STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A038	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTCHMAN LIVING CENTER	603 WEST PINE PHILIP, SD 57567

(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 12/17/24 through 12/19/24. Scotchman Living Center was found not in compliance with the following requirements: F657, F686, F692, F695, F812 and had past non-compliance at F600. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 12/17/24 through 12/19/24. The area surveyed was a resident who eloped (left the facility without staff knowledge) when he exited the front door of the building after he had followed a guest who was leaving the facility. Scotchman Living Center was found to have past non-compliance at F689.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maureen Cadwell

TITLE: CEO/Administrator

(X6) DATE: 01/15/2025

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 600	Continued From page 1 Based on interview, observation, and document review, the provider failed to protect one of one sampled resident's (4) right to be free from neglect by one of one certified nursing assistant (CNA) N who had not followed the resident's care plan related to transferring (moving from one place to another) which resulted in an open wound on her leg. This citation is considered past non-compliance based on review of the corrective actions the provider implemented immediately following the incident. Findings include: 1. Interview on 12/17/24 at 3:42 p.m. with resident 4 revealed: *She was talking about her recent dermatology appointment. *When asked if she had any sores or wounds, she pulled up her left pant leg. *She said she got that wound on her leg "over a year ago." *She explained that CNA N helped her into bed and her left leg got caught on something. -She got a skin tear from that accident. -CNA N transferred her using the pivot technique rather than with the full-body mechanical lift. -She said that "[CNA N] was in a hurry." *She did not blame the CNA for the accident and was very complimentary of the care he provided. 2. Review of resident 4's electronic medical record revealed: *Her care plan included a total of seven interventions that mentioned the use of a Hoyer lift (a band of full-body mechanical lift) and/or a total lift. -"Staff are to use [Hoyer] lift with all transfers." Initiated on 12/17/21. Revised on 6/12/23. -"DRESSING: ...Resident needs assist with staff	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 2	F 600		

member and Hoyer lift for dressing abilities." Initiated on 10/23/17. Revised on 4/1/23.
-"TRANSFER: The resident is fully dependent on staff with [Hoyer] lift for all transfers with two staff at all times." Initiated on 10/23/17. Revised on 11/6/22.
-"TOILET USE: The resident utilizes a total lift with 2 staff for toileting needs." Initiated on 10/23/17. Revised on 11/6/22.
-"Resident utilizes Tena products [a brand of incontinence products] to promote ability to toilet with Hoyer lift." Initiated on 6/12/18. Revised on 11/6/22.
-Resident uses [Hoyer] lift for transfers, however at times she refuses due to the amount of time it takes to hook up resident and transfer." Initiated on 6/26/19. Revised on 2/27/24.
-"Tena product utilized for [incontinence] and availability to change product while utilizing a [Hoyer] lift." Initiated on 10/23/17. Revised on 11/6/22.
*Her 9/19/24 quarterly Minimum Data Set assessment indicated she had a Brief Interview for Mental Status score of 15, indicating she was cognitively intact.
*There was a physician's order that read, "Wound care to LEFT lower leg: clean w/ wound cleanser. Apply Bacitracin ointment [an antibiotic ointment]. Cover with collagen pad. Secure with bordered gauze. Change QOD [every other day]. [One] time a day on even days change after showering."
*Progress note from 2/23/24 at 7:57 a.m.
-"Staff was transferring resident from her bed into her wheelchair using a pivot transfer, while transferring resident's left leg was cut open. A [four to five-inch] laceration noted to left lower extremity, gauze and paper tape applied to control bleeding. Assessed by wound care nurse,

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F 600	Continued From page 3 steri strips and mepilex applied." *She had a diagnosis of bullous pemphigoid, an autoimmune skin condition causing large, fluid-filled blisters. *At the time of the survey, the wound was still healing due to blisters forming in the wound area and continually opening per RN skin assessments. 3. Interview on 12/18/24 at 2:33 p.m. with registered nurse (RN) F about resident 4's skin revealed: *She remembered the accident where resident 4's skin on her left leg was torn due to an inappropriate transfer by a CNA. It happened on 2/23/24. *The resident's skin was very fragile due to a rare skin condition. -Her skin was a "constant cycle of open and closed." -Resident 4 also had a habit of picking at her skin. *She confirmed that resident 4 was supposed to have been transferred using the full-body mechanical lift rather than with a pivot transfer according to her care plan. 4. Interview on 12/18/24 at 2:59 p.m. with CNA N about the accident with resident 4 revealed: *At the time of the accident, resident 4 was not able to use the toilet in her room. *He was planning on taking resident 4 to the shower room to use the toilet. *He "cut corners" and transferred her using the pivot technique. -He later admitted the transfer technique he used was not the pivot technique as resident 4 was not able to put her feet on the ground. -Instead, he explained that he assisted her to the	F 600		

