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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/06/24 through 8/08/24. Dells Nursing and Rehab Center Inc. was found not in compliance with the following requirements: F658, F684, F803, and F812.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: A. Based on record review, interview, and policy review, the provider failed to report one of one sampled resident's 8 blood sugars that were out of parameter to the doctor per the doctor's order. Findings include: 1. Record review on 8/7/24 of resident 8's electronic medical record (EMR) revealed: *There was an order from his doctor on 3/21/24 to check his blood sugar four times daily and to call the provider if his blood sugar is less than 60 or greater than 500. *He had a blood sugar on 5/14/24 at 7:04 p.m. that was 542 and again on 5/25/24 at 7:01 p.m. that was 517 -There was no documentation in his EMR that the doctor was notified on the high blood sugars. 2. Interview on 8/8/24 9:41 a.m. with licensed practical nurse (LPN) G revealed she:	F 658	Unable to correct prior noncompliance of letting physician know when resident 8's blood sugar is out of range. Resident 27's bag balm was removed from bedside immediately. DON, nurse manager, or designee will educate all nurses on following resident physician orders along with any updated policies by 9/06/24. Administrator, DON, and interdisciplinary team will review and revise policies and procedures as necessary. DON or designee will audit nurses letting physicians know if resident has blood sugar out of range and storage of resident medications weekly for 4 weeks and monthly for 2 months. DON or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	9/6/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Calyn Togel
TITLE: Administrator
(X6) DATE: 8/30/2024

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

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F 658	Continued From page 1 *Agreed the high blood sugars were not reported to the doctor. *Would have been expected that the doctor to have been notified. 3. Interview on 8/8/24 at 10:37 a.m. with nurse manager C revealed: *She stated they had a new blood sugar parameter reporting policy as of 8/1/24 with the medical director. *She agreed resident 8's blood sugars had not been reported to his doctor and should have been faxed per the physicians orders. 4. Interview on 8/8/24 at 2:47 p.m. with administrator A regarding resident 8 revealed: *She had been auditing the staff to ensure they had been reporting abnormal blood sugars. *She had not been aware they were not reporting resident 8's abnormal blood sugar tests per physician's orders. 5. The provider's blood sugar parameter policy dated 8/1/24 revealed: *The purpose was to ensure adequate blood sugar parameters are reported and monitored by physicians. B. Based on observation, interview, record review, and policy review, the provider failed to follow their policy regarding storage of resident prescriptions for one of one sampled resident (27) who had prescription ointment on her bedside table. Findings include: 1. Observation on 8/6/24 at 2:25 p.m. in resident 27's room revealed there was a green tin of Bag Balm with a prescription label attached to it on the	F 658		

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F 658	Continued From page 2 resident's bedside table. 2. Interview on 8/7/24 at 3:58 p.m. with licensed practical nurse (LPN) G about storing prescription medications in a resident's room revealed: *A resident must have a physician's order for a medication to be kept at their bedside. *The resident must also be assessed for competencies regarding what medication it was, how to use it, how much to use, and when to use it. 3. Continued interview on 8/8/24 at 9:29 a.m. with LPN G about resident 27's prescription ointment revealed: *She confirmed there was no physician's order for resident 27's Bag Balm to have been kept at her bedside. *Resident 27 was not able to open the tin of ointment by herself. *The ointment was "probably there for staff" to use when they were performing perineal cares. *It should have been stored in the medication room. 4. Interview on 8/8/24 at 10:02 a.m. with director of nursing (DON) B about resident 27's prescription ointment revealed: *She indicated it was acceptable for resident 27 to have the Bag Balm at her bedside for the staff to use. *She confirmed that resident 27 was not able to use the ointment by herself. 5. Review of resident 27's electronic medical record revealed: *There was no physician's order for the Bag Balm to have been stored at resident 27's bedside. *There were no medication self-administration	F 658		

