

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

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435047	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/01/2026
NAME OF PROVIDER OR SUPPLIER AVANTARA PIERRE			STREET ADDRESS, CITY, STATE, ZIP CODE 950 EAST PARK STREET , PIERRE, South Dakota, 57501	
(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
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/29/26 through 7/1/26. Avantara Pierre was found not in compliance with the following requirements: F550, F554, F638, F658, F689, F699, F740, F755, F761, F880 and F919. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/29/26 through 7/1/26. Areas surveyed included staff not following a resident's care plan, nursing services, potential resident abuse, and quality of care related to a hot beverage spill. Avantara Pierre was found to have past non-compliance at F600.	F0000		
F0689 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 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 South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, observation, interview, and policy review, the provider failed to ensure the staff provided accident prevention interventions and device use according to the resident's care plans (personalized plan that addresses a resident's care needs, goals, and interventions) for one of one sampled resident (29) who needed to be transferred with the use of a full body mechanical lift (a mechanical lift and sling used to lift a person's full body) and sustained a	F0689	1. No immediate corrective action could be taken for the failure to follow resident 29's care plan to ensure he was transferred appropriately resulting in an injury. Certified Nursing Assistant (CNA) R is no longer employed at the facility. CNA S was a contracted CNA and is on the "do not return" list and cannot pick up shifts at the facility. All residents are at risk for their care plan not being followed to ensure they are transferred appropriately to prevent injury. 2. The Administrator, Director of Nursing (DON), and the interdisciplinary team (IDT), in collaboration with the medical director, will review the Fall Management, Transfer or Gait Belt Use, Mechanical Lifts, and Care Plans policies. DON or designee will educate all nursing staff, including LPN K and CNA T, on the Fall Management, Transfer or Gait Belt Use, Mechanical Lifts, and Care Plans policies to ensure residents are transferred appropriately per their care plans to prevent falls and/or injuries. All nursing staff will complete a competency of their knowledge on falls, mechanical lift transfer, transfers with a gait belt, and following care plan interventions. Education and competencies will be completed no later than August 1, 2026, and those not in attendance at education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 3. The DON or designee will audit 5 certified nursing assistants (CNAs) while assisting a resident with transfers to ensure the resident is transferred appropriately per their care plan. Audits will be completed weekly for four weeks and then	August 1, 2026

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Chase Watson	TITLE Administrator	(X6) DATE 7/24/2026
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F0689 SS = G	Continued from page 1 laceration (cut or torn skin) on his right lower leg when certified nursing assistant (CNA) R and contracted travel CNA S assisted the resident to pivot-transfer (when assisted to a standing position, the resident then turns their body to move to another surface) as directed by one of one licensed practical nurse (LPN) K. The resident subsequently was transferred to the emergency room for evaluation and laceration repair with staples and stitches. Findings include: 1. Review of the provider's 6/9/26 SD DOH FRI revealed that on 6/9/26 at approximately 11:00 a.m., contracted travel CNA T transferred resident 29 into a shower chair with the use of a full body mechanical lift. After resident 29's shower, CNA T attempted to transfer the resident with a sit-to-stand mechanical lift (a mechanical lift used to assist a person from a seated to a standing position). Resident 29 became upset and refused to transfer with the use of the sit-to-stand lift, stating that he could stand. Contracted travel CNA T moved the shower chair in front of a grab bar and assisted resident 29 to stand using the grab bar and a gait belt (a waist strap gripped as support for safe mobility and transfers), positioned his wheelchair behind resident 29, and he sat down in the wheelchair. At approximately 11:20 a.m. CNA R and contracted travel CNA S were going to transfer resident 29 from his wheelchair to his bed. There was not a full body mechanical lift sling under resident 29 in his wheelchair. CNA R asked licensed practical nurse (LPN) K how they should transfer resident 29 since he did not have a full body mechanical lift sling under him, and LPN K advised them to transfer resident 29 with a two-person assisted pivot transfer. CNA R and contracted travel CNA S pivot transferred resident 29 from his wheelchair to his bed without the use of a gait belt. During that pivot transfer, resident 29 told CNA R and contracted travel CNA S that his legs were tangled. When resident 29 was in his bed, CNA R and contracted travel CNA S noticed resident 29 was bleeding from his leg that which caused by an area on the bed frame that was missing a cover plug. LPN K was notified of the bleeding and assessed resident 29's leg. LPN K found a "large skin tear" and a puncture on the outside of resident 29's right	F0689	monthly for two months. Results of audits will be discussed by the DON or designee at the monthly Quality Assurance Performance Improvement (QAPI) meeting with the IDT and Medical Director of analysis and recommendations for continuation/discontinuation/revision of audits based on audit findings.	

