STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435038	A. BUILDING _____ B. WING _____	C 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEKAKWITHA LIVING CENTER	6 E CHESTNUT SISSETON, SD 57262

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F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/15/24 through 7/18/24. Tekakwitha Living Center was found not in compliance with the following requirements: F625, F657, F686, F689, F761, F812, F880, and F882. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/15/24 through 7/18/24. The area surveyed included quality of care and treatment related to skin breakdown. Tekakwitha Living Center was found in compliance.	F 000		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1)	F 625	F 625 Administrator, DON, and interdisciplinary team reviewed and revised the policies and procedures for bed-holds on 8/6/24. DON or designee will audit residents for bed-holds weekly for four weeks and monthly for two additional months. Administrator and DON created a nurse procedure for bed-hold notification. Created on 8/6/24. Bed-hold tracking for and audit sheet was also created on 8/6/24.	8/15/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jessica Wood | TITLE: Administrator - EPH | (X6) DATE: 8-13-24

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

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F 625	Continued From page 1 of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review the provider failed to provide bed-hold notices to the resident and/or their representative regarding a transfer to the hospital for one of two sampled residents (33). Findings include: 1. Review of resident 33's electronic medical record (EMR) revealed: *She fell on 7/14/2024. *The physician was called at 6:30 p.m. and updated on her incident, injuries, and vitals. *An order was received to send the resident to the emergency room (ER). *The resident's representative was called by registered nurse (RN) F and updated on the residents's accident and transfer to the ER. *On 7/14/2024 at 9:22 p.m. RN F called the ER for an update and was told the resident would be sent to a local hospital for further evaluation regarding a fractured right femoral head (hip). *Progress note on 7/16/2024 at 10:24 a.m. stated the resident would be hospitalized until further notice. Further review of the EMR revealed there was no written notification to the resident or her representative regarding the Bed Hold policy. 2. Interview on 07/18/24 at 10:26 a.m. with RN F	F 625	F625 Resident 33's bed hold was not completed due to already been to the hospital and back to nursing home. Nursing staff will be educated on the bed-hold policy at the nursing meeting by Administrator and DON on 8/8/24. If staff can't attend Administrator or DON will do 1 on 1 training with these staff members. DON or designee will report findings at monthly QAPI meetings continuously until determination.	

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F 625	Continued From page 2 regarding the bed hold policy revealed: *She did not notify resident 33 or their representative of the bed hold notice prior to or after the residents' transfer to the hospital. *She stated the charge nurse should have notified the resident representative of the bed hold notice and completed the form at the time of transfer to the hospital. *If the charge nurse had not done it then the facility office staff usually followed up. *She could not find a signed bed hold notice for resident 33 related to her 7/14/2024 hospital transfer. 3. Interview on 7/18/2024 at 11:15 a.m. with social service designee C revealed the nursing department took care of notifying family/power of attorney (POA) of bed hold notices regarding transfers to the hospital. 4. Interview on 7/18/2024 at 11:54 a.m. with director of nursing B revealed her expectation was for the charge nurse to get the signature for the bed hold form the day the resident left and transferred to the hospital. 5. Interview on 7/18/2024 at 12:05 p.m. with administrator A revealed: *The charge nurse should fill out the bed hold form when the resident left for the hospital or do a verbal notification with the resident's representative over the phone if the resident was unable. *She would collect the bed hold notice form once it was filled out and put it in a binder. *She confirmed that resident 33 did not have a bed hold policy form filled out for her 7/14/24 hospitalization.	F 625		

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F 625	Continued From page 3 6. Review of the provider's undated Bed Hold Policy and Notification revealed: *Bed Hold Policy was given on date of admission in the admission binder booklet. *It stated what "hospitalization" and "therapeutic leave" was and the general rules for holding and paying for a bed. *It had not stated when the bed hold policy notification was to be given to the resident and/or their representative.	F 625		
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	F 657	F657 Administrator, DON and interdisciplinary team reviewed and revised care plans on Resident 23 and Resident 10. DON or designee will update care plans. Resident 23 updates include: bunny boots, air mattress on bed, turn and repositioned every 2 hours, reposition clock in room, added protein supplement to diet and wound nurse will round monthly on resident. Resident 10 updates include: comprehensive care plan created on 8/2/24 and care plan for woodworking and driving golf cart on 8/2/24 OT will assess resident 10 monthly for 3 months and quarterly thereafter. DON or designee will audit resident 23 and resident 10 for care plans weekly for four weeks and monthly for two additional months.	8/15/24

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F 657	Continued From page 4 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure resident care plans were revised to reflect the current needs of two of fifteen sampled residents as follows: *One of one sampled resident (23) who had a pressure ulcer. *One of one sampled resident (10) who had leisure interests including woodworking and driving a golf cart. Findings include. 1. Observation on 7/17/24 at 10:15 a.m. of resident 23 revealed he was in bed lying on his back when licensed practical nurse (LPN) G went in to provide wound care. Interview on 7/17/24 at 10:41 a.m. with certified nursing assistant (CNA) H regarding resident 23 skin concerns revealed: *She stated, "I think the skin issues are from the residents not being repositioned and she had voiced her concerns to management." *Administrator A had started rounds and things had improved. Interview on 7/17/24 at 2:10 p.m. with licensed practical nurse (LPN) G regarding resident 23 revealed: *They had changed out his entire bed and mattress a couple of weeks ago because his old one folded him up like a "V" with both his head and feet elevated. *They changed his heel boots to bunny boots, (a resilient, breathable polyfiber liner that allows air	F 657	F657 DON or designee will report findings at monthly QAPI meetings continuously until determination.	

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F 657	Continued From page 5	F 657		

circulation for increased comfort for toe and heel pressure protection), but did not know when.
*They should have changed his interventions sooner.

Interview on 7/17/24 at 3:30 p.m. with director of nursing (DON) B regarding resident 23 revealed:
*His bed was changed to one with an air mattress because he would slide down in his old one and that should have been done sooner.
-This change was not on his care plan.
*He had a turn and reposition clock in room, but the (CNAs) took it down.
-That was not on his care plan.
*Interventions for the wound (or skin condition) on his buttocks area had changed and she thought they were improving. have changed and thinks they are improving.
-There were no wound interventions noted in his care plan.
*The provider had added a wound nurse who sells dressings and would give recommendations for skin interventions.
-That was not noted in his care plan.

Observation and interview on 7/18/24 10:45 a.m. of resident 23 with registered nurse (RN) F revealed:
*The resident was in his bed lying on his back when RN F entered his room to provide wound care.
*She said an air mattress had been added.
-That was not on his care plan.