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F 658	Continued From page 3 assessments. *Resident 27 was admitted on 3/21/23 and had a Brief Interview for Mental Status score of 7, which suggested severe cognitive impairment. *There was a physician's order for Bag Balm Ointment "APPLY TOPICALLY TO PERI AREA AS DIRECTED" that started on 7/19/24. *The resident's care plan did not indicate anything about Bag Balm being stored at her bedside. 6. Review of the provider's 6/15/24 Bedside Medication Storage policy revealed: *"Bedside medication storage is permitted for residents who wish to self-administer medications, upon the written order of the prescriber and once self-administration skills have been assessed and deemed appropriate in the judgement of the facility's interdisciplinary resident assessment team." *Procedures: -"A. A written order for the bedside storage of medication is present in the resident's medical record." -"B. Bedside storage of medications is indicated on the resident medication administration record (MAR) and in the care plan for the appropriate medication." 7. Review of the provider's 6/15/24 Storage of Medications policy revealed: *"Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. *The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications."	F 658		
F 684 SS=G	Quality of Care	F 684		

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F 684	Continued From page 4 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to report one of one sampled resident's (12) bruises of unknown origin to the nurse manager C and director of nursing (DON) B for further investigation. Findings include: 1. Observation and Interview on 8/06/24 at 8:32 a.m. with resident 12 revealed: *She had a bruise on her forehead above her right eye and stated she didn't know how she had gotten it. *The bruise measured 1¼ inch x ¼ inch and was dark purple with light yellow around the edge. 2. Interview on 8/7/24 at 10:36 a.m. with certified nursing assistant (CNA) K revealed she did not know how or when resident 12 got the bruise above her right eye. 3. Interview on 8/7/24 at 10:38 a.m. with licensed practical nurse (LPN) G revealed: *She had spoke to resident 12's daughter whom stated she had dropped her phone while they were visiting, and may have bumped her head	F 684	This deficiency has the potential to impact all residents. Administrator, DON, and interdisciplinary team in collaboration with medical director will review, revise, or create necessary policies and procedures to ensure staff are aware and follow investigating and documenting resident injuries of unknown origin. Administrator, DON, or designee will provide education to all licensed and unlicensed staff regarding their roles for ensuring the safety and wellbeing of residents along with the importance of their mandatory role. DON or designee will audit injuries of unknown origin weekly for 4 weeks and monthly for 2 months. DON or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	9/6/24

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F 684	Continued From page 5 while getting the phone. *She stated, "or she may have bumped on the bed rail." *She had not documented this but had said she would. 4. Phone interview on 8/7/24 at 3:00 p.m. with resident 12's daughters revealed: *They were not aware of the bruise above resident 12's right eye. *She had been contacted about a week ago in regards to her pneumonia vaccine but nothing about the bruise. *They had seen her mother last Friday during the facility picnic and she did not have a bruise then. *Their mother did not mention dropping her phone during any phone conversations. *Their mother said she was sitting in her chair during their conversations. 5. Interview on 8/7/24 at 3:15 p.m. with LPN G revealed: *She had mixed up the dates the bruise was found. *She had received report of the bruise on 8/5/24 at 8:00 a.m. *She stated she should have called the family that morning but she didn't. *She had talked to resident 12's daughter when she called in the afternoon and reported it to her then *She would have expected a progress note and pain assessment. *She should have faxed the doctor but did not. *She agreed she should have reported it to the charge nurse or director of nursing (DON) for an investigation but she did not. *The skin assessment would flag the MDS coordinator to investigate.	F 684		

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F 684	Continued From page 6 *She agreed it was an injury of unknown origin and should have been investigated to rule out abuse and neglect. 6. Interview on 8/7/24 at 3:38 p.m. with DON B revealed: *She was aware of the bruise above resident 12's right eye. *She said an investigation with other staff to see if they noticed the bruise should have been completed. *She stated the family and doctor should have been notified. *She agreed the bruise should have been investigated from the beginning. *A skin assessment to monitor the color of the bruise for healing progression should have been placed on the medication administration record (MAR). *She stated there was a bruise policy that would direct the process when a bruise occurred and if the resident could not explain how it happened. 7. Interview on 8/7/24 at 4:04 p.m. and 4:30 p.m. with administrator A revealed: *She was aware of the bruise above resident 12's right eye and it had not been investigated, nor had it been reported to the department of health (DOH) per policy. *She reported at 4:30 p.m. that the bruise had been investigated and she thought the bruise was from dropping her phone and it had hit her. -She stated the bruise was not reported to DOH because of the investigated findings. -The DOH complaints department confirmed this was not reported. 8. Interview on 8/08/24 at 1:32 p.m. LPN G revealed:	F 684		