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F0689 SS = G	Continued from page 2 lower leg. Resident 29 was transported by ambulance to the emergency room for evaluation of his right lower leg laceration. While in the emergency room, resident 29's laceration was repaired with staples and stitches. He returned to the facility with physician's orders for wound care every shift and cephalexin (an antibiotic) to be administered four times per day until 6/16/26. 2. Review of resident 29's electronic medical record (EMR) revealed he admitted to the facility on 7/19/23. His 5/18/26 Brief Interview of Mental Status (BIMS) assessment score was 9, which indicated his cognition was moderately impaired. His diagnoses included dementia (a group of symptoms affecting memory, thinking, and social abilities) with agitation. Resident 29's 6/29/26 care plan indicated he used a two-person full body mechanical lift for all transfers since 11/8/24. The care plan did not indicate the full body lift sling was supposed to be left under resident 29 after a transfer was completed, according to the provider's policy. A 6/9/26 Skin Alteration Evaluation indicated resident 29's laceration on the outside of his right lower leg was one centimeter (cm) in length by six cm in width with an unknown depth. There was a large amount of bloody drainage from the laceration and "Yes" was answered to the question, "Is the resident experiencing any pain?" A progress note on 6/9/26 at 4:50 p.m. written by LPN K stated, "Resident [29] returned from [name redacted] ER [emergency room] accompanied by [the] staff. RT [right] leg is wrapped with [an] ACE bandage and elevated on [a] foot rest. Dressing is dry/intact. Denies any pain. New orders received: Cephalexin 500 mg [milligrams] po [by mouth] qid [four times per day] x [for] 7 days, F/U [follow up] with [redacted name] wound care on 6/11/26 and F/U with [redacted physician name] prn [as needed]. [The] Resident was also given a Tetanus boost [booster] in the ER." 3. Observation and interview on 6/29/26 at 12:45 p.m. with resident 29 in his room revealed he had a full body mechanical light sling draped over his wheelchair. He was resting in bed. There were bed plugs (plugs placed in the open holes in the bed frame to cover the sharp edges of the holes) in the frame of the bed. Resident 29 did not know if he had ever been transferred in any other way than with a full body mechanical lift. He did not know if he had	F0689					

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F0689 SS = G	Continued from page 3 a cut on his leg. 4. Interview on 7/1/26 at 7:49 a.m. with administrator A revealed that the maintenance department staff did not check the residents' beds routinely to be sure the beds were working and that they did not require maintenance. The staff were educated to put a work order into the computer system for the maintenance staff to review if there were any issues identified with the residents' beds that required intervention. After resident 29 cut his leg on his bed frame there was a full facility sweep (check) of the residents' beds which identified the beds that were missing cover plugs on the bed frames. Coban (a cohesive elastic wrap) was placed on the bed frames with missing bed plugs until the bed plugs that were ordered arrived for installation. 5. Review of the 6/9/26 Full House Sweep on Bed Plugs documentation revealed there were 38 beds identified as missing bed plugs. The bed plugs were ordered for those beds missing bed plugs, and the bed plugs were installed on those beds, once they arrived at the facility. 6. Interview on 6/30/26 at 5:45 p.m. with contracted travel CNA S revealed that on 6/9/26 CNA R had asked her to help pivot transfer resident 29 from his wheelchair to his bed. Contracted travel CNA S told CNA R that resident 29 was to use a full body mechanical lift to transfer from his wheelchair to his bed. CNA R told contracted travel CNA S that she got permission from LPN K to transfer resident 29 by pivot transfer because there was no full body mechanical lift sling under him in his wheelchair. Contracted travel CNA S and CNA R completed a pivot transfer with resident 29 from his wheelchair to his bed without the use of a gait belt. When the pivot transfer was completed, they noticed resident 29's leg was bleeding, and notified LPN K. Contracted travel CNA S thought resident 29's leg got caught on the bed frame, which caused the laceration on his right leg. 7. A scheduled phone interview was attempted on 7/1/26 at 9:00 a.m. with contracted travel CNA T. Contracted travel CNA T did not answer the phone call and did not return the phone call by the completion of the survey. 8. Phone interview on 7/1/26 at 11:01 p.m. with LPN	F0689			