Review of resident 23's Minimum Data Set (MDS) assessment section M for skin conditions dated 3/10/24 signed by director of nursing (DON) B on 3/21/24 revealed:
*He did not have pressure ulcer/injury, or scar

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F 657	Continued From page 6 over bony prominence. *He was at risk of developing pressure ulcers/injuries. *He had a pressure reducing device for chair. *He had pressure reducing devices for bed. *He did not have a turning/repositioning program. *He did not have a nutrition or hydration intervention to manage skin problems. Review of resident 23's current care plan revealed the following: *He was at risk for pressure ulcers and skin breakdown due to incontinence and immobility. -That was initiated on 4/7/21. *[The resident first name] skin would be kept clean, dry and free of pressure ulcers and skin breakdown. *They would monitor for any signs and symptoms of skin breakdown and report to the primary care provider. *He had a pressure reducing mattress to bed and cushion to wheelchair to aid in the prevention of skin breakdown or pressure ulcers, initiated 4/7/21. *They would prevent shearing the resident's skin during transfers and repositioning if possible. - That was initiated on 4/7/21. *The resident was incontinent of urine and occasionally incontinent of bowel. He should have been assisted with incontinence care after each incontinence episode. -That was initiated on 4/7/21. *The resident had a heel ulcer related to immobility. -That was initiated on 5/21/24, with a revision date of 6/12/24. *The resident would have intact skin, free of redness, blisters or discoloration through the review date	F 657		

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F 657	Continued From page 7 -That was initiated on 12/11/23 with a revision date of 12/11/23, and a target date of 6/4/24. -Apply Bag Balm Ointment to buttocks as ordered for prevention and to heal breakdown on buttocks related to incontinence, was initiated on 12/28/22. *Apply heel foam Tegaderm to right heel ulcer as ordered and change every other day until healed, was initiated on 5/31/24. *He was dependent on one staff for assistance with bathing , dressing, personal care, and locomotion with a wheelchair and was dependent on two staff for assistance with transfers and toileting. -That was initiated on 3/21/23 with revision on 6/13/24. *The resident and staff were educated as to what caused skin breakdown including: transfers/positioning requirements and good nutrition and frequent repositioning. -That was initiated on 12/11/23, with a revision on12/12/23. *The resident and family were taught the importance of changing positions for prevention of pressure ulcers. They were encouraged to make small frequent position changes due to immobility. -That was initiated on 5/21/24 with a revision date of 6/12/24. *The resident needed turned or repositioned at least every 2 hours, more often as needed or requested. -That was initiated on 12/11/23 with a revision date of 12/12/23. *He required the bed as flat as possible to reduce shear when repositioning, was initiated on 12/11/23 with revision on the same date. *He would wear bunny boots while lying in bed every evening and night for skin protection and prevention was initiated on 1/24/23.	F 657		

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F 657	Continued From page 8 *The resident had limited physical mobility related to dementia was initiated on 9/11/23 with a revision on 6/12/24. *He would remain free of complications related to immobility, including contractures, thrombus formation, skin-breakdowns, and falls related injury throughout the next review date initiated on 9/11/23, with a target of date 6/4/24. *The resident was not able to ambulate was initiated on 9/11/23 with revision that same date. *For locomotion: the resident was totally dependent on one staff member for pushing his wheelchair short and long distances was initiated on 9/1123 and revised on 9/11/23. 2. Interview on 7/16/24 at 4:25 p.m. with resident 10 revealed he enjoyed: *Riding his golf cart around the town. *Woodworking and had a workshop in the facility's basement. Review of resident 10's electronic medical record (EMR) revealed: *He moved into the facility on 3/27/23. *His diagnoses included age-related cognitive decline and Alzheimer's disease. *An 11/9/23 Occupational Therapy (OT) Evaluation and Plan of Treatment documented: -A Saint Louis University Mental Status (SLUMS) exam scored at 26 out of a possible 30 indicating Mild Neurocognitive Disorder. -An Assessment Summary that stated " ...The patient has been performing woodworking tasks for years and resulting had an accident resulting in a hand injury. The patient was alert and oriented x 4 on this date and did assist with making a safety plan for all his woodworking tasks/tools... The patient is motivated to follow recommendations and continue with his loved	F 657		

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F 657	Continued From page 9 leisure task..." *An undated Electric Motorized Device Skills Test - Outdoor assessment completed by an occupational therapist documented: -For "Outside Safety" a handwritten comment "has cellphone". -He was "Independent (Can complete safely without assistance) (Pass)" for: --Negotiating the Outdoor Environment. --Negotiating the Street Crossing Environment. -"No concerns with inclines or declines." -He was "able to locate ramps and other pathways." -A handwritten comment stated "Need to address pathway to reach golf cart." *Had recently completed a Brief Interview for Mental Status (BIMS) exam on 7/12/24 and had scored 10 out of a possible 15 indicating he was moderately cognitively impaired. Review of resident 10's EMR's comprehensive care plan on 7/17/24 at 11:13 a.m. revealed that: *It did not address his goals, preferences, strengths, weaknesses, or needs that were related to his leisure interests of woodworking or driving a golf cart. *It did not refer to the supplemental paper care plan for his woodworking. Review of resident 10's 11/1/23 supplemental paper care plan for his woodworking revealed: *"OT evaluation related to woodworking safety." *"Orientate and instruct [first name of resident 10] and staff that he will use his cell phone and his pager to call the staff while in the basement or garage-Relate to anything that Paul may need. Cell Phone Number for [first name of resident 10] [10 digit phone number] *"Attempt to check on [first name of resident 10]	F 657		

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F 657	Continued From page 10 often." *"Family aware of woodworking in the basement and aware of the risks of wood working." *"Ventilation in room and wears a mask for dust." *"Make sure that [first name of resident 10] has non-skid shoes while doing wood working." *"[first name of resident 10] is aware to make sure the power switch is off before he plugs into a power tools." *"[first name of resident 10] is aware to not use a tool that is damaged." *"Reminders to [first name of resident 10] to not rush given daily." *"Will continue to update plan with issues as they arise." *"Given to Activities and Nursing Departments on-11/1/23". Review of resident 10's 11/23/23 supplemental paper care plan revealed an intervention had been added: *"Will Wear safety gloves and must wear a safety shield on the saw (special saw will shut off immediately.)" *"Given to Activities and Nursing Departments on 11-23-23". Review of resident 10's 3/24/24 supplemental paper care plan revealed two interventions had been added: *"Can only saw if he is supervised with a staff member." *"If you notice any concerns with [first name of resident 10]'s driving the golf cart-Let [first name of administrator A] know or the nursing staff-So we can have OT [Occupational Therapy] do an assessment on [first name of resident 10]. *"Given to Activities and Nursing Departments on 3-24-24".	F 657		