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F 600	Continued From page 4 edge of her bed, he wrapped his arms around her, lifted her up and transferred her to the wheelchair. *Resident 4's left lower leg got caught on either the bedframe or her wheelchair and caused a skin tear. *There was significant bleeding when that occurred. *Staff brought the resident to the neighboring clinic for treatment of the skin tear. *A large investigation was conducted after the accident. *He received verbal and written reprimands and education about following residents' care plans and how to properly transfer residents. *He knew what he did was wrong and that he should have transferred her according to her care plan. *All staff were reeducated on the importance of following residents' care plans at the February 2024 all-staff meeting. 5. Interview on 12/18/24 at 4:50 p.m. with director of nursing (DON) B revealed: *She confirmed that CNA N had not transferred resident 4 using the full-body mechanical lift on 2/23/24 which resulted in the skin tear to her left lower leg. *The wound was still healing. *Her skin condition made it hard for wounds to heal. *The investigation process included interviewing resident 4 and CNA N to get the whole story related to the accident. *They also interviewed other staff and residents to determine if anyone had concerns with the care that CNA N was providing. *CNA N was reeducated on safe resident transferring and the importance of	F 600		

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F 600	Continued From page 5 communicating with coworkers and following residents' care plans. *DON B reeducated all staff at the monthly staff meeting in February 2024. -Those staff who were not in attendance were reeducated prior to their next working shift on accident hazards and following residents' care plans. 6. Random interviews with residents during the survey on 12/17/24, 12/18/24, and 12/19/24 revealed no other residents voiced concerns regarding potential neglect. 7. Observations and interviews during the survey on 12/17/24, 12/18/24, and 12/19/24 with nursing staff throughout the survey revealed appropriate resident transfers according to residents' care plans. 8. Review of staff training records revealed staff were educated about the above resident's accident and re-educated about following residents' care plans on 2/28/24 and 2/28/24. 9. The provider's implemented systemic actions to ensure the deficient practice does not reoccur was confirmed on 12/19/24 after record review revealed the facility had followed their quality assurance process, education was provided to all staff about accident prevention and following resident care plans, and observations and interviews revealed staff understood the education provided regarding those topics. Based on the above information, non-compliance at F600 occurred on 2/23/24, and based on the provider's implemented corrective actions for the deficient practice confirmed on 12/19/24, the	F 600		

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F 600	Continued From page 6 non-compliance is considered past non-compliance.	F 600		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to ensure four of sixteen sampled residents (4, 8, 21, and 22) had their care plans updated, and revised	F 657	1. The Resident Care Manager, Director of Nursing,or designee will review, revise or create necessary policies for Care Plans to ensure resident care plans will be updated and/or revised to reflect their current status and care needs per regulation 483.21 by January 21st, 2025. 2. The Resident Care Manager, Director of Nursing or designee will ensure resident 4, 8, 21, and 22's care plans are updated and reflect current status and care needs by January 21st, 2025. 3. The Resident Care Manager, Director of Nursing or designee will educate all nursing staff at the next meeting on January 20, 2025 , on the process of the Resident Care Plan and review the updated an/or revised Care Plan policy to ensure resident status' and care needs are documented according to regulation 483.21. 4. The Director of Nursing or designee will randomly select 3 residents and review 3 categories of their care plans to ensure they reflect the current status of the resident. This will be completed weekly for 3 (three) months, then monthly for 3 (three) months. 5. The Director of Nursing or designee will report the findings to the Quality Assurance Team for 6 months for further recommendations.	01/21/2025

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F 657	Continued From page 7 promptly to reflect their current status and care needs. Findings include: 1. Observation on 12/17/24 at 3:42 p.m. in resident 4's room revealed: *There was an oxygen concentrator machine next to her sink. *She was using the portable oxygen machine at the time. -The flow rate was set at 2L/min (liters per minute) via nasal cannula. Review of resident 4's electronic medical record revealed: *There were two physician's orders related to her supplemental oxygen: -"Oxygen 1-10 liters to be applied PRN [as needed] via NC [nasal cannula] or high flow NC to maintain SPO2 [oxygen saturation] above 90% as needed for hypoxia." Ordered on 6/30/23. -"Oxygen 1-10 liters to be applied PRN via NC or high flow NC to maintain SPO2 above 90% three times a day." Ordered on 6/30/23. *Her care plan included the following intervention: -"Apply oxygen PRN 1-5L NC to maintain oxygen level above 90%." Date initiated 2/17/20. Revised on 7/12/23. 2. Interview on 12/17/24 at 1:06 p.m. during entrance conference with administrator A, director of nursing (DON) B, and clinical care coordinator/social service director (CCC/SSD) C revealed the facility was a non-smoking facility and there were no residents who smoked. Review of resident 8's medical record revealed: *Her admission date was 11/1/23. *Her diagnosis included: dementia, depression, psychotic disturbance, mood disturbance,	F 657		

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F 657	Continued From page 8 anxiety, history of urinary tract infections, history of pulmonary embolism, hearing loss, osterarthritis, wedge compression fracture of first lumbar vertebra, chronic obstructive pulmonary disease and chronic bronchitis. Review of resident 8's care plan revealed: *"Monitor location every 2 hours and PRN. Document wandering behavior and attempted diversional interventions in behavior note." -There were no specific diversional interventions listed. *"Provide resident with preferred food sources to encourage consumption". -There were no specific preferred foods listed. *An 11/14/23 intervention of "Educate the resident/family/caregiver about: ..., the adverse effects of tobacco and alcohol, ..." -The resident 8 did not use tobacco. 3. Review of resident 21's medical record revealed: *He had a diagnosis of dementia. *His Brief Interview of Mental Status score was 4, which indicated he had severe cognitive impairment. *He resided in the memory care unit. *His care plan included he was ambulatory and had a history of wandering. -Interventions for his wandering included: -Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. --There were no specifically identified pleasant diversions, structured activities, food, conversation, television, books. 4. Observation on 12/17/24 at 4:01 p.m. of	F 657		

