STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435056	A. BUILDING _____ B. WING _____	C 07/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNER REGIONAL HEALTHCARE CENTER	805 E 8TH ST WINNER, SD 57580

(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 7/18/22 through 7/20/22. Winner Regional Healthcare Center was found not in compliance with the following requirements: F609, F610, F657, F658, F686, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 7/18/22 through 7/20/22. Areas surveyed included neglect. Winner Regional Healthcare Center was found not in compliance with the following requirement: F686.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established	F 609	F609 Reporting Alleged Violations: Staff received written training with mandatory quiz on reporting any incidents to the charge nurse on duty who reports to it to the DON, SSW or her designee. All incidents will be added to the Risk Management program as soon as they are reported to the charge nurse after ensuring resident safety. The Risk Management program will be checked daily for new incidents and investigations begun on any unexplained incidents by the DON or designee. An inservice for all staff will be held on August 16, 2022 to review the policy for Incident Reporting (which was updated on 08/08/2022). This training will include a powerpoint to review reportable events. All progress notes are audited Monday through Friday by the DON or designee, and incidents are recorded on the Risk Management Completion Audit tool. The audit will be completed by the DON or designee and results taken to QAPI monthly for 3 months and then as needed. New incidents will be reported in the IDT meetings Monday through Fridays at 1000. The investigations will be discussed in the weekly Quality of Care committee meetings on Tuesday afternoons. Incidents and investigations continue to be discussed at monthly QAPI meetings.	08.17.22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 8/26/22

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

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F 609	Continued From page 1 procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the South Dakota Department of Health (SD DOH) had been notified of unexplained bruising for one of one sampled resident (20). Findings include: 1. Interview on 7/20/22 at 5:11 p.m. with director of nursing B regarding bruises found on resident 20 revealed: *She did not know how the bruising occurred. *SD DOH should have been notified of the bruising at the time they were first observed and an investigation should have been completed. *It was her responsibility to notify the SD DOH. Refer to F610.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.	F 610	F610 Investigate/Prevent/Correct Alleged Violations Staff received written training with mandatory quiz on reporting any incidents to the charge nurse on duty who reports it to the DON or her designee. All incidents will be added to the Risk Management program as soon as they are reported to the charge nurse after ensuring resident safety. Each incident will be	08.17.22

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F 610	Continued From page 2 §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure a thorough and accurately documented investigation had been conducted for one of one sampled resident (20) with unexplained bruising. Findings include: 1. Observation on 7/19/22 at 9:25 a.m. of certified nursing assistant (CNA) E using a mechanical lift to assist resident 20 to the bathroom revealed she: *Used a wheelchair pushed by staff to move about the facility. *Had bruising in her left groin and on her abdomen below her navel. *Did not appear to be in pain or fearful. Interview on 7/19/22 at 9:25 a.m. with CNA E regarding resident 20's bruises revealed she: *Had thought they were from a fall she had recently. *Was working at the time of the fall but did not witness the fall. Review of resident 20's medical record revealed: *She had short and long-term memory	F 610	F610 continued investigated by the LSW, DON, or designee as to cause of the incident and if required by the ARSD will have a report entered into the SD Launch-pad Applications within two hours of any incidents of potential abuse by the LSW or DON. An inservice for all staff will be held on August 16, 2022 to review the policy for Incident Reporting, (which was updated on 08/08/2022). This training will include a PowerPoint to review reportable events and investigations. An investigation will be completed with documentation of the investigation kept under the notes section of the Risk Management report, completion of the investigation will be monitored by the DON. LSW or designee will ensure the state report has been finalized and accepted into the system. A report of all the state reports will be taken to the QAPI monthly meeting by the LSW.	

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F 610	Continued From page 3 impairment. *She had an unwitnessed fall on 7/1/22. *On: -7/5/22 she started to show signs of pain to her left hip and was leaning to the left. -7/9/22 she: --Continued to lean to the left and was noted to be more sleepy. --Had a skin assessment completed with no bruising noted. -7/11/22: --She was noted to have a large bruise on her left upper inner thigh and continued to have left hip pain and signs of a UTI. --Her physician was notified and ordered an x-ray of her left hip and obtain urine for a urinalysis (UA). ---X-ray was negative for fracture or dislocation. --Her daughter was notified of her change in condition and the new physician orders. -7/12/22 she had a skin assessment completed showing "Bruising purple and yellow in stages of healing below umbilicus [navel]. Another bruise noted to left inner thigh yellow and purple in color." -7/13/22 her UA results came back showing she had a UTI and she was started on antibiotics. -7/19/22 she had a skin assessment completed showing "Bruising in stages of healing to right medial thigh and below umbilicus." Interview on 7/20/22 at 3:53 p.m. registered nurse (RN) C regarding resident 20 revealed she: *Was the nurse who assessed her after her fall on 7/1/22 and only noted some redness to her lateral left side and lateral left leg. *Did not think the bruising was from the fall as both bruises showed up days later. *Had completed the skin assessment on 7/9/22	F 610		

