STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 1/2/24 through 1/4/24. Strand-Kjorsvig Community Rest Home was found not in compliance with the following requirements: F582, F641, and F656.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide	F 582	Unable to correct the noncompliance for lack of NOMNC forms provided. Will ensure that residents receive the correct forms going forward. Administrator, DON, and interdisciplinary team will review and revise policies and procedures as necessary. SSD or designee will audit correct NOMNC forms given weekly for 4 weeks and monthly for 2 months. Findings of audits will be presented at monthly QAPI meetings.	2/18/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Samuel Van Voorst	Administrator	1/25/2024

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 582	Continued From page 1 notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to ensure the proper Medicare notices were completed and provided for one of three sampled residents (2) prior to discharge from skilled services. Findings include: 1. Review of resident 2's CMS (Centers for Medicare and Medicaid Services) SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review form provided by social service designee F on 1/4/23 revealed the Medicare Part A Skilled Services Episode start date was 5/18/23 and the last covered date was	F 582		

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F 582	Continued From page 2 on 7/2/23. Review of resident 2's electronic medical record revealed: *He was admitted on 4/12/23. *He was re-admitted on 5/18/23. *He had skilled covered days remaining and continued to reside in the facility. *His Notice of Medicare Non-coverage (NOMNC) was signed on 7/20/23 with the benefit's expiring on 7/3/23. *His SNF Advanced Beneficiary Notice of Non-coverage form was signed on 7/20/23. -That standardized notice would allow Medicare beneficiaries to make informed decisions about whether to receive certain Medicare services and accept financial responsibility for those services if Medicare would not cover the cost of those services. *Both forms were completed seventeen days after his last covered day of Part A services had ended. Interview on 1/4/24 at 12:00 p.m. with social service designee F revealed she: *Was a licensed practical nurse who worked as the social service designee. *Was responsible for issuing the Medicare notices. *Relied on e-mails from the director of rehabilitation (DOR) which informed her of when a resident's skilled services were ending. *Was not sure why resident 2's Medicare notices were not signed in a timely manner and could not find an e-mail from the DOR informing her of resident 2's end of skilled therapy services. *She recalled discussing the Medicare notices with resident 2's son/durable power of attorney for health care, but stated that the phone	F 582		

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F 582	Continued From page 3 conversation was on 7/17/23 and she had mailed the forms to him for his signature. *She agreed that resident 2's representative was not given a two-day notice before the end of his skilled services. Interview on 1/4/24 at 12:53 p.m. with director of nursing (DON) B revealed she: *Confirmed the process for reviewing residents' Medicare Part A stays with therapy services informing both social service designee F and herself of a resident's discharge from skilled services through an e-mail from the DOR. *Stated she could not find an e-mail communication from the DOR regarding resident 2's end of skilled therapy services. *Agreed the Medicare notices above were not provided timely. *Stated the reason why resident 2's Medicare notices were late was due to the miscommunication between therapy services and the provider. Review of the "Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123" provided to social services designee F revealed: *"When to Deliver the NOMNC". -"The NOMNC must be delivered at least two calendar days before Medicare-covered services end..."	F 582		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641	Unable to correct previous side rail documentation. Going forward all side rail documentation will be updated on quarterly assessments by MDS coordinator or designee.	2/18/2024