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F 657	Continued From page 9 resident 22 in her room revealed: *She was awake and lying in bed. *There was an oxygen concentrator in the room that was providing her oxygen through a nasal cannula. Review of resident 22's care plan revealed: *There was a revised 8/14/23 intervention that included "Encourage resident to avoid alcohol, smoking, ..." *There was a revised 8/7/23 intervention that included "Encourage resident to ... stop smoking, ..." -Resident 22 did not smoke. 5. Interview on 12/18/24 at 5:11 p.m. with Minimum Data Set nurse D, CCC/SSD C, and DON B, regarding the provider's care plan process revealed: *Care plans were reviewed each quarter and with a significant change of condition or status by the interdisciplinary team. -Resident care changes could happen daily. -The interdisciplinary team included the resident, their family or representative, CCC/SSD, DON, dietary manager, activity director, a nurse, therapy staff, a CNA and the resident's medical provider. *Any staff member with appropriate access to the resident's medical record was able to change the resident's care plan. *The facility was a non-tobacco and smoke free facility. *CCC/SSD C confirmed that several areas of resident's care plans were "general" and were the same care plan interventions for multiple residents that were not person-centered care for each resident. -She confirmed the resident's care plans were not	F 657		

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F 657	Continued From page 10 updated or revised in those areas. 6. Review of the provider's 6/2022 Comprehensive Care Plan policy revealed: *"The Interdisciplinary Team in conjunction with the resident and his/her family/representative develops and implements a comprehensive, person-centered care plan for each resident." *"The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment." *"Care plan interventions are chosen only after careful data gathering, proper sequencing of events, and careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making." *"The Interdisciplinary Team must review and update the care plan: -a. When there has been a significant change in the resident's condition -b. When the desired outcome is not met -c. When the resident has been readmitted to the facility from a hospital stay -d. At least quarterly, in conjunction with the required quarterly MDS assessment."	F 657		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 686	1. The Director of Nursing or designee, in consultation with wound care nurse and medical director, will review, revise or create necessary policies for ensuring assessment and treatment for pressure injury occur with physician awareness of resident status and needs per regulation 483.25 by January 21, 2025. 2. The Director of Nursing, wound care nurse, or designee will ensure resident 11's skin issue has current and updated orders with provider notification of skin issue and prevention measures are in place by January 21, 2025.	01/21/2025

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F 686	Continued From page 11 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation, interview, and policy review, the provider failed to adequately treat pressure injuries for one of one sampled resident (11) by not following wound care nurse recommendations, and not notifying the resident's physician, resulting in a non-healing pressure injury. Findings include: 1. Review of resident 11's electronic medical record (EMR) revealed: *He had decreased feeling in his lower legs due to paraplegia (the inability to voluntarily move the lower extremities) from a previous spinal cord injury. *He also had diagnoses of congestive heart failure and dementia. *He had a pressure related injury to his left lateral ankle diagnosed on 9/13/24. *His wound care was being managed by wound care registered nurse (RN) G. *RN G assessed his wound once weekly and placed orders for how to care for the pressure injury. 2. Review of resident 11's care plan revealed: *"The resident has an ADL [activities of daily living] self-care performance deficit r/t [related to] paraplegia." *"BATHING/SHOWERING: The resident requires extensive assist with 1 to 2 staff with bed bath 2x [two times] weekly and as necessary." *"BED MOBILITY: The resident is able to assist	F 686	3. The Director of Nursing, wound care nurse or designee will provide an inservice on January 14, 2025 and January 16, 2025 on policies and procedures on ensuring assessment and treatment for pressure injuries occur with physician awareness and resident status needs. This will include proactive interventions for prevention with individuals who are identified as a risk for skin breakdown. This training will include both licensed and unlicensed staff on their role and responsibilities for care with the resident identified with pressure injury or risk development. 4. The Director of Nursing or designee will randomly select 3 (three) residents who have current skin issues or who are at risk of compromised skin integrity to review compliance of prevention measures and provider notification of skin treatment and progress. This will be completed weekly for 3 (three) months, then monthly for 3 (three) months. 5. The Director of Nursing or designee will report the findings to the Quality Assurance Team for 6 (six) months for further recommendations.	