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F 657	Continued From page 11 On 7/17/24 at 2:40 p.m. DON B provided resident 10's comprehensive care plan from the resident's EMR that revealed: *His woodworking care plan was included in that comprehensive care plan. -She had added his woodworking care plan to his EMR's comprehensive care plan that day. -The resident's cell phone number had an incorrect area code. *It had not addressed his goals, preferences, strengths, weaknesses, or needs that were related to his leisure interest of driving a golf cart around town. Interview on 7/17/24 at 9:41 a.m. with activity director J regarding resident 10's leisure interests revealed: *He used one of the provider's garages in the building for parking his golf cart. *Their contracted therapy services had conducted an evaluation of his ability to safely navigate going to and from the garage and his ability to safely operate the golf cart. *He used a room in the provider's basement as his workshop for his independent woodworking activity. *She stated that he carried a walkie-talkie with him while he worked in the basement workshop and garage to communicate with staff. *When asked about his care plan and her involvement she stated that the above leisure interests were not part of his activities care plan and that she thought the nursing department had managed that aspect of his care. Interview and record review on 7/17/24 at 10:31 a.m. with director of nursing (DON) B regarding resident 10 revealed:	F 657		

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F 657	Continued From page 12 *She stated he had been assessed by the provider's contracted therapy services for his ability to -Safely operate his golf cart. -Safely pursue his independent woodworking activities. *She provided those assessments. -An undated "Electric Motorized Device (EMD) Skills Test- Outdoor". -An 11/9/23 Occupational Therapy (OT) Evaluation and Plan of Treatment. *She also provided an undated one-page printed paper titled "Care Plan for [resident 10's name] for Wood Working." -She agreed the supplemental paper care plan for his woodworking was not part of his EMR's comprehensive care plan. Interview on 7/17/24 at 11:30 a.m. with administrator A regarding resident 10 revealed: *The one-page printed paper care plan for the resident's woodworking was a supplemental care plan and was not reflected in the comprehensive care plan in the provider's electronic health record (EHR). *His leisure interest of driving a golf cart around town was not addressed in his comprehensive care plan. Interview on 7/18/24 at 9:54 a.m. with social service designee C regarding resident 10 revealed: *She conducted the Brief Interview for Mental Status (BIMS) exam with the residents. *She agreed he was forgetful at times but was very aware of what he was doing. *He was not doing the woodworking when he admitted to the facility, but needed to find something to do and started his woodworking last	F 657		

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	435038	A. BUILDING _____ B. WING _____	C 07/18/2024

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F 657	Continued From page 13 fall and that his family was very supportive of his woodworking. *She was aware of his driving the golf cart around town, but stated he was aware that he should not travel to certain busy areas and highways. *She agreed that his driving the golf cart was not addressed on his care plan. *She was aware of the supplemental paper care plan regarding his woodworking, but was not aware if staff members supervised him while he used his woodworking saw. *She agreed that his comprehensive care plan in the provider's EHR had not included his independent activity of woodworking. Interview on 7/18/24 at 10:21 a.m. with DON B regarding resident 10 revealed: *His supplemental paper care plan for his woodworking was kept in her office, and the interdisciplinary team had a copy of that care plan. *His comprehensive care plan in the provider's EHR had not included his independent activity of woodworking. Refer to F689. Review of the provider's undated policy on Care Plans - Comprehensive revealed: *"Policy Statement: An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident." *3.g. "Aid in preventing or reducing declines in the resident's functional status and/or functional levels; ...i. reflect currently recognized standards of practice for problem areas and conditions."	F 657		

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F 657	Continued From page 14 -9. "The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans; ...b. When the desired outcome is not met; ..."	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 (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 prevent one of one sampled resident (23) from developing facility-acquired pressure ulcers. Findings include: 1. Interview on 7/17/24 at 8:00 a.m. with director of nursing (DON) B revealed resident 23 had on heel protectors but wasn't sure the thread in them had not caused his pressure ulcer. Observation on 7/17/24 at 10:15 a.m. of resident 23 revealed resident 23 was in bed lying on his back when licensed practical nurse (LPN) G went in to provide wound care.	F 686	F 686 Administrator, DON and MD reviewed and revised the policies and procedures related to pressure ulcers. DON or designee will audit resident 23 for pressure ulcers weekly for four weeks and monthly for two additional months. Resident 23's care plan has been updated to include bunny boots, air mattress on bed, reposition clock in room, added protein supplement to diet and wound nurse to round monthly. All staff will be educated on their roles and responsibilities for proactive approach to skin care on 8/8/24. The training also included revised policy and procedure for pressure ulcers. If staff can't attend Administrator or DON will do 1 on 1 training with these staff members. All residents assessed for pressure ulcers by DON or designee will report findings at monthly QAPI meetings continuously until determination.	8/15/24

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F 686	Continued From page 15 Interview on 7/17/24 at 10:41 a.m. with CNA H in regards to skin concerns revealed: *She stated, "I think the skin issues are from the residents not being repositioned," and she had voiced her concerns to management. *Administrator A had started rounds and cares had improved. Interview on 7/17/24 at 12:45 p.m. with administrator A revealed: *She confirmed that resident 23's pressure ulcers on his sacrum and heel were avoidable, "yes, they got to lay him down and get him off that area and he has boots on now. *She confirmed she had started rounds and things are better. Interview on 7/17/24 at 2:10 p.m. with LPN G in regard to resident 23's pressure ulcers revealed: *His sacral pressure ulcer was new in the last 30 days. *She stated, "Yes they were preventable." *She stated she wondered if the certified nursing assistants (CNAs) knew what "floating the heels" meant. *They had changed out his entire bed and mattress a couple of weeks ago because his old one folded him he indicated like a "V" with both his head and feet elevated. *They changed his heel boots to bunny boots. *They should have changed the interventions for his skin sooner. *She thought his pressure ulcers were part of his dementia progression. *There had been some uneasiness among the CNAs playing the blame game in regards to care provided. -Administrator A had started doing rounds on the	F 686		