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F 684	Continued From page 7 *She stated it should have flagged from the skin assessment to DON for an investigation. *Resident 12's bruise should have been put on the medication administration record (MAR) so it could be monitored daily but she did not do this stating, "if it's not charted, it's not done." 9. Interview on 8/08/24 at 1:40 p.m. with DON B revealed: *Skin assessments do not flag the minimum data set coordinator and DON for further investigations. *She agreed LPN G should have known that the skin assessment would not flag or notify the MDS/DON. *She agreed that LPN G knew she should have reported a bruise of unknown origin to the nurse manager. 10. Interview on 8/08/24 at 2:13 p.m. with CNA L revealed: *She would complete a resident bath or shower and get the nurse to do their skin assessment. *She would report any new bruises or skin concerns to the charge nurse, nurse manager, or DON. *She was not aware that bruises were investigated. 11. Interview on 8/08/24 at 2:21 p.m. with administrator A revealed: *She stated a bruise of unknown origin would be investigated by DON B and nurse manager C. She agreed the process for reporting the bruises for further investigation was broken. *She had been monitoring this process for a few months but had recently stopped because they were doing a good job' -She stated, "clearly it had fallen back to the old	F 684		

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F 684	Continued From page 8 ways." 12. Record review of resident 12's electronic medical record (EMR) revealed. *The bruise located above her right eye was not documented on the MAR. *The family was not notified of the bruise. *The charge nurse and DON were not notified of the bruise to initiate the investigation. 13. The provider's bruise policy dated October 2023 revealed: *The purpose was,"to detect and monitor bruises early." *Identified bruises would be evaluated by nursing. *The bruise would be placed on the MAR for daily monitoring until resolved. *The color of the bruise, mechanism of injury if known and contributing factors if applicable, and notification of family and physician would be documented in the nurse's notes.	F 684		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as	F 803	Unable to correct prior noncompliance. Administrator or designee will educate dietary cooks on adequate portions by 9/06/24. Administrator or designee will audit adequate portion sizes weekly for 4 weeks and monthly for 2 months.	9/6/24

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F 803	Continued From page 9 input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on menu review, observation, and interview, the provider failed to ensure adequate portions were served according to the menu for one of one observed meal. This had the potential to affect all residents receiving the main menu in the facility. Findings include: 1. Review of the provider's menu for lunch on 8/8/24 revealed the following main menu items: *One cup of taco bake. *The pureed portion size was 2/3 cup. 2. Observation on 8/8/24 from 11:43 a.m. to 12:11 p.m. in the kitchen for lunch service revealed: *Cook H set up the steam tables, placed pans of food into the steam table, and placed the serving scoops next to each pan of food. *She used a 1/2 cup scoop for the taco bake, and another 1/2 cup scoop for the pureed taco bake. -1/2 cup of taco bake was 50% less than what the menu called for. -1/2 cup of pureed taco bake was about 33.33% less than what the menu called for. 3. Interview at that time with cooks H and I about	F 803	Administrator, dietary manager, and interdisciplinary team will review and revise policies and procedures as necessary. Administrator or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	