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F 610	Continued From page 4 and agreed the bruises had not been present. *Had learned about the bruises in shift report, was not sure of the date. *Did not know how the bruises occurred. Interview on 7/20/22 at 4:24 p.m. with RN D regarding resident 20 revealed: *In the shift report and in morning meeting on 7/12/22 he had been told about her bruises. *Had had completed the skin assessment on 7/12/22 and had documented the bruising in his assessment. *He did not know how the bruising could have occurred. *Director of nursing (DON) B had been at the morning meeting on 7/12/22 and was aware of the bruises. Interview on 7/20/22 at 5:11 p.m. DON B regarding resident 20 and her bruises revealed: *She did know about the bruise to her left groin but not the one on her abdomen below her navel. *She had not assessed the resident's bruising. *Had shown concern about the bruising during the interview. *An investigation had not been completed regarding the bruising. *The bruises were probably not related to her fall on 7/1/22. *An investigation should have been completed when the bruising was first noted. *It was her responsibility to conduct investigations. Interview on 7/20/22 at 5:35 p.m. with interim licensed master social worker (LMSW) F regarding resident 20 revealed he: *Was filling in for the social service designee while she was out on leave.	F 610		

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F 610	Continued From page 5 *Was not aware that resident 20 had unexplained bruising. *Would be involved if there was suspicion of abuse. *Had not been involved in investigations while working in the facility. Interview on 7/20/22 at 5:45 p.m. with administrator A revealed: *He was not aware of bruising that had been found on resident 20. *An investigation should have been completed. Review of the provider's December 2021 Abuse Investigation policy revealed: "All reports of resident abuse, neglect and injuries of an unknown source shall promptly and thoroughly investigated by facility management."	F 610		
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	F 657	F657 Care Plan Timing and Revision The facility procedure is to develop and implement individualized care plans for all residents to obtain the highest practicable well being. Care plans are reviewed and updated quarterly and when there is a significant change in condition or care needs. The care plan will reflect the current support required for each resident. Care plans are reviewed by the MDS coordinators quarterly and will be updated by the appropriate department for any changes as they occur. Resident 30 had therapy screen her and their recommendations have been added to her care plan and includes reminding her to take smaller bites, eat more slowly, and not talk while	08.18.22

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F 657	Continued From page 6 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, interview, and record review, the provider failed to ensure one of one sampled resident's (30) care plan was updated related to the needs of a resident who had coughing/choking spells while eating. Findings include: 1. Observation and interview on 7/18/22 at 5:44 p.m. during dinner service of resident 30 revealed: *She coughed up a small amount of food. *Certified nursing assistant V stated resident 30 coughed almost every time she ate. Observation and interview on 7/18/22 at 6:09 p.m. of resident 30 in her room after the above incident revealed: *She had been assisted on to the toilet and was still coughing. *She stated she had choked on a potato chip. *Registered nurse D stated: -Her lungs were clear and her oxygen saturation was 97%. -She had an upcoming swallow study appointment. Record review of resident 30's 3/24/22 and	F 657	F657 continued eating. Licensed nurses had training on August 10, 2022 on how to update care plans and will be expected to update the care plans with any changes daily. The DON or designee will review the daily documentation and audit the care plans for any incidents, condition and pertinent order changes on the Resident Condition Changes and Care Plan Updates form which includes the resident, condition requiring updated, provider contacted, date of care plan update, the nurse making the update and review by DON as to whether the update was sufficient and appropriate. The DON will take the audit to the QAPI meeting monthly for three month, then every other month for three months.	

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F 657	Continued From page 7 7/14/22 therapy notes revealed a swallow study had been completed, the results were normal, and no there were no other recommendations. Record review of resident 30's 7/15/22 care plan revealed she was: *On a regular diet. *At risk for aspiration due to having choking/coughing episodes during meals that had not been addressed. Interview on 7/20/22 at 2:40 p.m. with director of nursing B revealed she: *Was aware of resident 30's issue with coughing during meals. *Would have expected her coughing during meals to have been addressed in the care plan.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure: *Appropriate follow-up for weight variances to determine actual loss or gain for one of one sample resident (28). *Make notification to physician when the ordered size of catheter for insertion into a gastrostomy site was not available for one of one sample resident (11). *An assessment that included resident representative notification for need and intended	F 658	F658 - Services Provided Meet Professional Standards The physician for Resident 28 was notified of the weight loss and fluctuations in her weight that are normal patterns for her on 07/21/22. Dietary fortifies her foods. The staff will have inservice on 08/16 to review the policy for weights to be repeated if there is a discrepancy of five pounds up or down. The weights will be reviewed weekly in the Quality of Care committee meetings on Tuesdays. The DON or designee will ensure physicians are informed of significant weight changes.	08.17.22