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F 686	Continued From page 16 floor and followed up on complaints and things are better. *She did not work the night shift but the day CNAs did a good job but are rushed at times. Interview on 7/17/24 at 3:30 p.m. with DON B in regard to resident 23's pressure ulcers revealed: *His bed was changed to an air mattress because he would slide down in his old one. *She had placed a 'turn and reposition clock' in his room but the CNAs had taken it down and they would be written up for it but haven't been yet. *He has bunny boots now because he could feel the thread in the old ones which did not help. *His heels dug into the sheets when he moved around. *She agreed his pressure ulcers were avoidable and he should have been given an air mattress sooner. Observation on 7/18/24 10:45 a.m. of resident 23 with registered nurse (RN) F revealed he was in his bed lying on his back when RN F entered his room to provide wound care. Review of resident 23's electronic medical record (EMR) revealed his Braden scale for predicting pressure sores was scored at 13 (moderate risk) on 12/7/23 and 12 (high risk) on 7/17/24. Record review of resident 23's skin observation tool for his right heel pressure ulcer revealed: *It was discovered on 5/30/24 and measured 0.5 centimeters (cm) by 0.5 cm with no depth measurement noted. *It was staged at a two (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also	F 686		

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F 686	Continued From page 17 present as an intact or open/ruptured serum-filled blister). *It worsened to measure 1.1 by 1.1 cm by 0.1 cm on 6/18/24. Record review of resident 23's skin observation tool for his sacrum pressure ulcer revealed: *It was new on 6/20/24 and measured 1.0 cm by 0.6 cm and stage two. *It was documented on 7/9/24 to have worsened to 7.0 cm by 7.3 cm and stage three (full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling). Review of the provider's undated pressure ulcer prevention and wound care policy revealed: *General skin care guidelines 1.c. noted, "Nursing assistants and staff shall follow the turning schedule as assigned by the charge nurse, observe skin integrity and report changes to charge nurse immediately." -3.a noted, "The resident shall be turned and repositioned every 2 hours and as needed, unless contraindicated." *General pressure ulcer management guidelines 1. Noted, "the RN/LPN shall initiate Pressure Ulcer Management Guidelines for at risk resident on admission and/or later if the resident condition warrants."	F 686		
F 689 SS=G	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	F 689	F 689	8/15/24

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F 689	Continued From page 18 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: Based on interview, observation, record review, and policy review, the provider failed to implement effective precautions and interventions to ensure the safety for one of one sampled resident (10) that contributed to multiple accidents involving woodworking equipment resulting in bodily injury. Specifically, the provider failed to either complete follow-up assessments, incident analysis, or review/revise/monitor interventions. Findings include: 1. Interview on 7/16/24 at 4:25 p.m. with resident 10 revealed he enjoyed woodworking and had a workshop in the facility's basement. Interview on 7/17/24 at 9:41 a.m. with activity director J regarding resident 10's woodworking interest revealed: *He used a room in the provider's basement as his workshop for his independent woodworking activity. *She stated that he carried a walkie-talkie with him while he worked in the basement workshop and garage to communicate with staff. Interview on 7/17/24 at 10:31 a.m. with director of nursing (DON) B regarding resident 10 revealed: *She stated he had been assessed by the provider's contracted therapy services for his ability to safely pursue his independent woodworking activities.	F 689	F 689 Administrator, MD and DON reviewed and revised the policies and procedures related to resident safety and leisure pursuits on resident 10. MD or designee will evaluate all injuries for leisure pursuits at facility for resident 10. OT will evaluate resident 10 monthly for 3 months and quarterly thereafter. Evaluation will be for woodworking and golf cart. Administrator, DON and disciplinary team will audit interventions monthly for 3 months. Camera will be installed in resident 10's workshop and monitored by East side charge nurse. The nurse will have a screen that can make sure resident 10 is free of injuries and falls. Monitoring will be continuous until resident can no longer use the workshop. All staff educated about their roles and responsibilities for aiding and supervision for residents with independent pursuits at nurse meeting on 8/8/24 by administrator and DON. If staff can't attend Administrator or DON will do 1 on 1 training with these staff members.	8/15/24

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F 689	Continued From page 19 *She provided the 11/9/23 Occupational Therapy (OT) Evaluation and Plan of Treatment. *She also provided an undated one-page printed paper titled "Care Plan for [resident 10's name] for Wood Working." *When asked regarding ongoing assessments for the resident as he had a diagnosis of Alzheimer's Disease (a brain disease that gets worse over time), she agreed that ongoing assessments were necessary, but stated that since the 11/9/23 OT Evaluation, no other OT evaluation was completed. *After he had an accident in March 2024, she revealed the electric saw equipment was changed to the current equipment that had an automatic shut-off if a problem was detected. Interview on 7/18/24 at 9:54 a.m. with social service designee C regarding resident 10's woodworking revealed: *She agreed he was forgetful at times but stated he was very aware of what he was doing. *He was not doing the woodworking when he was admitted to the facility, but had started his woodworking last fall and she stated that his family was very supportive of his woodworking. *She was aware of the care plan interventions regarding his woodworking but was not sure if staff members supervised him while he used his woodworking saw. Interview on 7/18/24 at 10:21 a.m. with DON B regarding resident 10 revealed: *When asked about the care plan intervention that stated he was only to use the electric saw if supervised by a staff member, she stated -This does not happen all the time. -He was aware of the need to be supervised with the electric saw, but will use the saw	F 689	F689 All residents assessed for resident safety and leisure pursuits by Activity director or designee, will report findings at monthly QAPI meetings continuously until determination. DON or designee will report findings from monitoring camera/screen at monthly QAPI meetings continuously until determination.	

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F 689	Continued From page 20 unsupervised. -When the staff had a meeting and heard the electric saw in operation, a staff member went down to check on him. -He can get agitated with staff as he liked to be independent. *There was no video camera or alternative method that monitored his workshop activity when staff were not in supervising him. Interview on 7/18/24 at 10:25 a.m. with administrator A regarding resident 10's woodworking revealed: *The maintenance director's office and the provider's laundry area were also located in the basement, and maintenance and laundry staff checked with the resident during the day while they were working. *He was only to be working in the workshop between 7:00 a.m. and 8:00 p.m. *He had purchased a new electric saw in March 2024 after an incident had occurred. -The new saw had a special safety feature that shut off the saw if an error was detected. -When he was operating the saw, a staff member had to be supervising him. Observation and interview on 7/18/24 at 10:36 a.m. with resident 10 in his basement workshop revealed: *He was alone in his basement workshop. *He had a walkie-talkie on a shelf in his workshop and had his personal cell phone in the front pocket of his overalls. *When asked how often he used his electric saw, he stated, "Maybe once a day." -He stated he had called the maintenance director many times to supervise him while he was operating the electric saw.	F 689		