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F 803	Continued From page 10 the menu revealed: *Cook H had been working at that facility for about three weeks. *She had not made that recipe before. *Neither Cook H nor Cook I were aware that the serving size for the regular taco bake was one cup, and the serving size for the pureed taco bake was 2/3 cup. *Cook H indicated that she was trained to use the 1/2 cup scoop for every recipe. *When asked if cook H was aware how to verify the correct serving size, she looked at the posted menu with each diet listed and the serving sizes, but said, "No I was not aware of that." *Cook H continued to use the incorrect scoop sizes for the remainder of the meal service. 4. Interview on 8/8/24 at 2:55 p.m. with administrator A about the above observations revealed: *She was not aware that the dietary staff served the wrong portion sizes for lunch that day. *She was the acting dietary manager as the previous one had ended their employment the previous week.	F 803		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812	Dishwasher has been adequately cleaned and delimed. Administrator or designee will educate dietary staff on their roles and responsibilities to ensure adequate cleaning and deliming of the dishwasher by 9/06/24. Administrator or designee will audit dishwasher cleanliness weekly for 4 weeks and monthly for 2 months.	9/6/24

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F 812	Continued From page 11 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 ensure one of one dishwasher was adequately cleaned and delimed on a regular basis to prevent food scum and limescale buildup. Findings include: 1. Initial kitchen observation on 8/6/4 from 8:24 a.m. to 8:35 a.m. revealed: *The dishwasher was in use to clean dishes from breakfast. *There was a line of limescale buildup on the outside of the door where water was spraying out of a seam. *There was a buildup of food scum on the outside borders and inside seams of the dishwasher doors. *Limescale buildup was present on the wash arms and piping inside the dishwasher. 2. Interview on 8/8/24 at 11:57 a.m. with cook I and dietary aide J about the dishwasher revealed: *They did not know when the dishwasher was cleaned or how often. *Dietary aide J had never cleaned or delimed the dishwasher before. *Cook I had not been tasked with cleaning or deliming the dishwasher "in a long time." *The night shift was responsible for cleaning and	F 812	Administrator, RD, dietary manager, and interdisciplinary team will review and revise policies and procedures as necessary. Administrator or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	

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F 812	Continued From page 12 deliming the dishwasher. 3. Interview on 8/8/24 at 2:55 p.m. with administrator A about the dishwasher revealed: *She thought the dishwasher was supposed to have been delimed once per week. *The instructions and deliming schedule were hanging on the wall across from the dishwasher. *She confirmed the night shift was responsible for cleaning and deliming the dishwasher. *She was not aware of the state of the dishwasher. 4. Review of the dishwasher deliming schedule revealed the last time it was recorded that the dishwasher was delimed was on 6/12/24, about two months ago. 5. Review of the provider's 3/23 Dishwashing policy revealed: *Policy: "Dietary staff will ensure that food preparation equipment, dishes, and utensils are [effectively] cleaned and sanitized to destroy potential disease carrying organisms, and ensure equipment is stored in a protective manner." *Procedure: -"1. Follow the manufacturer's instructions for operation. ...14. The [dietary manager] will monitor completion of tasks and accuracy of records."	F 812		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	**1400 THRESHER DR DELL RAPIDS, SD 57022**

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K 000	INITIAL COMMENTS A recertification survey was conducted on 8/6/24 for compliance with 42 CFR 483.90 (a)&(b) requirements for Long Term Care Facilities. Dells Nursing and Rehab Center Inc was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K281 and K522 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 281 SS=B	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to ensure adequate illumination of means of egress was provided at one of six discharge locations (boiler room and laundry exterior exits). Findings include: 1. Observation on 8/6/24 at 9:45 a.m. revealed the second exit out of the laundry room and the second exit out of the boiler room were to the exterior of the building together in a recessed walled area below grade. The exit discharge was provided with a single lamp light fixture. The lamp was a compact	K 281	Maintenance director added light blub to ensure adequate illumination of means of egress. Administrator will educate maintenance director on adequate illumination by 9/6/24. Maintenance director or designee will audit adequate lighting for means of egress weekly for 4 weeks and monthly for 2 months. Maintenance director or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	9/6/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Calyn Togel	Administrator	8/30/24

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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K 281	Continued From page 1 fluorescent bulb. Lighting shall be provided such that minimum lighting is still provided in the event a single lighting source is lost. That lighting shall also be capable of providing one and one-half hours of emergency lighting upon loss of normal power. Interview with the maintenance supervisor at the time of the above observation confirmed that condition. He was not aware that exit discharge was not in compliance with the minimum lighting requirements. He also was not sure if the fixture was on emergency backup power. This deficiency has the ability to affect two required egress discharge paths.	K 281		