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F 658	Continued From page 8 use of a bed alarm was completed by a nurse prior to receipt of a physician order for one of one sampled resident (8). Findings include: 1. Observation on 7/19/22 at 9:55 a.m. of resident 28 in her room revealed she was in her wheelchair and had not responded when attempting to engage in conversation. Review of resident 28's electronic medical record revealed from: *6/26/22 through 7/17/22 she had a 10 and one-half pound weight loss,. *7/3/22 through 7/17/22 there was no documentation related to her weight loss. Interview on 7/20/22 at 2:40 p.m. with director of nursing (DON) B revealed: *She was unaware of resident 28's potential for weight loss related to questionable accuracy of weights. *If a resident had a weekly weight loss of 5 pounds up or down they were to be reweighed. *Notification of a weight change was to have been communicated to the nurse in charge, DON, physician, and documented in their progress notes. Review of the provider's February 2020 Weight policy revealed: *"If there is a discrepancy of 5 pounds up or down, obtain an automatic reweigh." *They were to have notified the physician and the dietician. 2. Review of resident 11's medication administration record (MAR) revealed an 18 French Foley catheter could be used if a	F 658	F658 continued The physician gave an order on 07/21 for resident 11 to use a #18 foley if there is no gastronomy tube available and if there are no #18's available to use a #16 foley. Nursing staff instructed to keep physicians notified if there are not ordered supplies available for acceptable alternatives. SCU staff instructed on 07/21 to document any instances of the alarm sounding. We have reviewed the use of the bed alarm on Resident 8's bed. She has had only one documentation of setting off the alarm, and that was when she was sitting up in the bed. Also, she has not had any falls since the alarm was initiated. We changed the bed alarm to a motion sensor alarm that will only alarm if she swings her legs over the edge of the bed but will be less restrictive to her on 08/10/22 and family was notified. Nursing staff will have inservice on 08/16 and will review the need to notify the MD of any changes in resident condition as well as to review the process needed prior to initiating any alarms or special equipment. The DON or designee will review the daily documentation	

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F 658	Continued From page 9 gastrostomy tube was not available. Observation and interview on 7/20/22 at 10:33 a.m. with registered nurse (RN) D in resident 11's room regarding the Foley catheter revealed: *Resident 11 was in his reclining wheelchair. *RN D pulled back his abdominal binder to assess his gastrostomy site. *A 16 French catheter was inserted in his gastrostomy site. *RN D stated an 18 French catheter was not available on 7/6/22 so a 16 French catheter was used. *RN D agreed the provider should have been called to verify if a smaller size catheter could have been used. Interview on 7/20/22 at 1:36 p.m. with DON B revealed: *If the correct catheter size was not available the provider should have been called. *The new order should have been entered in the MAR and documented in the progress notes. *They did not have a specific reference source. 3. Observation on 7/19/22 at 9:45 a.m. of resident 8's room revealed: *She was not in the room. *There was a pressure alarm device on her bed. Interview on 7/19/22 at 9:46 a.m. with certified nursing assistant (CNA) E revealed it was used at night to alert staff if she had tried to get up on her own so she does not fall. Review of resident 8's medical records revealed: *She had short and long-term memory impairment. *On 5/4/22 a physicians order was obtained for	F 658	P658 continued and audit the care plans for any Incidents, condition and pertinent order changes on the Resident Condition Changes and Care Plan Updates form and will take the audit to the QAPI meeting monthly for three months, then every other month for three months.	

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F 658	Continued From page 10 "May use a bed alarm on her bed only during the night to notify staff if she is getting up unassisted at bedtime for fall prevention." *There was no documentation: -Of an assessment prior to placing the alarm on her bed to ensure it was not a restraint. -Her guardian had been notified of the alarm being placed. -If the alarm was effective. Review of resident 8's 7/5/22 care plan revealed: *She was at risk for falling related to weakness and a history of falls. *Her last fall was out of her bed on 4/16/22. *The goal is to be free from falls and injuries. *Interventions included: -To anticipate and meet her needs. -To assist her promptly as she will get up on her own. -A fall mat on the floor next to her bed. -A bed alarm at night. -Appropriate footwear when mobilizing in her wheelchair. Interview on 7/20/22 at 11:24 a.m. with director of nursing B regarding the bed alarm for resident 8 revealed: *She had implemented the bed alarm. *She had not documented an assessment. *A night CNA was telling her the resident was trying to get up multiple times during the night and thought she may fall. *Since implementing the alarm the night staff have not reported her trying to get up on her own anymore. *She did update the guardian that the alarm was put on but did not document it. *She did not know if the alarm was effective as staff did not document how it was working.	F 658		

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F 658	Continued From page 11 Review of the provider's 4/26/22 Alarms policy revealed: *"5. Review of the resident's condition will determine if the resident will benefit from the use of an alarm. 6. The charge nurse will notify the family of the use of the alarm and educated staff regarding the alarm system. 7. The use of alarms will be reviewed on a regular basis but not less than quarterly by the interdisciplinary team. This can be done by the Reduction or Behavior Committee or the Care Plan Team."	F 658		
F 686 SS=D	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 (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 observation, interview, record review, and policy review, the provider failed to ensure interventions were in place to prevent the development of a pressure ulcer and weekly wound assessments had been completed for one	F 686	F686 Treatment/Services to Prevent/ Reviewed the resident's charts and a Braden scale was completed on 100% of residents within the last three months. The policy for prevention and treatment of skin breakdown has been reviewed and updated with pertinent and current practice. Weekly Skin Observations will be done on all residents at bath times. Any wounds identified during assessments or daily cares will be documented by Nursing staff on a tracking form for skin impairments to follow the wound from initial wound until healing to ensure all documentation has been completed. This form includes doing Braden Scale assessments for pressure ulcers weekly X 4.	08.17.22