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F 641	Continued From page 4 A. Based on observation, record review, and interview, the provider failed to ensure 11 of 15 sampled residents (2, 11, 12, 13, 16, 17, 18, 23, 27, 28, and 29) with bed rails had them accurately recorded on the Minimum Data Set (MDS). Findings include: 1. Observation on 1/3/23 at 9:15 a.m. of resident 2 revealed: *He was in his room, lying on his bed with partial bed rails on both sides of his bed. *He did not respond to verbal stimuli but remained in bed with his eyes closed. Interview on 1/3/24 at 9:21 a.m. with certified medication aide (CMA) J regarding resident 2 revealed he: *Had left-hand paralysis. *Required staff assistance for all his care. *Used the bed rails to help turn himself in bed. Review of resident 2's electronic medical record (EMR) revealed: *He was admitted on 4/12/23. *His 12/4/23 Brief Interview for Mental Status (BIMS) was scored at an 8, which indicated he was cognitively moderately impaired. *His "Informed Consent for Use of Bed Rails" documented "Partial rail recommended at all times when resident is in bed" and was signed on 4/12/23 by his wife. *A 10/3/23 physician order stated "May use bilateral top quarter rails for bed mobility, body positioning and to aid in turning right to left for incontinence cares." *His Bed Rail/Assist Bar Evaluation was signed by MDS coordinator D on 12/5/23 which documented: -He had expressed a desire to have the bed rails	F 641	Resident 17 and 29 medication coding revised and updated by MDS coordinator or desginee. All other residents will be reviewed and revised before quarterly submission to ensure accuracy. Administrator, DON, and interdisciplinary team will review and revise policies and procedures as necessary. MDS coordinator or designee will audit accurate side rail and medication record MDS documentation weekly for 4 weeks and monthly for 2 months. Findings of audits will be presented at monthly QAPI meetings.	

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F 641	Continued From page 5 for his safety and comfort. -"[Resident 2's first name] uses bilateral top quarter side rails to aid in bed mobility with staff assistance, positioning, and turning right to the left with staff assistance for incontinence care and to place lift sling under him for transfers with the mechanical full body lift. The rails add a level of independence for [resident's first name]." *The following MDS assessments documented in section P "Restraints and Alarms" his bed rails as a restraint that was used daily on the following: -4/20/23 admission assessment. -5/25/23 readmission assessment. -8/14/23 quarterly review assessment. -9/29/23 readmission assessment. -12/4/23 quarterly review assessment. 2. Observation and interview on 1/2/24 at 5:07 p.m. with resident 11 in her room revealed: *She had worked at the facility for 30 years as a licensed practical nurse (LPN). *She was admitted to the facility 5 years ago. *She stated the bed rails on her bed did not restrain her, but instead, she used the bed rails to assist her with turning in bed and getting in and out of bed. Review of resident 11's EMR revealed: *She was admitted on 12/12/18. *Her 11/19/23 BIMS was scored at 15, which indicated she was cognitively intact. *Her "Informed Consent for Use of Bed Rails" documented "1/2 partial rail recommended at all times when resident is in bed" and she had signed the form on 12/12/18. *A 9/9/22 physician order stated "May use side rails for bed mobility, body positioning, and transfers in/out of bed." *Her 11/21/23 Bed Rail/Assist Bar Evaluation was	F 641		

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F 641	Continued From page 6 signed by MDS coordinator D on 11/27/23 which documented: -She had expressed a desire to have the bed rails for her safety and comfort. -"[Resident 11's first name] is alert and oriented x 3 and has requested siderails to help with bed mobility, body positioning, and getting in and out of bed ..." *The following MDS assessments were documented in section P "Restraints and Alarms" her bed rails as a restraint that was used daily for the following: -1/16/23 quarterly review assessment. -4/17/23 quarterly review assessment. -7/10/23 quarterly review assessment. -8/28/23 readmission assessment. -11/19/23 quarterly review assessment. *Her 8/29/23 "Physical Restraint" care area assessment (CAA) for her 8/28/23 comprehensive readmission assessment revealed: -The CAA was triggered by the MDS assessment coded "Bed rail restraint" was used daily. -The "Evaluation of current restraint use (based on chart documentation, including care plan)" did not have any of the eleven factors checked including: --"Does not meet regulatory definition of restraint (stop here and check accuracy of MDS item that triggered this CAA)." 3. Observation on 1/3/24 at 9:36 a.m. of resident 13 in his room revealed he: *Was in bed covered with a blanket, eyes closed, and snoring. *Had bed rails were elevated on both sides of the bed. Review of resident 13's EMR revealed:	F 641		