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 8/6/24. Dells Nursing and Rehab Center Inc was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Calyn Togel
TITLE: Administrator
(X6) DATE: 8/30/2024

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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AUG 30 2024

South Dakota Department of Health

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	10613	A. BUILDING: _____ B. WING _____	08/08/2024

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DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/06/24 through 8/08/24. Dells Nursing and Rehab Center Inc was found not in compliance with the following requirements: S206 and S236.	S 000		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and. (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section. Additional personnel education shall be based on	S 206	Unable to correct noncompliance on initial staff training. Personnel training process for new employees will be reviewed and revised as needed and all staff responsible for new employee training will be re-educated for correct compliance by 9/06/2024. Business Office manager or designee will audit area identified to ensure compliance for all new hires weekly for 4 weeks and monthly for 2 months. Business office manager or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advised to discontinue monitoring.	9/6/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Calyn Togel

TITLE: Administrator

(X6) DATE: 8/30/24

South Dakota Department of Health

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S 206	Continued From page 1 facility identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee training record review and interview, the provider failed to ensure mandatory training was provided on all the required training subjects for one of five sampled employees (housekeeper D). Findings include: 1. Review of the housekeeper D's training records revealed: *She was hired on 6/19/23. *She had received training on required topics on 6/6/24, nearly a year after hire. *There were no other training records available. 2. Interview on 8/7/24 at 2:20 p.m. with administrator A revealed: *Each new hire performed the same onboarding and orientation with the training binder. *The training record available must have been from her annual retraining. *A request was made at that time to review housekeeper D's initial training record. Those records were not provided by the end of survey on 8/8/24 at 5:30 p.m.	S 206		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented	S 236	Unable to correct noncompliance of TB screening within 14 days of hire. The tuberculosis policy will be reviewed and revised as needed and all staff responsible for admissions will be re-educated on correct process for compliance by 9/06/24.	9/6/24

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S 236	Continued From page 2 tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to follow their facility policy to ensure three of five sampled employees (D, E, and F) were screened for tuberculosis within fourteen days of hire. Findings include: 1. Record review of housekeeper D's personnel file revealed: *They were hired on 6/19/23. *The first injection step of the tuberculin screening was read on 6/28/23 and the second injection step of the tuberculin screening was read on 7/5/23, which was 16 days after they were hired. 2. Record review of dietary assistant E's	S 236	Business office manager or designee will audit area identified to ensure compliance for all new hires weekly for 4 weeks and monthly for 2 months. Business office manager or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	

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S 236	Continued From page 3 personnel file revealed: *She was hired on 2/16/24. *The first injection step of the tuberculin screening was administered on 7/6/24 and the injection site was examined on 7/8/24. *The second injection step of the tuberculin screening was administered on 7/16/24 and the injection site was examined on 7/18/24, which was five months after she was hired. 3. Record review of certified nursing assistant (CNA) F's personnel file revealed: *He was hired on 3/27/24 *The first injection step of the tuberculin screening was read on 5/31/24 and the second injection step of the tuberculin screening was read on 6/6/24, which was two and a half months after he was hired. 4. Interview on 8/7/24 at 2:20 p.m. with administrator A revealed: *They identified several employees that had not been screened for tuberculosis through their quality assurance audits. *It was difficult to get parental approval for the evaluation as some employees were under the age of 18. *She stated the one step QuantiFERON test was too expensive which was why they performed the two-step screening. *She believed the tuberculosis screening needed to have been started within 14 days of hire, instead of needing to have been completed within that time frame. 5. Review of the provider's 9/23 Employee TB testing policy revealed: *"It is the policy of Dells Nursing and Rehab Center that every new healthcare worker shall receive Quantiferon Gold testing to establish a	S 236		

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S 236	Continued From page 4 baseline within 14 days of employment."	S 236		