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WINNER REGIONAL HEALTHCARE CENTER	805 E 8TH ST WINNER, SD 57580

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F 686	Continued From page 12 of one sampled resident (27) with a full-length leg brace. Findings include: 1. Observation on 7/18/22 at 5:00 p.m. of resident 27 revealed: *She was lying on her back in bed with the head of the bed raised slightly. *She had oxygen on at 2 LPM (liters per minute) via nasal cannula. *She had the appearance of sleeping, with her eyes closed and breathing was regular and unlabored. *She had a knee brace on her right leg. *There was a dressing in place over her right ankle. *She had not responded to the surveyor when her name was called. Observation on 7/19/22 at 9:00 a.m. of resident 27 revealed: *She had been lying on her back in bed with the head of her bed elevated slightly. *She had oxygen on at 2 LPM via nasal cannula. *She had the appearance of sleeping with her eyes closed and regular breathing. *She had not responded to the surveyor when her name was called. Interview and observation on 7/20/22 at 10:10 a.m. with RN (registered nurse) C as she completed a dressing change on resident 27's right inner ankle pressure ulcer revealed: *As she completed the care, RN C measured the area and indicated the pressure ulcer was "0.5 cm (centimeters) by 1 cm", the wound bed was pink and without any drainage. *She said the pressure ulcer had "improved greatly from a few weeks ago."	F 686	F686 continued A report of new and unhealed wounds and completion of the skin observations weekly will be taken to the QAPI committee monthly meeting. All nursing staff will review the new policy for pressure ulcers, treatment, prevention and documentation at a mandatory meeting on August 16th.	

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F 686	Continued From page 13 Observation on 7/20/22 at 12:00 p.m. of resident 27 revealed: *She had been in her bed with the head of her bed elevated to a sitting position. *She had oxygen on at 2 LPM via nasal cannula. *She had been eating her lunch with the assistance of an unidentified certified nursing assistant (CNA). *When the surveyor introduced herself to resident 27, her only response was, "hello". -She had not responded to any questions that were asked. Review of resident 27's medical record revealed: *An admission date of 12/1/14. *Diagnoses included: hypertension, depression, primary osteoarthritis of both knees, and hip fracture [recent]. Review of resident 27's 3/18/22 annual Minimum Data Set (MDS) assessment revealed she: *Required extensive assistance of two staff persons for bed mobility, transfers, and toileting. *Required supervision and assistance of one staff person for eating. *Had a Brief Interview for Mental Status (BIMS) examination score of 12 indicating mild cognitive impairment. *Had a Braden Scale (scale used to determine pressure ulcer risk) of 14 indicating she was at moderate risk of developing pressure ulcers. Review of resident 27's 6/17/22 significant change MDS revealed: *She was totally dependent on two staff persons for bed mobility, transfers, and toileting. *She could no longer stand. *She had a Braden score of 13 indicating she was at moderate risk of developing pressure	F 686		

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F 686	Continued From page 14 ulcers. *She had a BIMS score of 14 which had improved from the 3/18/22 MDS assessment. *She had a new hip fracture. *She had a new Stage III pressure ulcer identified. Review of resident 27's progress notes, UDA (user-defined assessment) wound, and skin assessments revealed the: *"Skin observation 2" UDAs on 4/23/22, 5/4/22, and 5/11/22 had not included any notes about a pressure ulcer. *5/11/22 observation had included notes of "multiple bruises to extremities in various stages of healing related to recent fracture." *5/16/22 observation included, "Resident has a small breakdown on right foot caused by immobilizer brace digging into skin. Mepilex [protective dressing] is in place." -No wound measurements had been included in this assessment. *5/27/22 skin observation had included notes about the area of breakdown on her right foot. The "area is now padded to protect the skin from further breakdown." -No wound measurements had been included. *6/1/22 observation had not included any description of the skin breakdown on her right foot. *6/11/22 observation had included "Resident continues to have small, scabbed area to inner right ankle from contact with leg brace; covered with Mepilex. -No wound measurements had been included. *6/22/22 observation included, "Present on right lower extremity are two open sores located on her ankle sustained from immobilizer. Mepilex had been placed over wounds."	F 686		