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F 686	Continued From page 12 with turning in bed with use of grab bars. Staff assist of 1-2 needed for position changes." *"Resident transferred with staff assist of 2 and hoyer lift [mechanical lift that uses a sling] when getting out of bed or obtaining weights." *"The resident has potential for pressure ulcers r/t immobility and paraplegia." -"Assess/record/monitor wound healing q [every] Week. Measure length, width, depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD [physician]. Revision on: 12/31/2020." -"Follow facility policies/protocols for the prevention/treatment of skin breakdown. Date Initiated: 12/28/2020." -"Wash feet daily with warm soap and water, pat dry. Apply silicone cream. Ensure heels and LEFT lateral ankle is floated at all times. Date Initiated: 04/05/2021. Revision on 03/02/2023." -"Wound care nurse to assess on Wednesdays. Date Initiated: 07/13/2023." -"Heel protectors on while in bed and in wheelchair. Nurse to check skin and placement every shift. Date Initiated: 10/23/2023." -"Ensure LEFT lateral ankle is floated [elevated to avoid pressure] with pillow support whenever in bed. Date Initiated: 12/17/2024." 3. Observation on 12/17/24 at 3:16 p.m. of resident 11 revealed the resident laying in his bed with his left ankle not floated, laying directly on a pillow without support under his calf. 4. Observation on 12/18/24 at 2:15 p.m. RN G performing a dressing change on resident 11's left ankle pressure injury revealed: *The dressing was removed, there was a small amount of blood-tinged drainage to the dressing.	F 686		

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F 686	Continued From page 13 *A small circular wound to his left outer ankle. *RN G measured the wound, measurements were 0.8 cm (centimeters) x (by) 0.5 cm. *The wound was cleansed with wound cleaner. *New dressing was applied. *Resident 11 did not have complaints of pain. 5. Observation on 12/18/24 at 2:45 p.m. revealed a sign on resident 11's closet door that read, "Float Left Outer Ankle. Remove heel protector and use it and a pillow under the calf area. This should float the heel as well, preventing pressure injury to it. Thank you! [RN G]." 6. Observations on 12/18/24 at 5:00 p.m. and 6:23 p.m. revealed the resident laying in his bed with his left ankle not floated, laying directly on a pillow without support under his calf. 7. Observation and interview on 12/19/24 at 11:43 a.m. with RN F of resident 11 in his room revealed: *RN F reported that the wound care RN would see the resident weekly on Wednesdays. -She reported that care instructions would frequently change after the wound care nurse visit, and those instructions usually were not verbalized to nursing staff, but were updated in the resident's care plan. *The resident was sitting up in his wheelchair. *His left ankle was resting on a pillow with no pillow support under his calf to float it. *RN F's definition of "floating" the resident's ankle would be by placing main support under the resident's calf to avoid pressure on the resident's ankle. -When the surveyor asked if the resident's ankle was floated, RN F replied "No". -She agreed that a lack of circulation to the	F 686		

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F 686	Continued From page 14 resident's wound could delay wound healing. 8. Interview on 12/19/24 at 11:55 a.m. with resident 11 revealed: *He was unsure of how long he had resided at the facility. *He reported he received good care from the staff. *He was unsure of how long he had the pressure injury to his left ankle. *He had some sensation in his lower extremities, but the pressure injury did not hurt. 9. Interview on 12/19/24 at 10:15 a.m. with director of nursing (DON) B and clinical care coordinator (CCC) C revealed: *Resident 11 could be difficult to provide care for due to his decreased sensation in his lower extremities and his inability to convey his feeling of discomfort to staff. *DON B followed the wound care of resident 11. *DON B expected her staff to follow the orders of the wound care nurse. *DON B reported that it was her impression that resident 11 should only have had his left heel "floated" when he was in bed. *DON B did not always agree with the care recommendations of the wound care nurse. *When asked if there had been any attempt to consult a physician when the DON was not in agreement with the wound care nurse, she responded that it was difficult to "step on toes." 10. Review of resident 11's progress notes documented by wound care RN G related to the left ankle pressure injury revealed: *10/23/24 Skin/Wound note, "Outcome: Not progressing-LEFT lateral not floated upon arrival 10/23."	F 686		

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F 686	Continued From page 15 *11/20/24 Skin/Wound note, "Resident resting in bed upon arrival. Agrees to wound assessment and cares. Ankle not floated upon arrival. Staff education needed. Float instructions hanging above bed.", "Wound Healing % -166.67." *11/27/24 Skin/Wound note, "Wound Healing % 0." *12/4/24 Skin/Wound note, "Wound Healing % 0." *12/11/24 Skin/Wound note, "Wound is stagnant with little to no progress.", "Wound Healing % 0." *12/18/24 Skin/Wound note, "Wound Healing % -33.33." *There was no documentation that the resident's physician was notified of the lack of healing for the left ankle pressure injury. 11. Review of the providers 12/2019 Pressure Ulcers policy revealed: *"10. Pressure ulcers will be treated as ordered by the physician and/or wound care RN and documented in the medical record." *"11. No change or deterioration in a pressure ulcer over a 2-4 week period of time will warrant physician notification for evaluation of the current treatment plan."	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		