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F 641	Continued From page 7 *He was admitted on 2/12/20. *His 11/20/23 BIMS was scored at 1, which indicated he was cognitively severely impaired. *His "Informed Consent for Use of Bed Rails" documented "1/2 partial rail recommended at all times when resident is in bed" and was signed on 2/19/20 by his wife. *An 8/24/21 physician order stated "May use side rails for positioning and transfers." *His 11/21/23 Bed Rail/Assist Bar Evaluation was signed by MDS coordinator D on 11/27/23 which documented: -He had expressed a desire to have the bed rails for his safety and comfort. -"[Resident 13's first name] benefits from top quarter rails for positioning and transferring with the assistance of staff." *The following MDS assessments were documented in section P "Restraints and Alarms" his bed rails as a restraint that was used daily for the following: -1/2/23 quarterly review assessment. -3/27/23 quarterly review assessment. -6/19/23 quarterly review assessment. -9/4/23 annual assessment. -11/20/23 quarterly review assessment. *His 9/6/23 "Physical Restraint" CAA for his 9/4/23 comprehensive annual assessment revealed: -The CAA was triggered by the MDS assessment coded "Bed rail restraint" was used daily. -The "Evaluation of current restraint use (based on chart documentation, including care plan)" did not have any of the eleven factors checked including: --"Does not meet regulatory definition of restraint (stop here and check accuracy of MDS item that triggered this CAA)."	F 641		

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F 641	Continued From page 8 4. Observation and interview on 1/3/24 at 9:01 a.m. with resident 28 and her husband revealed: *Resident 28 had bed rails on both sides of her bed. *Resident 28 responded with limited speech and struggled to express herself, looking at her husband to answer the questions. *Resident 28's husband stated the bed rails did not stop his wife from getting up out of bed but instead helped her to get in and out of bed. Review of resident 28's EMR revealed: *She was admitted on 8/23/23. *Her 11/6/23 BIMS was scored at 3, which indicated she was cognitively severely impaired. *Her "Informed Consent for Use of Bed Rails" documented "1/2 partial rail recommended at all times when resident is in bed" and was signed on 8/23/23 by her son and power of attorney. *A 10/16/23 physician order stated "May have bedrails to aid in mobility and repositioning." *Her 11/6/23 Bed Rail/Assist Bar Evaluation was signed by MDS coordinator D on 11/27/23 which documented: -She had expressed a desire to have the bed rails for her safety and comfort. -"[Resident 28's first name] uses bilateral top quarter rails for bed mobility, positioning, and getting in and out of bed." *Her 11/6/23 quarterly review MDS assessment documented in section P "Restraints and Alarms" that her bed rails were a restraint that were used daily. 5. Observation on 1/2/24 at 3:27 p.m. with resident 29 in his room revealed: *He was sitting in a recliner in his room. *His speech was limited. *He had bed rails on each side of his bed.	F 641		

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F 641	Continued From page 9 Review of resident 29's EMR revealed: *He was admitted on 10/2/23. *His 12/18/23 BIMS was scored at 6, which indicated he was cognitively severely impaired. *His "Informed Consent for Use of Bed Rails" documented "1/4 partial rail recommended at all times when resident is in bed" and was signed on 10/2/23 by his daughter and power of attorney. *A 10/19/23 physician order stated "Resident may have Bedrails to aid in bed mobility and repositioning." *His Bed Rail/Assist Bar Evaluation was signed by MDS coordinator D on 12/20/23 which documented: -He had expressed a desire to have the bed rails for his safety and comfort. -"[Resident 29's first name] uses bilateral quarter top rails for bed mobility, body positioning, and getting in and out of bed." *His 12/18/23 quarterly review MDS assessment documented in Section P "Restraints and Alarms" that his bed rails were a restraint that was used daily. Interview on 1/4/24 at 9:55 a.m. with director of nursing (DON) B and MDS Coordinator D regarding coding of physical restraints on the MDS and CAA for "Physical Restraints" revealed: *The initial "Resident Matrix" provided to the survey team on 1/2/24 had identified 23 of the current 30 residents who had a physical restraint in use. *Both DON B and MDS Coordinator D agreed: -The 1/3/24 evaluations of current residents' bedrail use had not met the regulatory definition of a physical restraint. -They had made mistakes completing the MDS assessments for residents that were using bed	F 641		

