on the end of that drainage tube. -The date "5/22" was in the corner of the urinary drainage catheter bag. That bag did not contain the resident's name or initials. -The bottom basin was labeled "Dirty 5/22." -The graduated measurements container was on a washcloth on a shelf inside the cabinet and was not labeled or dated. *There were no gowns or eye protection in resident 39's room or shared bathroom. *RN E expected that the catheter bag to have been labeled with the resident's initials, and a cap to have been on the end of that tube. *She was unaware that resident 39 required the	F 880			

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F 880	Continued From page 41 use of EBP. 10. Interview on 6/04/25 at 1:25 p.m. and again at 3:04 p.m. with infection preventionist (IP) C revealed: *She confirmed that resident 39 had a suprapubic catheter and required the use of EBP with all close contact care, including assisting with toileting, bathing, and care of his catheter bag. *She expected there would have been a sign outside of resident 39's room to notify staff that resident 39 was on EBP and what PPE was required to use while completing his care needs. *She confirmed that items, including bleach, a graduated measurement urine collection container, and syringes, would be left in the soiled utility room and used to clean resident 39's catheter. -She expected those items to be changed monthly, dated, and labeled with resident 39's initials. *She expected that staff members would use a two-basin system for transporting resident 39's catheter items in the hall. She expected those bins to be covered during transport and stored in resident 39's room, and not in the bathroom shared with another resident. *Staff members received education when they were hired and annually on hand washing and the use of PPE. *She expected staff members to wash their hands when they were visibly soiled or to use hand sanitizer when changing their gloves. 11. Interview on 6/5/25 at 11:38 a.m. with geriatric program director of nursing (DON) B revealed: *Resident 39 had a suprapubic catheter that was last changed on 5/22/25 as ordered. -That catheter was ordered to be changed	F 880			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/05/2025
NAME OF PROVIDER OR SUPPLIER SD HUMAN SERVICES CENTER - GERIATRIC PROGRAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3515 BROADWAY AVE YANKTON, SD 57078		
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F 880	Continued From page 42 monthly and was not required to be changed to obtain a urine specimen or after a resident had a UTI. *She expected resident 39 to have been on EBP and that staff members would have worn a gown and gloves when providing close contact care to resident 39. *She expected staff to wash their hands or use hand sanitizer when they changed their gloves. 12. Review of the provider's ENHANCED BARRIER PRECAUTIONS door sign revealed: *"TO PREVENT THE SPREAD OF INFECTION, Staff performing the following resident care activities: -Dressing, Bathing/Showering, Changing Linens, Providing Hygiene, Assisting with toileting, Transferring (with high degree of contact - PT [physical therapy] bathing, etc.), Device care/use (urinary catheter, feeding tube, etc.), Chronic wound care Must wear the following PPE: PRACTICE HAND HYGIENE *Including before entering and when leaving the room WEAR GLOVES WEAR GOWNS ..." 13. Observation on 6/3/25 at 9:49 a.m. with custodial crew leader (CCL) S while cleaning resident rooms revealed: *Without completing hand hygiene, CCL S put on a pair of gloves and entered room 207. *With those gloved hands, CCL S completed the cleaning of that room, exited that room, removed those gloves, disposed of them in her housekeeping cart, and pushed that cart down the hall. *Without completing hand hygiene, CCL S reached into the next room, turned on the light switch, put on a pair of gloves, and began to clean that room.	F 880			

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NAME OF PROVIDER OR SUPPLIER SD HUMAN SERVICES CENTER - GERIATRIC PROGRAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3515 BROADWAY AVE YANKTON, SD 57078		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page 43 Observation and interview on 6/4/25 at 11:26 a.m. with CCL S while cleaning resident rooms revealed: *Without completing hand hygiene, CCL S put on a pair of gloves and entered a resident's room. With those gloved hands, she completed the cleaning of that room, exited the room, removed her gloves, disposed of them in her housekeeping cart, and without completing hand hygiene, she put on a new pair of gloves. *CCL S stated she was taught to change her gloves between every room she cleaned when she received her training when she was hired about six months ago, and that this was her routine practice between each room she cleaned. -She had not been told that she needed to wash her hands or use hand sanitizer when she changed her gloves *She confirmed that she removed her gloves and, without washing her hands or using hand sanitizer, she had put on a new pair of gloves. *CCL S cleaned all the resident rooms on the W1 hall each day. Interview on 6/4/25 at 3:04 p.m. with infection preventionist (IP) C revealed: *All staff receive education on hand washing and the use of hand sanitizer when they are hired and annually. *She expected all staff members, including housekeepers, to complete hand hygiene whenever they changed their gloves. *She expected all staff member to wash their hands with soap and water when they were visibly dirty. Review of the provider's undated Handwashing Techniques and Use of Hand Sanitizers policy revealed:	F 880			