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F 689	Continued From page 16 Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI) review, observation, interview, record review, and policy review, the provider failed to ensure the safety of one of one sampled resident (21) who eloped (left the facility without staff knowledge) when a visitor exited the building. This citation is considered past-noncompliance based on review of the corrective actions the provider implemented following the incident. Findings include: 1. Review of the provider's submitted SD DOH FRI regarding resident 21 revealed: *On 10/29/24 at 2:10 p.m., resident 21 followed an unidentified visitor out the front door of the facility. *The visitor had used a key fob to unlock the door and once in the parking lot the visitor realized resident 21 was a resident. *The visitor assisted the resident back into the lobby of the facility where staff were present. -Upon his return, the resident was assessed with no injuries and was dressed appropriately for the weather that day. -At the time of the elopement, resident 21 was in the main lobby of the facility attending a birthday party. *The facility was considered a locked unit, all exterior doors of the building were locked, and the front door had a delay of ten seconds before closure after it was opened. Review of resident 21's medical record revealed: *He had a diagnosis of dementia *His Brief Interview of Mental Status score was 4, which indicated he had severe cognitive impairment. *He resided in the memory care unit. *His care plan included he was ambulatory and	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 17 had a history of wandering. -Interventions for his wandering included: -Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. -Monitor the resident's location every fifteen minutes. -Offer diversion activities when resident begins talking about leaving facility. -Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes. The provider implemented systemic actions to ensure the deficient practice does not reoccur by having: *Notified families in the monthly newsletter and posted signage at the facility's exits that there are residents who wander and not to let residents out of the facility without staff knowledge. *Provided education to staff members regarding the elopement policy. *A practice elopement drill was conducted. *Ensured their FRI's were presented at the next Quality Assurance meeting. *An exit door in the memory care unit had been frosted, which maintains the natural light but obscures the view of the exit. *There have been no other elopements. *Visitors have been monitored to ensure they are following instructions and ensuring residents do not follow them out. The provider's implemented systemic actions to ensure the deficient practice does not reoccur was confirmed on 12/19/24 after record review revealed the facility had followed their quality assurance process, education was	F 689		

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F 689	Continued From page 18 provided to all staff about the resident's elopement, and observations and interviews revealed staff understood the education provided regarding those topics. Based on the above information, non-compliance at F689 occurred on 10/29/24, and based on the provider's implemented corrective actions for the deficient practice confirmed on 12/19/24, the non-compliance is considered past-noncompliance.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview,	F 692	1. The Director of Nursing or designee, in consultation with the medical director, will review, revise or create necessary policies for Resident Weight, including notifying the Registered Dietitian, and transcribing new provider orders, by January 21st, 2025. 2. The Director of Nursing or designee will ensure resident 34's weight is current, accurate and the provider and Dietitian have been notified of weight status and confirm diet order by January 21st, 2025. 3. The Director of Nursing or designee will provide education to staff during January 20th staff meeting, on policies and procedures on resident weight, including provider and RD notification, and diet changes/new orders to meet the standards of regulation 483.25. 4. The Director of Nursing or designee will randomly select 3 residents on varying days of the week throughout the monitoring period, in which those specific residents are being weighed, to ensure proper procedure and policy compliance has been obtained within the proper time frame. This will include monitoring diet order changes from outside providers. This will occur weekly for 3 (three) weeks, then monthly for 3 (three) months. 5. The Director of Nursing or designee will report the findings to the Quality Assurance Team for 6 (six) months for further recommendations.	01/21/2025

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F 692	Continued From page 19	F 692		

and policy review, the provider failed to follow their Resident Weight policy and notify the registered dietitian (RD) and begin follow-up for one of one sampled resident (34) who experienced a significant weight loss. Findings include:

1. Observation on 12/17/24 at 3:37 p.m. revealed resident 34:
*Was asleep in a group/activity room recliner with a hat and glasses on.
*His clothes were loose-fitting.

2. A review of resident 34's medical record revealed:
*He was admitted on 10/10/24.
*His 10/18/24 Brief Interview of Mental Status (BIMS) assessment score was 99, indicating he had not participated or was unable to participate in the assessment.
*His diagnoses included vascular dementia (a type of dementia caused by reduced blood flow to the brain) with anxiety, cerebral infarction (stroke), and depression.
*Review of the resident's weight records revealed:
-On 10/10/24, he weighed 186.4 pounds.
-On 11/2/24, he weighed 185.4 pounds. On 11/9/24, he weighed 178.6 pounds.
--A loss of 6.8 pounds in one week.
-On 12/13/24, he weighed 170.6 pounds which was an 8.5% weight loss since his admission.
*His care plan interventions for his weight included:
-To "Monitor/document/report PRN [as needed] any signs/symptoms of dysphagia [difficulty swallowing]: Pocketing [when someone holds food in their mouth rather than swallowing], Choking, Coughing, Drooling, Holding food in

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F 692	Continued From page 20 mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals" initiated on 10/24/24. -"RD [registered dietician] to evaluate and make diet change recommendations PRN [as needed] initiated on 10/24/24." *On 11/15/2024, the resident had an outpatient dentist appointment to check his denture fit. -The dentist's progress note indicated: --He had not seen any sore spots. --The resident was not able to wear his dentures predictably due to dementia. --"Please use soft foods- patient is not likely to keep dentures in." ---The progress note was acknowledged by a nurse in his chart, and the note was entered into his electronic medical record (EMR). *On 12/12/24, the registered dietician (RD) performed a significant weight change assessment on the resident and recommended continuing his current diet order and added a Magic Cup (a nutritional supplement) once a day. -She did not change the resident's regular diet to a soft diet. *His dietary orders included: -Regular diet, regular consistency, large portions at meals. These were ordered on 10/10/24 on admission. --The diet orders had not been changed related to the dentist's 11/15/24 diet recommendation. -Magic Cup one time a day at noon, ordered on 12/13/24. *On 12/18/24 at 2:10 p.m., a nurse's note indicated that he had refused to wear his dentures that morning. 3. Interview on 12/18/24 at 3:59 p.m. with RD (M) regarding resident 34 revealed: *She had reviewed the resident's weight last	F 692		