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F 641	Continued From page 10 rails. 6. Observation and interview on 1/3/24 at 11:12 a.m. with resident 12 regarding his bed rails revealed he used the two half bed rails to reposition himself. Review of resident's 12 (EMR) revealed: *On 9/9/22 a physician's order was written for the use of the bed rails for mobility. *He had been assessed quarterly for the use of the bed rails. *No consent for the bed rails was located in his EMR. *On 10/16/23 his MDS was signed by MDS coordinator D coding section P bed rail as a restraint used daily. 7. Observation and interview on 1/3/24 at 11:36 a.m. with resident 27 regarding his bed rails revealed he used the bed rails to reposition himself. Review of resident 27's EMR revealed: *On 7/17/23 a physician's order was written for the use of the bed rails for mobility. *He had signed a consent for the bed rail use. *He had been assessed for the of bed rail use. *On 12/26/23 his MDS was signed by MDS coordinator D coding section P bed rail as a restaint used daily. Interview on 1/2/24 at 2:15 p.m. with MDS coordinator D regarding restraint use revealed she was unsure if the bed rails should have been coded as a restraint or not, and she had coded the bed rails as a restraint. 8. Observation on 1/2/24 at 3:04 p.m. of resident	F 641		

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F 641	Continued From page 11 16's room revealed: *She was not in her room. *There were bed rails on both sides of her bed. Interview on 1/2/24 at 3:32 p.m. with resident 16 revealed she had requested the bed rails to aid in repositioning herself. Review of resident 16's EMR revealed: *She was admitted on 7/14/23. *Her BIMS was scored at 14 which indicated she was cognitively intact. *Her "Informed Consent for use of Bed Rails" documented "Partial rail recommended at all times when resident is in bed" and was signed by the resident. *Physician ordered, "May have bilateral ½ rails for bed mobility" on 10/11/23. *Her 12/4/23 Bed Rail/Assist Bar Evaluation was signed by MDS coordinator D on 12/5/23 which documented the following: *She had expressed a desire to have the bed rails for her safety and comfort. *"[Resident 16's first name] uses bilateral top quarter rails for bed mobility, body positioning and getting in and out of bed. She always locks the brakes on her wheelchair and pivot transfers from her bed to her chair and chair to bed." *The following MDS assessments documented in section P "Restraints and Alarms" her bed rails as a restraint used daily: -7/31/23 admission assessment. -10/9/23 quarterly review assessment. 9. Observation on 1/2/24 at 3:51 p.m. of resident 18's room revealed: *He was not in his room. *There were two half bedrails on his bed.	F 641		

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F 641	Continued From page 12 Interview on 1/4/23 at 8:55 a.m. with resident 18 revealed he used the bed rails for repositioning when in bed. Review of resident 18's EMR revealed: *He was admitted on 9/2/21. *His BIMS on 7/25/23 was scored at 11 which indicated he was moderately cognitively impaired. *His "Informed Consent for Use of Bed Rails" documented "Partial rail recommended at all times when resident is in bed" and was signed by the resident on 10/16/23. *A physician order "May use side rails for bed mobility, body positioning, and transferring in/out of bed" on 9/14/22. *His 10/23/23 Bed Rail/Assist Bar Evaluation was signed by MDS coordinator D on 10/24/23 which documented: -He had expressed a desire to have the bed rails for his safety and comfort. -"[Resident's first name] uses bilateral half rails for bed mobility, positioning and getting in and out of bed. The rails help to keep some of his independence." *The following MDS assessments were documented in section P "Restraints and Alarms" his bed rails as a restraint used daily on the following: -2/6/23 quarterly review assessment. -5/1/23 quarterly review assessment. -7/24/23 annual assessment. 10. Observation and interview on 1/3/23 at 8:25 a.m. with resident 17 revealed: *His bed had two quarter bed rails in the raised position. *He had used the bed rails for repositioning in bed and to assist him in sitting up.	F 641		