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F 686	Continued From page 16 -No wound measurements had been included. *6/29/22 observation had included "right inner ankle wounds remains open with yellow exudate present. The wound had been assessed, cleansed, and a Mepilix applied to the area. Her leg brace remains on her right leg and had been assessed for proper fitting." -No wound measurements had been included. *7/9/22 weekly wound observation tool had described a facility acquired pressure ulcer on resident 27's right medial (inner) ankle, measuring 3.8cm by 3.8cm. -This note had the date the pressure ulcer had been acquired as 5/16/22. *7/14/22 note had not included wound measurements. Review of resident 27's care plan, revised on 7/1/22, revealed: *"Focus- [resident name] is at risk for developing pressure ulcers and skin breakdown as she is either in her recliner chair, w/c [wheelchair], or her bed." -Updated on 5/16/ [22], [resident name] developed a pressure area to medial right ankle from the full leg brace. -Treatment started. [did not specify what that treatment included] -She is at increased risk of skin impairments." Interventions had included: *"Do a skin inspection with ADLs [activities of daily living] and notify the nurse for any skin conditions or changes. Weekly head to toe skin assessments after bath by nurse with any skin issues documented. *[Resident name] has pressure redistribution mattress on her bed and gel cushion in her w/c. *[Resident name] needs extensive help repositioning every two hours, make sure she	F 686		

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F 686	Continued From page 16 makes significant shifts in her weight when she is up in her chair. *Knee brace on at all times, wear protective layer of clothing underneath brace to protect the skin. *Assess skin underneath the brace once a shift. Monitor for redness and impairments. *Therapy notified that brace is rubbing at ankle." *Nutritional interventions included supplements to promote wound healing. -"Regular diet with regular food textures. -Finger foods as able per OT [occupational therapy] screen 3/24/21. -Started on nectar thickened liquids 7/3/22. -Mighty Shakes (high calorie, high protein drink) TID [three times a day]. [Started 6/30/22] -Juven [supplement to promote wound healing] 1 packet BID [twice a day] due to wound healing." [Started 7/7/22] Interview on 7/20/22 at 6:10 p.m. with director of nursing (DON) B revealed: *Her expectations were that appropriate interventions were in place prior to the resident developing a pressure ulcer and measurements of wounds completed weekly. *She agreed those measurements had not been completed. Review of the provider's Pressure Ulcer Policy, revised 7/16 revealed: *"Purpose: -2. To identify individuals at risk for developing pressure ulcers. -3. To define interventions for prevention of pressure ulcers. -4. To define treatment, activity, pain management, infection control management, and monitoring methods used for pressure ulcers. -6. To provide education, in-service, continuous	F 686		

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F 686	Continued From page 17	F 686		

quality management and care plan guidelines for prevention and treatment of pressure ulcer to residents, staff, and family.
-7. Pressure Ulcer Definition
--A pressure ulcer is defined as any lesion caused by unrelieved pressure resulting in damage to underlying tissue. Pressure ulcers are usually over bony prominences and are staged to clarify the degree of tissue damage observed (agency for health care policy research, 1994).
Staging Classifications:
---c. Stage III. Full thickness of skin loss involving damage or necrosis of subcutaneous tissue which may extend down to, but not including the fascia, The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.
-11. All residents will be screened on admission, readmission, change of condition and quarterly with the MDS [minimum data set assessment] by using the Braden scale [numerical scale used to indicate resident's risk of skin breakdown].
--A score of 18 or less indicates a resident at risk for pressure ulcers.
--a. Use the Pressure Ulcer Prevention-Braden Scale Protocol to implement the appropriate prevention devices/techniques for all risk areas.
-Update or add all prevention devices to be used on the Safety and Prevention flow sheets.
-b. Bed and chair bound individuals or those with impaired ability to reposition will be assessed for additional factors increasing risk for pressure ulcers. These factors include:
-i. Immobility
-ii. Incontinence
-iii. Inadequate nutritional intake
-iv. Altered levels of consciousness.
-12. Prevention of Pressure ulcers
--"a. Notify Director of Nursing, Skin Care Nurse,

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F 686	Continued From page 18 Dietician/Dietary Manager, Certified Nurse's Aide of risk factors identified from Braden Scale Score or Comprehensive Skin Assessment. --b. Nutritional support -i. A nutritional assessment is completed when a resident is identified at risk for skin breakdown... -The assessment will be completed by the Certified Dietary Manager [CDM] or the facility Dietician. -Documentation by the Dietary Manager is reviewed by the Dietician. -ii. The nutritional standing order will be implemented when a resident scores less than 18 on the Braden scale or when skin breakdown is present. --iii. Percentage of meal intake recorded by the nursing department will be reviewed by the CDM or [the] Dietician. Appropriate meal substitutes and meal replacements will be offered, and additional foods/beverages provided to meet nutrients needs as clinically indicated. -v. Documentation for nutritional support will include: -1. Calorie, protein, and fluid requirements -2. Assessment of skin condition -3. Assessment of laboratory values: ... Serum Albumin, hemoglobin, and hematocrit... -5. Review of current dietary plan and any recommendations for appropriate changes in meal plan and/or supplementation should be provided -6. Reassess, reevaluate, and revise interventions when progress is not noted. [several weeks had gone by with no measurements or treatments documented] -13. Mobility and Activity. --a. Reposition bed-bound residents every 2 hours, every 2 hours if chair-bound. Encourage chair-bound residents to shift weight every 15	F 686		