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F0689 SS = G	Continued from page 4 K revealed she was the nurse on duty when resident 29's leg was cut by the bed frame during a transfer. CNA R told her that resident 29 did not have a full body lift sling under him in his wheelchair and CNA R needed to transfer him into bed. LPN K knew that resident 29's care plan indicated he was supposed to transfer with the full body mechanical lift, but she did not think the CNAs would be able to put the full body lift sling under him while he was in the wheelchair. LPN K advised CNA R to pivot transfer resident 29 from his wheelchair to his bed. LPN K thought the CNAs would be able to pivot transfer resident 29 safely but stated that was a "bad call." CNA R had alerted LPN K that resident 29's leg was bleeding after the pivot transfer from his wheelchair into his bed was completed. LPN K assessed resident 29's legs, which were swollen and he had thin skin. When his legs were against the bed frame he sustained a laceration on his right leg. She described the laceration as a "big gash" that "bled a lot". LPN K felt that resident 29 needed to go to the emergency department to have the laceration evaluated. She covered the laceration with gauze dressing and an ace wrap and sent resident 29 to the emergency room by ambulance. 9. Phone interview on 7/1/26 at 11:30 a.m. with CNA R revealed she and contracted travel CNA S were going to transfer resident 29 from his wheelchair into his bed after his shower on 6/9/26. He did not have a full body mechanical lift sling under him in his wheelchair. CNA R asked LPN K how to transfer him because the full body mechanical lift sling was not under him, and LPN K told her to pivot transfer him. CNA R and contracted travel CNA S pivot transferred resident 29. CNA R did not know resident 29's leg was against the metal bed frame, and the metal bed frame punctured his leg. CNA R stated that she knew that resident 29 was supposed to be transferred with a full body mechanical lift, but she did not think they could get the sling under him when he was already in the wheelchair. 10. Interview and review of the staff education documentation on 7/1/26 at 3:35 p.m. with director of nursing (DON) B revealed she expected the staff to follow each resident's care plan when they provided care for that resident. She acknowledged resident 29's care plan was not followed by LPN K, CNA R or contracted CNAs S and T. She expected all staff to review the education that was provided to them related to the provider's care plan policy, the abuse and neglect policy, the policy related to	F0689					

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F0689 SS = G	Continued from page 5 transferring a resident with the use of a gait belt, and the mechanical lift policy. She acknowledged that all of the contracted travel staff failed to sign the education documentation to indicate they had received the education after 6/9/26 incident. 11. Review of the provider's 5/14/25 Care Plans policy revealed, "Individual, resident-centered care planning will be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence." "Each staff member working with the individual resident is responsible to read, utilize and offer input to improve the care plan content ongoing." 12. Review of the provider's 11/18/25 Transfer or Gait Belt Use policy revealed, "A transfer belt or gait belt must be used with each assisted transfer and assisted ambulation, unless [the] care plan indicates otherwise." 13. Review of the provider's 5/14/25 Mechanical Lifts policy revealed, "Staff will be trained on the use of mechanical lifts upon hire and annually with return demonstrations." "The sling may be left under the resident after the transfer if it is resident preference or if removing/placing sling may cause resident pain or skin problems. If sling is left under the resident, the reason for such should be care planned."	F0689		
F0638 SS = E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual review, the provider failed to ensure 19 of 19 sampled residents (5, 6, 7, 23, 24, 28, 29, 34, 35, 36, 37, 38, 39, 43, 44, 53, 54, 55, and 57) Minimum Data Set (MDS) assessments (a tool used to evaluate a resident's health status and to develop	F0638	1. No immediate corrective action can be taken for residents 5, 6, 7, 23, 24, 28, 29, 34, 35, 36, 37, 38, 39, 43, 44, 53, 54, 55, and 57 Minimum Data Set (MDS) being completed late. RN/MDS Coordinator completed and submitted resident 31's discharge assessment on July 24, 2026, and the discharge assessment was accepted. All MDSs that are late at this time will be completed and submitted no later than August 1, 2026. All residents are at risk for their MDS assessments not being completed within 14 days after the assessment reference date. All residents who have been discharged from the facility are at risk for their discharge assessment not being completed. 2. The VP of Clinical Reimbursement and Assessment educated RN/MDS coordinator D on the MDS completion rules per the Resident Assessment Tool (RAI) manual. This education was completed on July 23, 2026. 3. The VP of Clinical Reimbursement and Assessment or designee will complete an audit of 5 residents to ensure their MDS assessments were completed within 14 days after	August 1, 2026