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F 641	Continued From page 13 Review of resident 17's EMR revealed: *On 11/22/22 a physician ordered "May have bilateral quarter bed rails for body positioning/transferring/bed mobility." *His 10/23/23 Bed Rail/Assist Bar Evaluation stated that the resident used the bilateral half bed rails for bed mobility, repositioning, and getting in and out of bed. The bed rails assisted him to maintain his mobility. The MDS for resident 17 was signed on 10/23/23 at 2:00 p.m. and coded as a restraint for daily use by MDS coordinator D. 11. Observation and interview on 1/3/23 at 9:38 a.m. with resident 23 revealed: *He was lying in bed with two half bed rails in the raised position. *He stated that he used the bed rails for repositioning, moving in bed, and to assist him in sitting up. Review of resident 23's EMR revealed: *On 10/9/23 a physician order that indicated may use bilateral top bed rails for bed mobility, body positioning, and assistance getting in and out of bed. *Bed rail assessments dated 10/2/23 stated the resident used the half rails for bed mobility, body positioning and assistance getting in and out of bed. *Bed rail assessment dated 12/26/23 stated the resident used bilateral top quarter rails to aid in bed mobility, repositioning and assistance getting in and out of bed. The signed MDS for resident 23 dated on 12/26/23 at 3:46 p.m. was coded for restraint use daily.	F 641		

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F 641	Continued From page 14 Review of the provider's 7/14/21 Bed Rails policy revealed: *The "Purpose": -"To promote appropriate use of bed rails for resident safety." -"To reduce entrapment risk by providing appropriate resident assessment ..." *The "Policy" was outdated, referring to older federal tags that were no longer in use (i.e. F323 and F221). *The "Action Steps" included "Residents will be assessed for the appropriateness of side rails ..." B. Based on record review and interview, the provider failed to ensure 2 of 15 sampled residents' medications (17 and 29) had been accurately recorded on the MDS. Findings include: 1. Review of the Long-Term Care Survey Process revealed resident 17 had an MDS indicator for anticoagulation use. Review of resident 17's EMR revealed: *On 7/24/23 a physician's order was received for Aspirin EC (enteric coated) tablet delayed release 81 milligrams (mg) take one tablet daily. *The MDS dated 10/23/23 at 2:00 p.m. coded as an anticoagulant by MDS coordinator D. 2. Review of the Long Term Care Survey Process revealed resident 29 had an MDS indicator for anticoagulation use. Review of resident 29's EMR revealed: *A 10/2/23 physician's order was received for "Clopidogrel Bisulfate Oral Tablet 75 MG (Clopidogrel Bisulfate) Give 1 tablet by mouth in	F 641		

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F 641	Continued From page 15 the morning." -The medication was related to his "Arteriosclerotic heart disease." *His MDS dated 12/18/23 coded as a anticoagulant by MDS coordinator D. *A review of his physician orders from his 10/2/23 admission to 1/4/24 revealed no anticoagulant medication had been ordered. Interview on 1/4/24 at 9:55 a.m. with DON B and MDS coordinator D revealed they had incorrectly coded the medications as anticoagulants.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656	Resident 23's care plan updated to match orders by DON or designee. All other resident care plans updated for pressure ulcers and interventions to match orders. Administrator, DON, and interdisciplinary team will review and revise policies and procedures as necessary. DON or designee will audit accurate comprehensive care plans weekly for 4 weeks and monthly for 2 months. Findings of audits will be presented at monthly QAPI meetings	2/18/2024