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F 686	Continued From page 19 minutes if able. --b. Utilize pressure reducing mattress or pressure reducing overlays (air or gel). -14. Skin Care and Moisture --a. Observe skin daily, especially bony prominences -21. In-servicing and Education --b. Ongoing staff education regarding causal factors and interventions for pressure ulcers and when an existing pressure ulcer is present. --c. Skin care and pressure ulcer prevention/treatment training will be included in orientation of clinical staff."	F 686		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880	F880 Infection Control Hand Hygiene Compliance and glove use during performance of personal cares by both a CNA and an RN: The staffing coordinator or DON will do hand hygiene competencies on all new hires and agency staff. A copy of the Hand Hygiene Policy will be given to all new staff and a copy of a Moments Of Hand Hygiene handout will be given to all new staff, and then a quiz and a hand washing competency will be completed. All current staff will be reeducated on hand hygiene and will receive a copy of the Moments Of Hand Hygiene handout and will be required to complete a handwashing competency by 8/17/22.	08.17.22

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F 880	Continued From page 20 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880	F880 continued Audits will begin on 8/11/22 by the DON or her designee for 5 staff members weekly for 1 month, then twice a month for 3 months and then monthly for 6 months. Failure to comply with proper handwashing techniques will require additional training. Audits will be taken to the QAPI meetings monthly. Proper glove use during performance of personal cares by both a CNA and an RN: All current staff will be reeducated on the proper use of gloves to include not wearing the same gloves when doing cares and moving from the dirty stage of cares, ie brief and dressing changes, to the clean stage of cares. The meeting on 8/16 will include education on changing gloves and doing proper hand hygiene when moving from contaminated to a clean site during care of a resident. An audit will be completed weekly on 2 staff members, one from each shift, while providing cares for 8 weeks, and if there are no unmet expectations monitoring will decrease to twice a month for 3 months and then monthly and the results reported monthly to the	

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F 880	Continued From page 21 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure infection procedural techniques for: *Appropriate hand hygiene and glove use during performance of personal care by certified nursing assistants (CNA) (G) and (H) for resident 27. *Appropriate hand hygiene and glove use as well as lack of placing a barrier during performance of a dressing change by registered nurse (RN) (C) for resident 27. Findings include: 1. Observation and interview on 7/19/22 at 4:20 p.m. with CNA G and CNA H while providing personal care for resident 27 revealed: *CNA G: -Removed the soiled brief, cleaned the resident with a cleansing wipe, and applied ointment to her bottom. -Removed the glove she used to apply the ointment. -Applied a clean brief with the soiled glove she left on. -Agreed she had missed an opportunity to complete hand hygiene when going from soiled to clean when performing personal care for resident 27. 2. Observation and interview on 7/20/22 at 10:10 a.m. with RN C while completing a dressing change to resident 27's right inner ankle pressure ulcer revealed: *RN C completed hand hygiene and put on gloves, then took a basket with dressing change	F 880	F880 continued QAPI committee. Barrier was not used between the basket with dressing supplies, the overbed table or the bed: Residents dressing supplies are kept together in a basket in their rooms. A disposable barrier will be added to the wound kit to trigger staff to use the barrier when performing cares. Training will be completed at the nursing meeting on 8/16 and a review of the circumstances under which the employees protect the resident from equipment and supplies that could be contaminated per facility policy. An audit will be completed weekly on 2 staff member, 1 from each shift, while providing cares for 8 weeks, then twice a month for 3 months and if there are no unmet expectations monitoring will decrease to monthly with the results reported monthly to the QAPI committee. All facility staff who provide or are responsible for "appropriate hand hygiene and glove use during the performance of resident personal cares and dressing change" will be educated/reeducated by the DON by August 17th, 2022.	

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F 880	Continued From page 22 supplies from resident 27's over bed table and placed them directly on the bed without placing a barrier down first. *RN C removed the old dressing, cleansed the area with gauze and normal saline, then took a wrapped tongue blade and measured the pressure ulcer. *With her soiled gloves, she opened the tongue blade, squeezed some Medi-Honey (product to heal wounds) on the tongue blade, applied it to the pressure ulcer, and applied a new dressing. *RN C then removed her gloves and performed hand hygiene. Interview with RN C directly after the above observation revealed she: *Had missed an opportunity to complete hand hygiene when going from a soiled task to a clean task when changing resident 27's pressure ulcer dressing. *Had not realized she had not placed a barrier for the dressing change supplies. 3. Interview on 7/20/22 at 6:15 p.m. with DON (director of nursing) B revealed, "Yes, I would expect hand hygiene to be completed any time they are going from soiled to clean. We discuss that at least once a week in our 'huddles'." Agreed that a barrier should be used for wound care supplies. 4. Review of the provider's 3/30/22 Infection Control, Long-Term Care policy revealed: Policy: "1. All body [bodily] substances and contaminated equipment and supplies are to be considered potential sources of infection and handled in accordance to the Standard BSI [body substance isolation] policy."	F 880	F880 continued Lori Hintz, RN with the QIO was contacted on 8/10/22 at 1700 and discussed the infection control survey results and her suggestions were received and appreciated. Root Cause Analysis: The following issues are identified: Several of the staff are travelers with varying contract start and end dates so consistency is difficult. Auditing for infection control has declined over the last 3 months due to decrease in staffing in key positions. (MDS, Infection Preventionist) People taking over these roles have had insufficient training for the processes that were in place. Lack of adherence to the facility policy, in part staff forgets, is not in the habit and gets busy and just gets the job done without thinking through the consequences. There is a lack of routine with the change of staff so the staff are not familiar with the residents and their care needs.	