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F 692	Continued From page 21 week while performing a significant weight loss assessment and started an intervention of adding a nutritional supplement. -She was unaware of the dentist's 11/15/24 recommendation for a soft diet until 12/18/24. Interview on 12/18/24 at 4:17 p.m. with dietary department manager J regarding resident 34 revealed: *He was not aware resident 34 was to have a soft diet until 12/18/24. *He stated "the speech therapist emailed" him on 12/18/24 of the diet change. -He was unable to find a soft diet order in the resident's current orders. 4. A review of the provider's 5/15/23 Resident Weight policy revealed: *Weight Assessment - "3. Any weight change of 5 lbs more or less since the last weight assessment is retaken the next day for confirmation. --a. If the weight is verified, nursing will immediately notify the dietician in writing." *Evaluation - "1. Undesirable weight change is evaluated by the treatment team whether or not the criteria for "significant" weight change has been met. The evaluation includes:" --"c. the relationship between current medical condition or clinical situation and recent fluctuations in weight" - "2. The physician and the multidisciplinary team identify conditions and medications that may be causing anorexia, weight loss or increasing risk of weight loss."	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		

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F 695	Continued From page 22 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to follow their policy related to oxygen administration for two of five sampled residents (4 and 12) who received oxygen therapy: *Resident 4's oxygen tubing was not dated. *Resident 12's oxygen tubing was not changed monthly per facility policy. *Resident 4's nasal cannula was observed on the floor during one of three observations. *Resident 4's foam filter on the back of the oxygen concentrator machine had a buildup of dust. Findings include: 1. Observation and interview on 12/17/24 at 3:42 p.m. with resident 4 in her room revealed: *She was wearing a nasal cannula and using a portable oxygen tank. That tubing was not dated. *There was an oxygen concentrator machine next to her sink. -The foam filter on the back of the machine had a buildup of dust and fuzz. -The nasal cannula for that machine was on the floor. 2. Observation on 12/18/24 at 9:39 a.m. in	F 695	1. The Director of Nursing or designee, in consultation with medical director, will review, revise or create necessary policies for Oxygen Administration by January 21, 2025. 2. The Director of Nursing or designee will ensure resident 4 and 12's oxygen tubing has been replaced and dated, as well as ensuring concentrator filter task is current by January 5th, 2025. 3. The Director of Nursing or designee will provide education during January 20th staff meeting on policies and procedures on oxygen administration, including concentrator filter cleaning and tubing changes, to meet the standards of regulation 483.25. 4. The Director of Nursing or designee will randomly select 3 residents with oxygen administration to ensure proper oxygen tubing and procedure and policy compliance has been obtained. This will occur weekly for 3 (three) months, then monthly for 3 (three) months. 5. The Director of Nursing or designee will report the findings to the Quality Assurance Team for 6 (six) months for further recommendations.	01/21/2025

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F 695	Continued From page 23 resident 12's room revealed: *There was a section of extension tubing from the oxygen concentrator machine to the water chamber with a handwritten date of "9/28" on it. *The water chamber had a handwritten date of "12/13/24" on it. 3. Interview on 12/18/24 at 2:28 p.m. with registered nurse (RN) F revealed: *They previously used plastic baggies to store the residents' oxygen tubing when not in use. Residents did not like these baggies and would throw them in the trash. *They now used hooks that were adhered to the side of the concentrator machines to wrap the oxygen tubing around when not in use to keep it off the floor. *She expected staff to replace a nasal cannula if it was found on the floor. *The reason why resident 12's oxygen extension tubing had not been replaced was due to supply issues. -They did not have that particular tubing in stock. -The employee in charge of ordering supplies went on medical leave for approximately two months, and the backup person was not aware of that specific type of extension tubing to ensure it was ordered and available. *She indicated that "sometimes cleaning the filter each week does not get done like it should." 4. Observation on 12/18/24 at 2:50 p.m. in resident 4's room revealed: *The nasal cannula was stored wrapped up and tucked under the handle of the oxygen concentrator machine. The nasal cannula was not on the floor. *There was no indication to note if the nasal cannula had been replaced or not.	F 695		