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F 689	Continued From page 21 -He wasn't sure where his safety gloves were that he was supposed to wear when using his electric saw. -He stated "At times the staff was busy, and I don't always get someone [when operating the electric saw]." Interview on 7/18/24 at 10:55 a.m. with activity director J regarding resident 10's woodworking revealed: *She checked in with him throughout the day when she worked. *He would call me at times when he needed to cut a board on his electric saw. *She agreed with the safety interventions on his supplemental paper care plan. *She had no concerns with his woodworking. An interview on 7/18/24 at 1:36 p.m. with administrator A and DON B regarding the provider's walkie-talkies revealed that multiple staff members, including the administrator, DON, dietary manager, cooks, nurses, medication aides, certified nursing assistants, housekeepers, and maintenance director, had walkie-talkies with them while they worked. Review of resident 10's electronic medical record (EMR) revealed: *He moved into the facility on 3/27/23. *His diagnoses included age-related cognitive decline and Alzheimer's disease. *A 10/23/23 Health Status progress note at 12:01 a.m. stated "At approximately 7:30 pm last evening [10/22/23] resident came to this nurse with his left pointer finger bleeding, resident stated he was working with his table saw and the piece of wood slipped and got his finger, tip of finger noted to be cut off, area cleaned,	F 689		

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F 689	Continued From page 22 Bactroban applied and covered with pressure bandage, Dr. [last name of resident's primary physician] and family updated on the above, new orders for Bactroban and dressing daily until healed." *An 11/9/23 Occupational Therapy (OT) Evaluation and Plan of Treatment documented: -Diagnoses "Age-related cognitive decline". -Current Referral Reason for Referral: "The patient has been referred for a cognitive evaluation s/p [status post] a wood working injury resulting in a cut to digit." -Background Assessment: "Patient Preferences: Hobbies: Wood working, making bird houses." -A Saint Louis University Mental Status (SLUMS) exam scored at 26 out of a possible 30 indicating Mild Neurocognitive Disorder. -An Assessment Summary that stated " ...The patient has been performing woodworking tasks for years and resulting [sic] had an accident resulting in a hand injury. The patient was alert and oriented x 4 on this date and did assist with making a safety plan for all his woodworking tasks/tools. Per the SNF [skilled nursing facility], the facility will be placing together a policy to ensure safety during such leisure tasks. The patient is motivated to follow recommendations and continue with his loved leisure task..." Review of resident 10's initial care plan for his woodworking revealed the following interventions: *"OT evaluation related to woodworking safety." *"Orientate and instruct [first name of resident 10] and staff that he will use his cell phone and his pager to call the staff while in the basement or garage-Relate to anything that [first name of resident 10] may need. Cell Phone Number for [first name of resident 10] [10 digit phone number]	F 689		

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F 689	Continued From page 23 *"Attempt to check on [first name of resident 10] often." *"Family aware of woodworking in the basement and aware of the risks of wood working." *"Ventilation in room and wears a mask for dust." *"Make sure that [first name of resident 10] has non-skid shoes while doing wood working." *"[first name of resident 10] is aware to make sure the power switch is off before he plugs into a power tools." *"[first name of resident 10] is aware to not use a tool that is damaged." *"Reminders to [first name of resident 10] to not rush given daily." *"Will continue to update plan with issues as they arise." *"Given to Activities and Nursing Departments on-11/1/23". Continued review of resident 10's electronic medical record (EMR) revealed: *An 11/13/23 Daily Charting progress note at 10:30 a.m. stated "Skilled OT d/c [discontinued] due to evaluation only 11-9-23 with safety recommendations issued." *An 11/17/23 Skin/Wound progress note at 9:10 p.m. stated "Resident came to nurse's station after working in his shop, left arm noted to be bloody, resident stated he ran into a piece of wood downstairs, large abrasion to left arm, area cleaned, Bactroban applied and covered with 4X4 Island dressing, Tx [treatment] received to monitor and cover area during the day until healed." *An 11/18/23 Skin/Wound progress note at 9:54 a.m. stated "Resident to nurses station, stated that he bumped his Lt. [left] thumb on hood, 1.5 x 1cm open area where skin was off, moderate amount of bleeding due to blood thinners. Tx.	F 689		

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F 689	Continued From page 24 [treatment] received for cleanse with betadine, apply bactroban and dressing daily until healed." *No follow-up assessment or incident analysis had been documented in the resident's EMR for the 11/17/23 incident or the 11/18/23 incident. Review of resident 10's 11/23/23 woodworking care plan revealed an intervention had been added that stated "Will Wear safety gloves ..." Continued review of resident 10's electronic medical record (EMR) revealed: *A 3/16/24 Incident progress note at 12:00 noon stated "Resident called for help from basement work room and was assisted by med [medication] aide who entered to find resident with left hand wrapped in a bloody paper towel. Med [medication] Aide brought resident upstairs to nurses station. Resident is alert and oriented and conversing and answering questions appropriately. Moderate amount of blood covering hand. Noted deep, jagged cuts to 2nd, 3rd and fourth fingers. Immediately placed 4x4's and wrapped generously with kerlix, elevated the extremity. Resident placed call to his Grandson at this time and transport to CDP [Coteau des Prairies] ER [Emergency Room] was arranged." *A 3/16/24 progress note at 2:00 p.m. stated "Resident returned from CDP [Coteau des Prairies] ER [Emergency Room] at this time. The affected fingers are wrapped. Resident states 20 stitches total. Written Orders Received: Wash the laceration with peroxide and apply and antibiotic ointment twice a day. Dr. [last name of resident's primary physician] to remove stitches on 03/28/24." *No follow-up assessment or incident analysis had been documented in the resident's EMR for the 3/16/24 incident.	F 689		

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F 689	Continued From page 25 Review of resident 10's 3/24/24 woodworking care plan revealed an intervention had been added that stated "Can only saw if he is supervised with a staff member." Continued review of resident 10's electronic medical record (EMR) revealed: *A 6/19/24 Skin/Wound progress note at 12:10 a.m. stated "Resident rang call light at this time to ask to see the nurse, when nurse entered room resident was sitting in his recliner with shirt off and abdomen exposed, nurse noted a large bruise to the right side of abdomen that measured 5 in [inches] X 3 in [inches] with a small gash in the middle, resident then turned and showed nurse his left side of abdomen and nurse noted large bruise with scrape running through the middle of the bruise, area measures 10 in [inches] X 5 in [inches], both sides were cleaned and antibiotic ointment was applied to open area on right abdomen and then covered with 4x4 island dressing, resident denies pain to areas when asked, he states he was using his saw in his work shop and it kicked the boards back at him and hit his abdomen a few times, when asked about how long ago this happened and resident stated around 8 pm tonight [6/18/24], resident offered a cold pack and Tylenol but interventions were refused." *No follow-up assessment, incident analysis or review/revision of current interventions was documented in the resident's EMR for the 6/18/24 incident. *A recently completed Brief Interview for Mental Status (BIMS) exam on 7/12/24 was scored at 10 out of a possible 15 indicating he was cognitively moderately impaired.	F 689		