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F 880	Continued From page 23 Procedure: 1. Strict adherence to all Infection Prevention and Control policies and departmental procedures is the foundation of any successful departmental infection Control program. 2. Good personal hygiene practices will be followed (Hand Hygiene Policy)." Review of the provider's 10/21 Hand Hygiene policy revealed: *Procedure: -"1. Remove gloves after caring for a patient [resident]. -IV. Change gloves any time you move from a contaminated area to a clean area during the care of a patient [resident] or when preparing food or if cleaning a room."	F 880	F880 contued Compliance with hand hygiene, lack of appropriate glove changes during procedures, and lack of appropriate procedural techniques with use of barriers remains a priority for protecting the health and safety of our resident population. Providing frequent and intensified training, surveillance with feedback and reminders when needed and by a variety of individuals is essential to maintain a high level of compliance with infection control practices. Staff will be required to alter behaviors, model hand hygiene, and provide a safe and suitable work environment to attain the highest levels of infection control. It is every health care workers responsibility to put forth a high level of effort and awareness in maintaining our resident's safety.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435056	A. BUILDING _____ B. WING _____	07/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNER REGIONAL HEALTHCARE CENTER	805 E 8TH ST WINNER, SD 57580

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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 7/18/22 through 7/20/22. Winner Regional Healthcare Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 08.12.2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435056	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/19/2022

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WINNER REGIONAL HEALTHCARE CENTER	805 E 8TH ST WINNER, SD 57580

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 7/19/22. Winner Regional Healthcare Center was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 08.12.2022

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STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435056	MULTIPLE CONSTRUCTION A. BUILDING: **01 - MAIN BUILDING 01** B. WING	DATE SURVEY COMPLETE: **7/19/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNER REGIONAL HEALTHCARE CENTER	**805 E 8TH ST WINNER, SD**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 712	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on interview and observation, the provider failed to ensure staff were familiar with the provider's fire drill procedures (RACE - Rescue/Alarm/Contain/Evacuate). Findings include: 1. Interview on 7/19/22 at 10:00 a.m. with the maintenance supervisor revealed the provider staff members were trained to utilize the RACE (Rescue/Alarm/Contain/Evacuate) acronym when responding to a fire drill or fire condition. Observation on 7/19/22 at 10:15 a.m. revealed a fire drill was initiated for resident room 202 by the maintenance supervisor. The staff member instructed to respond to the fire simulation removed the resident from the room and then reported the condition to the charge nurse at the nurse station. The charge nurse announced the "Code Red Room 202" three times on the overhead paging system. A large group of approximately 15 staff responded to the announcement bringing fire extinguishers and closing corridor doors. After the simulation was declared all clear a review was held at the nurse station. At no point from the initiation of the fire drill to the all clear announcement was the fire alarm attempted to be activated. A manual fire alarm pull station was located at the nurse station. After the review discussion a staff member pulled the alarm to show the respondents the proper course of action under fire/fire drill conditions. Interview with the maintenance supervisor at the time of the observation confirmed those findings. The deficiency had the potential to affect 100% of the occupants.

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The above isolated deficiencies pose no actual harm to the residents

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10713	A. BUILDING: _____ B. WING _____	07/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNER REGIONAL HEALTHCARE CENTER	805 EAST 8TH ST WINNER, SD 57580

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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 7/18/22 through 7/20/22. Winner Regional Healthcare Center was found not in compliance with the following requirements: S206, S236, 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	S206 Personnel Training A form was developed "Personnel Training" that includes the mandatory annual nursing inservice training. This will be completed on all staff in the next six weeks, and completed by the DON or designee for all existing employees on each staff member within a month prior to reviewing the annual evaluation; the form will be completed as part of their hiring process for any new WRH staff. Staff will be required to make up the annual required training that is overdue within one month. The education for the travlers will be reviewed by the scheduler and any required education they do not have will be required by the end of the first week of their contract. An audit will be completed monthly by the staffing coordinator to ensure all of the appropriate training for new staff has been completed. A report will be sent	08.17.22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 08.12.2022