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F 695	Continued From page 24 *The foam filter was still dusty. 5. Interview on 12/18/24 at 2:59 p.m. with certified nurse assistant (CNA) N about oxygen tubing revealed: *The nurses changed the residents' oxygen tubing weekly. *If he found a nasal cannula on the floor, he would have wiped it off with an alcohol wipe, wrapped the tubing up, and tucked it under the handle of the oxygen concentrator machine. 6. Interview on 12/18/24 at 4:45 p.m. and again on 12/19/24 at 8:12 a.m. with director of nursing (DON) B revealed: *She expected the residents' oxygen tubing to be changed monthly. *The backup supply person may not have known about that style of extension tubing to be able to order it. *She expected the foam filters on the oxygen concentrators to be cleaned weekly. *RN F was usually responsible for ordering the oxygen tubing supplies for residents. -She indicated that RN F was "probably waiting for [the employee in charge of ordering supplies] to get back to order that part." *She confirmed that oxygen extension tubing was about two months overdue for changing. 7. Review of resident 4's physician orders revealed: *"Change O2 [oxygen] tubing on concentrator/tank Q month [every month]." -That order was scheduled "one time a day every 14 day(s)." *"Clean O2 concentrator filter Q week [every week] one time a day every 7 day(s)."	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A038	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTCHMAN LIVING CENTER	503 WEST PINE PHILIP, SD 57567

(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 695	Continued From page 25 *Those orders were placed on 6/6/23. 8. Review of resident 4's December Treatment Administration Record revealed that the filter was documented as having been cleaned on 12/5/24 and 12/12/24. 9. Review of the provider's 9/23 Oxygen Administration policy revealed: *"Maintenance: -1. Oxygen tubing is to be changed monthly. -2. Concentrator filters are to be cleaned and checked monthly. -3. Humidifier containers are to be cleaned weekly with a 1:1 [1 to 1] vinegar/water solution or as per manufacturer recommendations." *"Documentation: -1. After completing the oxygen set up or adjustment, the following information should be documented in PCC [PointClickCare]. --a. The date and time the oxygen was applied ..." *"Reporting: - ...2. Report other information in accordance with facility policy and professional standards of practice."	F 695		
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	Cleaning Food Safety 1. All items identified that required cleaning during the survey were all cleaned as of December 25, 2024. Dietary Director reviewed all areas to ensure that appropriate cleaning was completed as of December 25, 2024. 2. The items identied area dded to the deep cleaning list. This list is broken down into two lists, a daily cleaning and a weekly cleaning list. The daily cleaning list will be adjusted to add flattop and grease traps. The weekly cleaning list will be adjusted for the juice dispenser, hood ventilation panels, ceiling tiles and fans and every two weeks the fryer and the area around the fryer.	01/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SCOTCHMAN LIVING CENTER	503 WEST PINE PHILIP, SD 57567

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F 812	Continued From page 26 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the provider failed to properly label foods and discard foods on or before the manufacturer's best-by date, and failed to maintain the following kitchen items in a clean and sanitary manner: *In the kitchenette: -The flattop grill. -The grease trap drawer beneath the flattop grill. -The juice dispenser. -The overhead ventilation hood panels. *In the main kitchen: -The ceiling and ceiling vents throughout the kitchen. -The grease trap drawer beneath the flattop grill. -The deep fat fryer and the spaces in between the fryer and the adjacent equipment. Findings include: 1. Observation on 12/17/24 at 1:27 p.m. in the kitchenette revealed: *The flattop grill was stained with a burnt-on substance. *The grease trap drawer beneath the flattop grill contained a thick brown sludge of burnt food and grease. *There was a layer of dust buildup on the overhead ventilation hood panels.	F 812	3. Staff education on the updated cleaning lists was provided on January 13, 2025 by the Dietary Director. 4. These items will be monitored by the Dietary Director weekly and reported to the Quality Assurance Team monthly. This will be monitored for 6 months. Tracking of data will begin on January 13, 2025. Outdated and unlabeled items 1. All items identified were removed from stock on December 17, 2024. Dietary Director reviewed all other stock items to ensure that any expired or unlabeled items were removed as of December 25, 2024. 2. Policies and checklists were updated on January 13, 2025. 3. Dietary Director will hold an inservice and education to staff on proper storage policies on January 13, 2025. 4. Dietary Director will monitor storage for 6 months to ensure that storage policies are being followed. This will be monitored weekly and reported to Quality Assurance Team monthly. Tracking of data will begin on January 13, 2025.	

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	43A038	A. BUILDING _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTCHMAN LIVING CENTER	803 WEST PINE PHILIP, SD 57567

(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 812	Continued From page 27 *There was an unidentified white growth inside the grape juice dispenser. 2. Continued observation on 12/17/24 at 1:41 p.m. in the main kitchen revealed: *There was a buildup of dust on the ceiling and ceiling vents throughout the kitchen, including above food preparation areas. *The grease trap drawer underneath the flattop grill was filled with a yellowish oily liquid. There were bits of what appeared to be eggs floating around in that liquid. *The sides of the deep fat fryer were covered in crumbs and grease. -The fryer was situated in between the gas stovetop and the ovens. -There was a buildup of grease and food crumbs on the paneling of the stovetop and the oven, which was a potential fire hazard as the gas stovetop used an open flame to operate. *In one of the reach-in coolers, there were two foods past the manufacturer's best by dates: -One opened jug of lime juice with "BEST BEFORE 2024 NOV 13." -One opened container of pesto with "BEST IF USED BY: 11.11.2024." *There was a container of orange powder with a handwritten label of "Taco Seasoning 6.1.23 - 6.1.24." -A measuring scoop was stored inside that container. *There were two large containers of what appeared to have been sugar and flour. There was no label or date on them. 3. Interview on 12/18/24 at 3:28 p.m. with cook I revealed that the juice machine was supposed to have been taken apart and cleaned weekly.	F 812		