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F0638 SS = E	Continued from page 6 an individualized care plan to manage the resident's care needs) were signed by a registered nurse (RN), to verify their MDS assessments were completed, within 14 days after the assessment reference date (ARD) (the specific end date of the observation period used to complete the MDS) and a discharge assessment was completed for one of one sampled discharged resident (31) who was transferred to a hospital and did not return to the facility. Findings include: 1. Review of resident 36's electronic medical record (EMR) revealed her entry tracking MDS ARD was 6/1/26, and the RN signature completion date was 6/16/26. 2. Review of resident 24's EMR revealed his annual MDS ARD of 5/22/26, and the RN signature completion date was 6/12/26. 3. Review of resident 54's EMR revealed her annual MDS ARD was 5/29/26, and the RN signature completion date was 6/23/26. 4. Review of resident 55's EMR revealed his end of PPS stay MDS ARD was 5/28/26, RN signature completion date was 6/17/26. His significant change MDS assessment ARD was 5/26/26, and the RN signature date was 6/17/26. 5. Review of resident 5's EMR revealed her quarterly MDS ARD was 5/27/26, and the RN signature completion date was 6/18/26. 6. Review of resident 6's EMR revealed his quarterly MDS ARD date was 5/16/26, and the RN signature completion date was 6/5/26. 7. Review of resident 7's EMR revealed her quarterly MDS ARD was 5/21/26, and the RN signature completion date was 6/12/26. 8. Review of resident 23's EMR revealed her quarterly MDS ARD was 5/6/26, and the RN signature completion date was 5/28/26. 9. Review of resident 28's EMR revealed her quarterly MDS ARD was 5/31/26, and the RN signature completion date was 6/26/26. 10. Review of resident 29's quarterly MDS ARD was 5/18/26, and the RN signature completion date was 6/9/26. 11. Review of resident 34's EMR revealed her			F0638	the assessment reference date. The VP of Clinical Reimbursement and Assessment or designee will complete an audit of all discharged residents to ensure a discharge assessment is completed. Audits will be completed weekly for four weeks and then monthly for two months. The VP of Clinical Reimbursement and Assessment will review results of the audits with the Administrator and RN/MDS Coordinator D. Results of audits will be discussed by the Administrator or designee at the monthly QAPI meeting with the IDT and Medical Director of analysis and recommendations for continuation/discontinuation/revision of audits based on audit findings.		

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F0638 SS = E	Continued from page 7 quarterly MDS ARD date was 5/27/26, and the RN signature completion date was 6/17/26. 12. Review of resident 35's EMR revealed her quarterly MDS ARD was 5/11/26, and the RN signature completion date was 6/3/26. 13. Review of resident 37's EMR revealed his quarterly MDS ARD was 2/25/26, and the RN signature completion date was 4/10/26. 14. Review of resident 38's EMR revealed her quarterly MDS ARD was 5/20/26, and the RN signature completion date was 6/9/26. 15. Review of resident 39's EMR revealed her quarterly MDS ARD was 5/12/26, and the RN signature completion date was 6/3/26. 16. Review of resident 43's EMR revealed his quarterly MDS ARD was 5/25/26, and the RN signature completion date was 6/12/26. 17. Review of resident 44's EMR revealed her quarterly MDS ARD was 5/25/26, and the RN signature completion date was 6/15/26. 18. Review of resident 53's EMR revealed his quarterly MDS ARD was 5/20/26, and the RN signature completion date was 6/12/26. 19. Review of resident 57's EMR revealed her quarterly MDS ARD was 5/10/26, and the RN signature completion date was 5/30/26. 20. Review of resident 31's EMR revealed she was transferred to the hospital on 3/11/26, did not return, and was discharged from the facility on 3/16/26. There was no discharge return anticipated or return not anticipated MDS assessment completed. 21. Interview on 7/1/26 at 8:05 a.m. with RN/MDS coordinator D regarding the process for MDS assessment completion revealed she used the RAI manual that was located within the provider's electronic medical record system for reference. She was not certain which version of the RAI manual it was. RN/ MDS coordinator D confirmed she was responsible for reviewing each resident's MDS assessment for completion and for signing the Z0500 section of the MDS. She knew the requirement was for an RN to review and sign that the MDS was completed within 14 days of the MDS ARD. She was			F0638			