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F 689	Continued From page 26 Review of the provider's undated policy on Resident safety during leisure tasks revealed: *"Policy Statement: Resident will be free from accidents and hazards while doing leisure tasks." *"Accidents and Supervision". -"[Name of provider] will ensure that the resident's environment will be free from accidents and hazards over which the facility has control to prevent avoidable accidents and will provide supervision and assistive devices to each resident. This will include identifying, evaluating, analyzing and then implementing interventions to reduce hazards and risks and then monitoring for effectiveness and then modifying interventions if necessary." A request for resident 10's incident reports related to his woodworking was made on 7/18/24 at 10:20 a.m. from administrator A and no incident reports were received by the end of the survey.	F 689		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761	F 761 Administrator, DON and interdisciplinary team reviewed and revised the policies and procedures related to expired medications. DON or designee will audit medications weekly for four weeks and monthly for two additional months. All licensed staff will be educated on expired mediations and dressings at the nurse meeting by Administrator and DON on 8/8/24. If staff does not attend Administrator or DON will do 1 on 1 training with these staff members.	8/15/24

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F 761	Continued From page 27 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure expired medications were removed from one of one medication room, one of two medication carts, and one of two treatment carts. Findings include. 1. Observation and interview on 7/18/24 at 10:00 a.m. of the provider's north hall medication room, medication cart, and treatment cart with registered nurse (RN) F revealed: *Two of seven containers of stock aspirin enteric coated 25 milligram (mg) had expired in April 2024. *Eight of eight hydrogen peroxide had expired in April 2023. *Three of three isopropyl rubbing alcohol 70 % had expired in March 2023. *Two of two tubes of oral glucose gel had expired in October 2023. *Three of three Heparin injectable syringes had expired in December 2023. *Five of five Prevnar "13" (pneumococcal vaccine) injectable had expired in September 2023. *One of one bottle of Aalcare hand sanitizer had expired in March 2024.	F 761	F 761 DON or designee will check for all expired medications in the med room, med cart and treatment cart. All expired medications will be disposed of properly. Medications and biologicals that were found during survey that were expired have been disposed of. All medications assessed by DON or designee, will report findings at monthly QAPI meetings continuously until determination.	

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F 761	Continued From page 28 *Thirty two of thirty six packets of white petroleum had expired in 2019. *Six of six packets of Vaseline gauze six of six had expired in June 2022. *She stated medication expiration dates would have been checked before administering to a resident and should have been removed. Interview on 7/18/24 at 3:30 p.m. with director of nursing (DON) B revealed: *She had not been able to keep up with removing expired medications from the medication rooms and carts but should have been removed and destroyed. *She confirmed the pharmacy audits were completed but their audits did not include expired medications. Review of the provider's undated storage of medications policy revealed "4. NO discontinued, outdated, or deteriorated drugs or biologics are available for use in the facility, All such drugs are destroyed." Review of the provider pharmacy 5/29/24 and 6/27/24 audits revealed that outdated medications were not part of their audit.	F 761		
F 812 SS=E	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	F 812	F 812 Administrator, RD and DM reviewed policies and procedures for temperatures for food and coolers. DM or designee will audit temperatures weekly for four weeks and monthly for two additional months.	8/15/24

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F 812	Continued From page 29 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure: *Necessary food safety guidelines were followed for appropriate storage and labeling of food items in one of one main kitchen. *Proper temperature documentation was completed for three of three refrigerators and three of three freezers in the main kitchen. Findings include: 1. Observation on 7/15/24 at 5:11 p.m. during the initial tour of the main kitchen revealed: *The document posted on the walk-in refrigerator was titled sanitation/record of refrigerator temperatures. *The document had six columns labeled: -Walk-in cooler. -Walk-in Freezer. -Reach-in Freezer. -Cooks cooler. -Reach-in Juice cooler. -Unlabeled. *The documentation was missing for at least five days in July for all six columns of the temperature record.	F 812	F 812 The sanitation and record of temperature logs were not able to be completed as the dates had already passed. Improper stored food items were addressed and put into the correct containers, labeled and dated appropriately. All foods without dates or labels were thrown immediately by dietary staff. All dietary staff will be educated on proper handling and storage of food and temperatures. The monthly meeting will be conducted on 8/14/2024. DM or designee will present findings and continue audits at monthly QAPI meetings continuously until determination.	

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F 812	Continued From page 30 Interview on 7/16/24 at 11:52 a.m. with cook I in the kitchen revealed: *He agreed the sanitation/record for refrigerator and freezer temperatures should have been filled out daily. *Staff were educated on refrigerator and freezer documentation on a regular basis. *He confirmed he had not documented the temperatures for his last two shifts. Record review and interview on 7/17/24 at 2:18 p.m. with dietary manager D regarding the sanitation/record of refrigerator temperatures revealed: *The April, May, and June 2024 sanitation/record of refrigerator temperature logs were each missing several days of documentation for temperatures. *She had provided education to staff for temperature documentation. *Her expectation was that staff would document refrigerator and freezer temperatures daily. *She had given verbal warnings to staff that had not completed documentation. *She agreed staff were not documenting refrigerator and freezer temperatures. Review of the provider's undated refrigerator/freezer temperature monitoring policy revealed: *"Temperatures of all freezers and refrigerators will be monitored daily." *"4. All unit temperatures are to be recorded daily on the Record of Refrigeration Temperatures form. Records of forms will be maintained for 6 months." 2. Observation on 7/15/24 from 5:11 p.m. to 6:10 p.m. during the initial main kitchen tour revealed: *There was a metal shelving unit which held the	F 812		

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F 812	Continued From page 31 following improperly stored and labeled food items: -Opened powdered sugar in the original package, closed with a twisty tie, and no use by date. -Opened bag of Rice Krispies, closed with a twisty tie, and no use by date. -Opened spice cake mix with no use by date. -Cinnamon rolls in metal baking pan, covered with plastic wrap, and no use by date. -Marshmallows in a plastic container with no use by date. *Outdated food items in one of two refrigerators: -Bag of chopped chicken dated 3/20/24, closed with a twisty tie. -Sausage patties and links with no use by date, closed with a twisty tie. -Coleslaw in a metal bowl covered with plastic wrap and handwritten date of "7/9." -Meatloaf in plastic container with handwritten date of "7/9" -Opened turkey breast in original package with handwritten date of "7/7". -Roast beef slices in zip lock bag with handwritten date of "6/7". -Chicken salad in metal bowl covered with plastic wrap and handwritten date of "7/3". *Uncovered food items in one of two refrigerators: -Pumpkin pie with one slice missing. -Butterscotch pudding dished into individual serving cups and placed on serving tray. -Sliced cheese on a tray. 3. Interview and observation on 7/17/2024 at 2:06 p.m. with dietary manager D in the main kitchen regarding food storage and labeling revealed: *She tossed the uncovered pie with no date on it into the trash and stated it should have been covered and thrown out by now. *She threw away outdated items in one of two	F 812		