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F 656	Continued From page 16 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the provider failed to ensure an individualized care plan for one of one sampled resident (23) who had a pressure ulcer had been developed, reflecting identified interventions and implementation and evaluation of them. Findings include: 1. Observation on 1/3/24 at 9:26 a.m. of resident's heel lift boot sitting on his dresser, and no pillow under left foot while the resident was lying in bed on his right side with his heels laying on the bed. 2. Review of resident 23's electronic medical record (EMR) revealed:	F 656		

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F 656	Continued From page 17 -On 5/10/23 a physician's order was received to cleanse the stage three pressure ulcer (the wound has burrowed through the second layer and has reached the subcutaneous tissues [fat layers]) with wound cleanser and gauze, apply Medi honey gel, and apply a bordered foam dressing. Change twice daily. -Elevate his left heel on a pillow or use the heel lift boot while he was in bed. Review of resident 23's care plan: -On 10/30/23 his care plan was revised but did not indicate the left heel pressure ulcer or interventions to elevate his left heel on a pillow or use the heel lift boot while in bed. *On 1/2/24 the care plan was revised but did not indicate the left heel pressure ulcer or interventions to elevate his left heel on a pillow or use the heel lift boot while the resident was lying in bed. 3. Interview on 1/4/24 2:55 p.m. with director of nursing (DON) B regarding resident 23's heel lift boot revealed: *She had agreed that interventions should have been on care plan.	F 656		

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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 from 1/2/24 through 1/4/24. Strand-Kjorsvig Community Rest Home was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Samuel Van Voorst

TITLE: Administrator

(X6) DATE: 1/25/2024

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.

South Dakota Department of Health

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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 1/2/24 through 1/4/24. Strand-Kjorsvig Community Rest Home was found not in compliance with the following requirements: S206 and S301.	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.	S 206	Employee H, I J, K, L completed required trainings by 2/18/24. Administrator, DON, and interdisciplinary team will review and revise policies and procedures as necessary. Business office manager or designee will audit employees for completion of required trainings monthly for 3 months. Findings of audits will be presented at monthly QAPI meetings.	2/18/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Samuel VanVoorst

TITLE: Administrator

(X6) DATE: 1/25/2024

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S 206	Continued From page 1 Additional personnel education shall be based on facility identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on review of employee personnel records, training transcript review, and interview, the provider failed to ensure training was completed for the following: *Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms for five of five sampled employees (H, I, J, K, and L). *Fire prevention and response, emergency procedures and preparedness, including responding to resident emergencies and information regarding advanced directives, and nutritional risks and hydration needs of residents for four of five sampled employees (H, J, K, and L). *Accident prevention and safety procedures and resident rights for three of five sampled employees (J, K, and L). *Infection control and prevention for two of five sampled employees (J and K). Findings include: 1. Review of employee personnel records revealed: *Employee H was hired on 4/19/23. *Employee I was hired on 7/29/23. *Employee J was hired on 11/15/22. *Employee K was hired on 10/5/23. *Employee L was hired on 10/17/23 Interview and review of employee training records and online training transcripts with business office manager (BOM) D on 1/3/24 at 4:42 p.m. and on 1/4/24 at 11:37 a.m. revealed:	S 206		

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S 206	Continued From page 2 *The provider used both online training programs and in-person training for employees. *She was responsible to assign each employee's online training. *She confirmed employees H, I, J, K, and L had not completed training for the above required topics. *She was responsible to ensure each employee's training was completed as required. Interview on 1/4/23 at 4:10 p.m. with DON B and BOM D revealed: *They confirmed there was no documentation to support employees H, I, J, K, and L had received any of the required training topics noted above. *They agreed they had no organized orientation and training programs for the employees. Review of the provider's June 2001 policy "163P. In-services" revealed: *"All employees will participate in scheduled In-service training or workshops." *"[Name of provider] will provide on-going in-service training plans and will work closely with employees wishing to continue education in the long term health care field."	S 206	All dietary staff will complete required training by 2/18/24.	2/18/2024
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements.	S 301	Administrator, dietary manager, and interdisciplinary team will review and revise policies and procedures as necessary. Dietary staff will be audited for completion of required training monthly for 3 months. Findings of audits will be presented at monthly QAPI meetings.	