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NAME OF PROVIDER OR SUPPLIER SD HUMAN SERVICES CENTER - GERIATRIC PROGRAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3515 BROADWAY AVE YANKTON, SD 57078		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	Continued From page 44 "Protect yourself and your patient by frequently hand washing or the use of hand sanitizers if your hands are not obviously soiled." "Cleanse hands before: ... Caring for a patient, Donning gloves." "Cleanse Hands after: Using [the] toilet or assisting [the] patient [resident] in using [the] toilet, Handling body secretions, Giving care to patient or handling his equipment, ... Following the removal of gloves." Review of the provider's undated Suprapubic Catheter Replacement and Care policy revealed: *The policy did not include the need for EBP, gowns, or eye protection in the care of a resident with a suprapubic catheter. *For "Care of Indwelling Catheter:" there was a referral to "(See policy entitled "Catheterization-Insertion, Care and Removal of Indwelling Urethral Catheter" located in this document)." Review of the provider's undated Catheterization-Insertion, Care and Removal of Indwelling Urethral Catheter revealed: *The policy did not include the need for EBP, gowns, or eye protection in the care of a resident with a catheter. *"Care of Leg Bag and Drainage Bag: Patient's name or initials and date bag initiated or changed should be on the leg bag and drainage bag." *"When alternating between the leg bag and drainage bag, they are washed daily, after use with diluted bleached solution (1 part bleach to 10 parts water). Perform hand hygiene before and after cleaning the bag. Apply gloves per precaution standards. Wipe the outside of the leg bag or drainage bag with soap and then rinse with water. Use [a] funnel to flush diluted bleach	F 880			

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NAME OF PROVIDER OR SUPPLIER SD HUMAN SERVICES CENTER - GERIATRIC PROGRAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3515 BROADWAY AVE YANKTON, SD 57078		
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F 880	Continued From page 45 solution (1 part bleach to 10 parts water) through tubing. Completely fill and soak the inside of the leg bag or drainage bag with diluted bleach solution. The bag and tubing with water." ***"Daily cleanse around [the] area where [the] catheter enters the urethral meatus with soap and water. Inspect the tissue around the suprapubic insertion site for signs of irritation." -Cleansing of the suprapubic insertion site was not addressed. Review of the provider's undated Enhanced Barrier Precautions policy revealed: ***"Enhanced Barrier Precautions are recommended for residents during high contact resident care activities with any of the following conditions which places them at high risk ... indwelling medical device ... urinary catheters." ***"Perform hand hygiene before and after leaving the room and between patient cares in addition to the use of gowning gloves for high contact resident care activities ... These cares include the following activities: Dressing ..."	F 880			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A067	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02 B. WING _____		(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER SD HUMAN SERVICES CENTER - GERIATRIC PROGRAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3515 BROADWAY AVE YANKTON, SD 57078		
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E 000	Initial Comments	E 000			
K 000	A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness requirements for Long Term Care Facilities, was conducted on 6/4/25. SD Human Services Center - Geriatric Program (Buildings 01 & 02) was found in compliance. INITIAL COMMENTS	K 000			
K 000	A recertification survey was conducted on 6/4/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. SD Human Services Center - Geriatric Program (Building 01) was found in compliance. INITIAL COMMENTS	K 000			
K 000	A recertification survey was conducted on 6/4/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. SD Human Services Center - Geriatric Program (Building 02) was found in compliance.	K 000			

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

TITLE

(X6) DATE

James J. [Signature], Acting Administrator

7/2/2025

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

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10719SD	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER SD HUMAN SERVICES CENTER - GERIATRIC PROGR		STREET ADDRESS, CITY, STATE, ZIP CODE 3515 BROADWAY AVE POST OFFICE BOX 7600 YANKTON, SD 57078			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 6/2/25 through 6/5/25. SD Human Services Center-Geriatric Program was found in compliance.	S 000			
S 000	Compliance/noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 6/2/25 through 6/5/25. SD Human Services Center-Geriatric Program was found in compliance.	S 000			

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

TITLE

(X6) DATE

STATE FORM

6899

PHTS11

If continuation sheet 1 of 1



Acting Administrator

06/20/2025