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F 812	Continued From page 32 refrigerators including the roast beef, chicken salad, and sausage. *She stated food items in the fridge are only good for seven days and everything should have been covered, dated, and thrown away if outdated. 4. Interview on 7/18/2024 at 12:05 p.m. with administrator A about expectations on food storage and labeling revealed: *Her expectations were that staff will throw away outdated items. *The staff should keep food items covered and and date them accordingly. 5. Review of the provider's 2013 Food Storage policy "Procedure" revealed: *"4. Plastic containers with tight-fitting covers must be used for storing cereals, cereal products, flour, sugar, dried vegetables, and broken lots of bulk foods. All containers must be legible and accurately labeled and dated." *"13. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food is used within three days or discarded." *"14. Refrigerated Food Storage: -f. All foods should be covered, labeled, and dated. All foods will be checked to assure foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable), or discarded."	F 812		
F 880 SS=E	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	F 880	F880 Administrator, DON and interdisciplinary team reviewed and revised the policies and procedures related to infection control.	8/15/24

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F 880	Continued From page 33 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; §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	F 880	F 880 All staff including LPN G and RN F was educated on infection control and hand hygiene at nurse meeting by Administrator and DON on 8/8/24. If staff can't attend Administrator and DON will do 1 on 1 training with these staff members. DON or designee will audit staff for hand hygiene weekly for 4 weeks and monthly for two additional months. DON or designee will audit staff during dressing changes weekly for four weeks and monthly for two additional months. DON or designee will assess hand hygiene and infection control, will report findings at monthly QAPI meetings continuously until determination.	

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F 880	Continued From page 34 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. §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, record review, and policy review, the provider failed to ensure appropriate infection control measures were followed by two of two nurses licensed practical nurse (LPN) G and registered nurse (RN) F for pressure ulcer dressing changes. Findings include: 1. Observation and interview on 7/17/24 at 10:15 a.m. of resident 23's wound care with LPN G revealed she: *Stated he was on enhanced barrier precautions (EBP) (precautions to prevent transmission of infectious agents) due to his wounds. *Prepared for the resident's wound care at the	F 880		

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F 880	Continued From page 35 nurses' station. *Poured Vashe wound solution into a med cup and placed a gauze in the cup without gloves and placed it on top of the treatment cart. *Opened the Mepilex sacral dressing package, placed it on its wrapper and wrote the date on it with a marker and placed it top of the treatment cart. *Pushed the wound treatment cart down the hall and into the resident's room. *Confirmed the resident did not have a dressing on his sacrum when the certified nursing assistants (CNA's) H and K removed his brief. *Cleaned bowel movement from the area. *Changed her gloves but did not wash her hands or use hand sanitizer. *Sprayed the wound with wound cleanser and changed her gloves but did not wash her hands or use hand sanitizer. *Applied the gauze that had been soaked in Vashe wound solution to the wound. *Covered the wound with the Mepilex sacral dressing. *Removed her gloves and washed her hands. *Cleaned the wound cart and hard-surfaced items used and removed the cart from the resident's room. Observation and interview on 7/18/24 at 10:45 a.m. of resident 23's heel dressing change with RN F revealed she: *Confirmed he was on EBP. *Entered his room with the wound treatment cart. *Removed the bunny boot and sock from his right foot. *Confirmed he did not have a dressing on his heel wound. *Did not change her gloves or wash her hands after she removed his boot and sock.	F 880		

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F 880	Continued From page 36 *Sprayed the wound with dermal wound cleanser and placed a foam Tegaderm dressing on the wound. *Removed her gown and gloves, wiped down the treatment cart and items she had used prior to pulling the cart out of the room and into the hall. *Confirmed the resident was on EBP due to his wound. *Was not sure if she should have taken the wound treatment cart into the room for a resident on EBP, but that is was what she was used to doing. *Agreed she should have changed her gloves and washed her hands after removing his boot and sock before applying the new dressing to his heel wound. Interview with DON B on 7/18/24 at 3:30 p.m. related to infection control in regards to dressing changes and wound care revealed: *She was frustrated that the nurses had not performed hand hygiene appropriately during wound care. *She stated, "Hand hygiene during wound care was standard care and they had been educated about this frequently." *She stated there was nothing to say but the treatment cart should not have gone into the resident's room as resident 23 was on EBP. Review of the provider's undated pressure ulcer prevention and wound care policy revealed wound care for dressing changes indicated that nurses should have used clean (meticulous handwashing, maintaining a clean environment by preparing a clean field, using clean gloves, and prevention of direct contamination of materials and supplies).	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 37 Review of the providers undated enhanced barrier precautions policy revealed: *The provider would have implemented barrier precautions for the prevention of transmission of multidrug-resistant organisms. *The definitions noted "Enhanced barrier precautions" were an infection control intervention designed to reduce transmission or multidrug-resistant organisms (MDROs) in nursing homes. Enhanced barrier precautions involved gown and glove use during high-contact resident care activities for residents known to be colonized (germs are on the body but do not make you sick) or infected with a MDRO as well as those at increased risk of MDROs acquisition (ex: residents with wounds or indwelling medical devices). -Wound in relation to this guidance, this generally had included residents with chronic wounds, and not those with shorter -lasting wounds, such as skin breaks or skin tears covered with a Band-Aid or similar dressing. Examples of chronic wounds include but are not limited to, pressure ulcers diabetic foot ulcers, unhealed surgical wounds and chronic venous stasis ulcers. *Wound care would be any skin opening requiring a dressing would have been considered a high contact resident activity. *General considerations indicated, "enhanced barrier precautions are recommended for residents with indwelling medical devices or wounds, who do not otherwise meet the criteria for contact precautions, even if they had no history of MDRO colonization. This was because devices and wounds are risk factors that would have placed these residents at high risk for carrying or acquiring a MDRO and many residents colonized with a MDRO are asymptomatic or not presently known to be	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435038	A. BUILDING _____ B. WING _____	C 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 38 colonized."	F 880		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the provider failed to have a qualified infection preventionist for the facility. Findings include. 1. Interview on 7/15/24 at 6:05 p.m. with administrator A revealed: *Director of nursing (DON) B was the infection preventionist (IP). *DON B had not been trained as an IP but had been completing some of the tasks. *The provider had not had an IP for at least two years.	F 882	F 882 DON will be enrolled into a nursing home infection control preventionist program. The program is through the center for disease and prevention (Nursing home infection preventionist program). Program completed by 2/15/25. Administrator will monitor DON's progress monthly until completed. DON will report to administrator the progress met for each month until completion. DON will be assessed for progress of program completion by Administrator, then report findings at monthly QAPI meetings continuously until determination.	8/15/24