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S 301	Continued From page 3 This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, policy review, and job description review, the provider failed to ensure required dietary training for food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftovers food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements had been completed for five of five sampled dietary staff members (K, M, N, O, and P). Findings include: 1. Review of dietary employee personnel records revealed: *Cook K was hired on 10/5/23. *Cook M was hired on 8/21/23. *Waitress N was hired on 2/10/23. *Waitress O was hired on 8/28/23. *Waitress P was hired on 9/6/23. Interview and review of dietary training records and online training transcripts with business office manager (BOM) D on 1/3/24 at 4:42 p.m. and on 1/4/24 at 11:37 a.m. revealed: *They used both online training programs and in-person training. *She stated she assigned the online dietary training programs to each dietary employee. *She had reviewed the list of assigned online dietary trainings and stated none of the assigned trainings had been started. *She provided staff reminders to complete the dietary training that was assigned. Review of the 1/3/24 "Course Completion History" online training records revealed: *Cook K and M, Waitress N, O, and P had been assigned the required dietary inservice online	S 301		

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S 301	Continued From page 4	S 301		

trainings.
-The "Due Date" for these trainings was thirty days after the dietary employee's hire date.
-The status for each of these trainings was "Not Started".

Interview on 1/3/24 at 4:58 p.m. with dietary manager E regarding dietary training revealed:
*He works with new dietary employees for the first three to seven days after the start of their employment:
-Together they go through the various dietary tasks.
-The employees would following the dietary manager or another cook.
*He stated he trains new dietary staff on the nine required topics but he had not documented any of that training.
*He stated BOM D assigned the online dietary training to dietary staff.
*He stated he had not been tracking the completion of the required dietary trainings for any of his staff.
*He was not aware that the dietary staff had not completed the required dietary training by the assigned due date.

Interview on 1/4/24 at 12:57 p.m. with dietary manager E revealed:
*The 2017 policy on "Training/Orientation" was the current policy.
*He agreed with the above findings that dietary staff had not completed their assigned training.

Review of the provider's 2017 "Training/Orientation" policy revealed:
*The policy was from the Becky Dorner & Associates, Inc. 2017 "Policy & Procedure Manual"
*"Policy: Food and nutrition services staff will be

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S 301	Continued From page 5 adequately trained to perform assigned duties and are required to participate in regularly scheduled inservice training sessions ... The director of food and nutrition services will be responsible for department orientation and training of new staff." *"Procedure: Staff will be trained on the following:" -"Overview of Food Service." --"Meal services/tray line training." -"Sanitation." --"Personal hygiene." -"Safety." -"Food Preparation and Food Safety." --"Food safety/preventing foodborne illness." --"Temperature protection (internal cooking temperatures, holding, storage, reheating and cooling temperatures)." --"Proper storage of left-over food." -"Nutrition." *"(See Sample Training/Orientation Form later in this chapter of the manual for recording each new employee's training.)" *The training topics listed above covered the nine required training topics. Review of the provider's undated Dietary Services Manager job description revealed: *"The primary purpose of your job position is to assist the Dietitian in planning, organizing, developing and directing the overall operation of the Dietary Department in accordance with current federal, state, and local standards, guidelines and regulations governing our facility ..." *"Staff Development". -"Assist in the development of and participate in the planning, conducting, and scheduling of timely in-service training classes that provide instructions on 'how to do the job,' and that	S 301		

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S 301	Continued From page 6 ensure a well-educated dietary services department." -"Encourage the dietary staff to attend and participate in training programs." *"Personnel Functions". -"Counsel/discipline dietary personnel as requested or as necessary." *"Specific Requirements". -"Must be knowledgeable of dietary practices and procedures as well as the laws, regulations and guidelines governing dietary functions in the long-term care facility."	S 301		