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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 record review and interview, the provider failed to ensure two of two sampled employees (R and S) had attended annual training that covered the following required subjects: fire prevention/response, incidents/disease reporting, dining assistance, nutritional risks, and hydration. Findings include: 1. Review of certified nursing assistant (CNA) R's personnel and training files revealed: *She had been hired on 2/15/21. *Had completed all the orientation training. *Had not completed training on fire prevention/response, incidents/disease reporting, dining assistance, nutritional risks, and hydration since her orientation training. 2. Review of certified nursing assistant (CNA) S's personnel and training files revealed: *She had been hired on 2/8/21. *Had completed all the orientation training. *Had not completed training on fire prevention/response, incidents/disease reporting, dining assistance, nutritional risks, and hydration since her orientation training. Interview on 7/20/22 at 3:00 p.m. with human resources director W revealed: *Each employee was required to complete each required training on a yearly basis. *There was no tracking to ensure this was completed on a timely basis. *The employee training was computer-based. Review of the revised February 2020 provider's	S 206	to QAPI monthly with the number of annual evaluations and percent of staff education completed.	

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S 206	Continued From page 2 Required Annual Training of Healthcare Workers policy revealed: *Orientation and ongoing education would cover the following required subjects annually. Those subjects included: -Fire prevention/response, incidents/disease reporting, dining assistance, nutritional risks, and hydration. *Evidence of completion of the required training/education modules and/or job-related competencies would be maintained online and accessed by a report by the education coordinator or supervisor when needed.	S 206		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new	S 236	S236 TB Screening Requirements: TB policy process has been changed to drawing lab work when doing facility orientation and doing the drug screens. The hospital DNS or her designee will now contact the lab for requisition for the needed lab work. The two staff who had not been tested will receive their labs as soon as they are available to do so. The DNS or designee will forward the lab results on the new staff to the scheduler to include in their LTC record. Contract labor are required to have the testing a part of their contract on hire. The Staffing Coordinator will ensure s/he has record of this information prior to them working on the floor and will document it on the TB spread sheet. A report of new hires and new travelers and completion of the TB testing will be sent to the QAPI committee monthly for six months.	08.17.22

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S 236	Continued From page 3 healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, personnel health file review, and policy review, the provider failed to ensure two of three recently hired sampled employees (T and U) had completed tuberculin (TB) testing within fourteen days of being hired. Findings include: 1. Review of employee T revealed she had been hired on 6/13/22. There was no record of any type TB testing completed. 2. Review of employee U revealed she had been hired on 5/18/22. There was no record of any type TB testing completed. Interview on 7/20/22 at 3:45 p.m. with human resources director W revealed: *Employees T and U had no record of any TB testing. *She had asked chief nursing office (CNO) X at the hospital and had been told they had 90 days to complete the tests. *She was not sure where hospital CNO X obtained that information. *She indicated hospital CNO X had left for the day and was unable to have been interviewed. Review of the provider's reviewed April 2020 Employee Health Program policy revealed: *Applicants would have been screened for tuberculosis. *There was indication of when the TB screening	S 236		

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S 236	Continued From page 4 should have been completed.	S 236		
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. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and record review, the provider failed to ensure all the required dietary training's (food safety, handwashing, food handling and preparation techniques, food-borne illness, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements) were completed by eight of eight (J, K, L, M, N, O, P, and Q) dietary employees annually. Findings include: 1. Review of the dietary training logs for 2022 revealed: *Nutrition and hydration training had been provided in June of 2021. *Food-borne illness training had been provided in December of 2021. *Handwashing training had been provided in January of 2022. *Time and temperature controls for food preparation and food pieces trainings had been provided in February of 2022.	S 301	S301 Mandatory Dietary Staff meeting was held on 07.26.2022 with all staff in attendance to discuss State survey findings. General education on changing processes and TTC for prep and service education to meet requirement. Meetings will be held the 4th Friday of each month or otherwise indicated and a required topic will be discussed and training completed. During on-boarding process, employees will be required to do inservices on Food Safety, IDDSI training, Food Service education, Nutrition Hydration and Feeding Assistance and Thermometer Calibration and Cleaning. Audit log will be maintained and completed by employee's anniversary date of required training as indicated by 44:73:07:16 Required Dietary Inservice Training.	08.17.22

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S 301	Continued From page 5 Interview on 7/19/22 at 4:10 p.m. with certified dietary manager (CDM) I regarding dietary training revealed she: *Often filled in as a cook and dietary aide due to staffing issues and had not had time to ensure staff received the education. *Had worked 51 hours in the last 3 days. *Was aware of the required trainings. *Had been in her position since June 2021. *Was responsible to ensure all dietary staff received the required trainings. Interview on 7/19/22 at 5:10 p.m.with administrator A regarding the required dietary trainings revealed he: *Had been informed by the registered dietician in April 2022 the required trainings were not being completed. *Had not been aware they still had not been completed. *Had offered to support the CDM during as staff meeting. *Had not ensured staff meetings had been held to provided the required trainings. Review of the provider's February 2020 Required Annual Training of Healthcare Workers policy revealed it had not included the required trainings for dietary staff.	S 301		