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	435038	A. BUILDING _____ B. WING _____	C 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 882	Continued From page 39 Interview on 7/18/24 at 3:30 p.m. with DON B revealed she: *Had been acting as the facility's IP the last two years. *She had not signed off as an IP because she had no training or certification as an IP. *They had tried to get one of their registered nurses to take the program but it had not worked out for them. Record review of the providers infection control program revealed: *The provider did not have an IP. *The annual review signature form had not been signed by an IP for at least two years.	F 882		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435038	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/16/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEKAKWITHA LIVING CENTER	**6 E CHESTNUT** **SISSETON, SD 57262**

(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
K 000	INITIAL COMMENTS Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 7/16/24 of the facility was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 7/16/24. Please mark an F in the completion date column for K233 and K251 deficiencies identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K363 and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 233 SS=C	Clear Width of Exit and Exit Access Doors CFR(s): NFPA 101 Clear Width of Exit and Exit Access Doors 2012 EXISTING Exit access doors and exit doors are of the swinging type and are at least 32 inches in clear width. Exceptions are provided for existing 34-inch doors and for existing 28-inch doors where the fire plan does not require evacuation by bed, gurney, or wheelchair. 19.2.3.6, 19.2.3.7 This REQUIREMENT is not met as evidenced by:	K 233		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jessica Watts — TITLE: Administrator - EPH — (X6) DATE: 2-8-24

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435038	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/16/2024

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K 233	Continued From page 1 Surveyor: 27198 Based on observation and record review, the provider failed to maintain clear door widths of at least thirty-two inches for one randomly observed set of exit access doors (double-door number 7). Findings include: 1. Observation on 7/16/24 at 2:36 p.m. revealed the leaves for double-door number 7 between the stairwell and the corridor were only thirty inches wide. They did not provide a clear opening width of thirty-two inches. Record review of the previous survey report confirmed the doors were part of the original construction. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct the deficiencies identified in K000.	K 233		
K 251 SS=C	Dead-End Corridors and Common Path of Travel CFR(s): NFPA 101 Dead-End Corridors and Common Path of Travel 2012 EXISTING Dead-end corridors shall not exceed 30 feet. Existing dead-end corridors greater than 30 feet shall be permitted to be continued to be used if it is impractical and unfeasible to alter them. 19.2.5.2 This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation, measurement, and interview, the provider failed to maintain exit and exit access, so any dead-end corridor (south corridor by kitchen) did not exceed thirty feet. Findings include:	K 251		F

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	435038	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/16/2024

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TEKAKWITHA LIVING CENTER	6 E CHESTNUT SISSETON, SD 57262

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K 251	Continued From page 2 1. Observation and measurement on 7/16/24 at 12:28 p.m. of the south corridor from the south, east-west corridor to resident rooms 207, 208, 209, and 210 were not provided with an exit. The dead-end corridor measured seventy-two feet in length. Interview with the director of maintenance at the time of the observation and measurement revealed during a remodel of that area years ago the exterior door had been removed. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct the deficiencies identified in K000.	K 251		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or	K 363	K 363 Maintenance or designee will fix Dutch door on RM 2016, nursing supply closet. Maintenance or designee will fix latch on the door frame to the north shower room.	8/15/24

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	435038	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEKAKWITHA LIVING CENTER	6 E CHESTNUT SISSETON, SD 57262

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K 363	Continued From page 3 pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation, testing, and interview, the provider failed to maintain latching corridor doors for two randomly observed locations (nursing supply closet and the north shower room) as required. Findings include: 1. Observation on 7/16/24 at 12:53 p.m. revealed the corridor door to the nursing supply closet (Room 216) was equipped with a dutch door. Testing of that door revealed the top section would open when it was pushed on, that section of the door was not provided with a means to latch into the door frame. Interview with the administrator at the same time as the observation and testing confirmed that finding. The deficiency had the potential to affect 100% of the occupants of the smoke compartment.	K 363		

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	435038	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/16/2024

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K 363	Continued From page 4 2. Observation on 7/16/24 at 2:40 p.m. revealed the corridor door to north shower room did not latch into the door frame when closed. Further observation and testing revealed the latch assembly for that doors handle had had been removed. Interview with the administrator at the same time as the observation and testing confirmed that finding. The deficiency had the potential to affect 100% of the occupants of the smoke compartment.	K 363		
K 712 SS=E	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: Surveyor: 27198 A.) Based on record review and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (inadequate number of required fire drills) for one of four yearly quarters from January through December 2024. Findings include:	K 712	K 712 Maintenance or designee will audit fire drills on each shift monthly for 3 months and 1 shift monthly thereafter.	8/15/24

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K 712	Continued From page 5 1. Record review at 3:45 p.m. on 7/16/24 revealed there was no documentation of fire drills for quarter two (April, May, and June) in 2024. Interview with the administrator at the same time as the record review confirmed that finding. She stated she was unaware the minimum number of fire drills per the required frequency had not been met for quarter two of 2024. The deficiency had the potential to affect 100% of the occupants of the building. B.) Based on observation and interview the provider failed to ensure staff were familiar with the provider's fire drill procedures (closing corridor doors and checking the door for the fire location). Findings include: 1. Observation beginning on 7/16/24 at 3:17 p.m. of a drill for a simulated fire in resident room 113 revealed two certified nursing assistants (CNAs) responded to the call light in the simulated fire location. Those staff after some time came back into the corridor and stated they didn't know what to do as they "hadn't done one in a while". At that point the administrator and maintenance director intervened, and directed the CNAs to use the paging system and further directed them to "go pull the alarm". At that point the drill preceded without further incident. Interview with the administrator and maintenance supervisor at that same time confirmed those findings. The deficiency had the potential to affect 100% of the occupants.	K 712		

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

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E 000	Initial Comments Surveyor: 27198 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 7/16/24. Tekakwitha Living Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jessica Wilson
TITLE: Administrator-EPH
(X6) DATE: 8-9-24

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South Dakota Department of Health

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	10685	A. BUILDING: _____ B. WING _____	07/18/2024

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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 7/15/24 through 7/18/24. Tekakwitha Living Center was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jessica Wiese — TITLE: Administrator- EPH — (X6) DATE: 8-9-24