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	43A038	A. BUILDING _____ B. WING _____	C 12/19/2024

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SCOTCHMAN LIVING CENTER	503 WEST PINE PHILIP, SD 57567

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F 812	Continued From page 28 4. Interview on 12/18/24 at 3:51 p.m. with certified dietary manager (CDM) J revealed: *The overhead ventilation hoods were cleaned professionally every six months. -The hood panels were cleaned as needed by himself or the dietary staff. -He estimated the hood panels in the kitchenette had not been cleaned in approximately a month and a half. -That task was not on the cleaning checklist. *The deep fat fryer was cleaned at least every two weeks, but sometimes more depending on the menu. *Staff were cleaning the fryer that day. *He recently put the protective guards up as another layer of protection between the fryer and the gas stovetop. 5. Interview on 12/18/24 at 4:20 p.m. with cook I revealed: *The grease trap drawers were supposed to have been cleaned daily. *She was not sure why there was so much liquid in the grease trap drawer in the main kitchen. *The flattop grill in the kitchenette was hardly ever used, and she was unsure about when the grill or the grease trap drawer were last cleaned. 6. Interview on 12/18/24 at 4:30 p.m. with dietary aide (DA) H in the kitchenette revealed: *The flattop grill in the kitchenette was not used often as it would take a long time to warm up and clean afterwards. -She did not know when it was last cleaned. *The juice machine was supposed to have been cleaned weekly. -She indicated the juice machine was not always cleaned weekly as it took a long time to drain it, put warm water through it, take it apart, bring it	F 812		

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F 812	Continued From page 29 back to the kitchen, wash it, bring it back to the kitchenette area, and put it back together again. 7. Interview on 12/19/24 at 10:28 a.m. with CDM J revealed: *He expected staff to wipe down the ceilings and vents once per week. -He indicated the task on the checklist was to wipe the walls down, but he expected staff to wipe the ceilings as well. -He was aware that task "does not always get done." *The grease trap drawer in the main kitchen fills up with liquid daily as they pour large volumes of water and lemon juice onto the grill to clean it. That liquid pours down the drain into the drawer. *He expected the drawers to have been cleaned daily. *He was not aware of the unidentified white growth or sediment in the grape juice dispenser. -He expected the juice dispenser to have been disassembled and cleaned weekly. -He explained that some staff may not take the machine all the way apart because they did not know how to take it apart or put it back together. --He confirmed there are directions to do so on the inside of the juice dispenser door. *He confirmed the food items that were past their best-by dates were thrown away. 8. Review of the provider's "Daily Cook Cleaning List" for the week of 12/8/24 through 12/14/24 revealed all items on the cook's list were initialed off as having been completed. 9. Review of the provider's "Weekly Cleaning List" from 11/17/24 through 12/14/24 revealed: *Cleaning the deep fat fryer was not included on the list.	F 812		

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F 812	Continued From page 30 -Someone had written that the fryer was cleaned the week of 12/1/24 to 12/7/24. *Cleaning the overhead ventilation hood panels was not on the list. *Wiping the ceiling and ceiling vents was not on the list. *Cleaning the flattop grill and the grease trap drawer was not on the list. *Cleaning the juice machine was a weekly task on Fridays. That task was initialed as having been completed each week. 10. Review of the provider's 8/28/23 policy that did not have a title revealed: *"POLICY STATEMENT -It is the policy of the Dietary Department that all perishable foods are refrigerated at the appropriate temperature and in an orderly and sanitary manner." *There were no guidelines describing expectations on labeling and storage of bulk items like sugar, flour, and taco seasoning. *There were no guidelines describing expectations on storage of foods past the manufacturer's best-by date.	F 812		

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	43A038	A. BUILDING _____ B. WING _____	12/18/2024

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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 12/18/24. Scotchman Living Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maureen Cadwell
TITLE: CEO/Administrator
(X6) DATE: 01/10/2025

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.

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

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	43A038	A. BUILDING **01 - MAIN BUILIDING 01** B. WING _____	**12/18/2024**

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SCOTCHMAN LIVING CENTER	**503 WEST PINE PHILIP, SD 57567**

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K 000	INITIAL COMMENTS A recertification survey was conducted on 12/18/24 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Scotchman Living Center was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K226 in conjunction with the provider's commitment to continued compliance with the fire safety standards..	K 000	A second point of latching was ordered on January 7, 2025 and will be intalled upon receipt. Maintenance Director will report the completion of the second point of latching to the Quality Assurance Team at the January meeting.	01/21/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Maureen Cadwell | CEO/Administrator | 01/10/2025

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

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	10661	A. BUILDING: _____ B. WING _____	12/19/2024

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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 12/17/24 through 12/19/24. Scotchman Living Center was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 12/17/24 through 12/19/24. Scotchman Living Center was in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maureen Cadwell

TITLE: CEO/Administrator

(X6) DATE: 01/10/2025