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F0638 SS = E	Continued from page 8 aware the MDS's were not always signed within those 14 days. Regarding resident 31's discharge MDS assessment, RN/MDS coordinator D confirmed there was no discharge MDS completed. She stated, "I must have missed that."	F0638		
F0761 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. §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 insulin pens with shortened expiration dates (medications that, after opening, expire before the manufacturer's expiration date) were labeled for two of two sampled residents (10 and 27) insulin pens stored in one of one observed medication cart. Findings include: 1. Observation and interview on 6/29/26 at 4:46 p.m. with licensed practical nurse (LPN) L while she was administering insulin revealed resident 10's	F0761	1. Resident 10's NovoLOG FlexPen Subcutaneous Solution-Pen injector 100 unit/ml, Lantus SoloStar Subcutaneous Solution-Pen injector 100 unit/ml, and Resident 27's Lantus SoloStar Subcutaneous Solution-Pen injector 100 unit/ml was destroyed by LPN L upon discovery during the annual recertification survey on 7/1/2026. All residents with orders for insulin pens with shortened expiration dates are at risk of receiving medications that have expired. 2. The DON or designee will educate all licensed nurses, including LPN L, on the Vials and Ampules of Injectable Medications policy and Appendix 28: Medications with Shortened Expiration dates to ensure insulin pens with shortened expiration dates are dated with the date opened and the expiration date. Education will be completed no later than August 1, 2026, and those not in attendance at education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 3. The DON or designee will audit all medication carts to ensure medications with shortened expiration dates are dated with the date opened and the expiration date. Audits will be completed weekly for four weeks and then monthly for two months. Results of audits will be discussed by the DON or designee at the monthly QAPI meeting with the IDT and Medical Director of analysis and recommendations for continuation/discontinuation/revision of audits based on audit findings.	August 1, 2026

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NAME OF PROVIDER OR SUPPLIER AVANTARA PIERRE			STREET ADDRESS, CITY, STATE, ZIP CODE 950 EAST PARK STREET , PIERRE, South Dakota, 57501		
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F0761 SS = E	Continued from page 9 NovoLog insulin pen had a blank yellow expiration label on it. The nurse who first used the insulin pen was to determine when the insulin's shortened expiration date was and to write that date on the yellow expiration label. 2. Interview and review of the provider's guidelines for determining the expiration date of insulin pens after opening on 7/1/26 at 8:28 a.m. with director of nursing (DON) B revealed that the insulin pen had a pre-placed yellow label on them that had a blank space to document the date when the pen was first opened for use, and a blank space to document when the insulin pen would expire. She expected the nurse who opened the pen and used it for the first time to document the date the insulin pen would expire. She indicated that each insulin type may have a different number of days it could safely be used after opening based on the provider's guidelines. 3. Observation and interview on 7/1/26 at 2:35 p.m. with LPN L regarding insulin pens stored in the medication cart revealed there were two insulin pens for resident 10, one was NovoLOG FLeXPen Subcutaneous Solution Pen-injector 100 unit/milliliters (mL) (Insulin Aspart), and the other was Lantus SoloStar Subcutaneous Solution-Pen Injector 100 unit/mL (Insulin Glargine). There was one insulin pen of Lantus SoloStar Subcutaneous Solution-Pen Injector 100 unit/mL (Insulin Glargine) for resident 27. LPN L confirmed none of those three insulin pens had an expiration date recorded on the yellow expiration date labels. She stated she was not the licensed nurse who first opened those pens, and there was no way to determine which nurse did. 4. Review of the provider's 6/3/24 guidelines for determining expiration of open insulin pens revealed that NovoLog FLeXPen Subcutaneous Solution Pen-injector 100 unit/mL (Insulin Aspart) and Lantus SoloStar Subcutaneous Solution-Pen Injector 100 unit/mL (Insulin Glargine) both expired after 28 days of opening. 5. Review of the provider's January 2018 Preparation and General Guidelines for Vials and Ampules of Injectable Medications revealed: "Expiration Dates: Unopened vials expire on the manufacturer's expiration date. Opening a vial triggers a shortened expiration date that is unique for that product. The date opened and this triggered expiration date are both important to be recorded on the multidose vials (on the vial label or an accessory label affixed for that purpose). At a minimum, the date opened must be recorded. These labels are not required on	F0761			

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F0761 SS = E	Continued from page 10 single-use vials or ampules. Triggered expiration dates may be found in the manufacturer's package insert, on the package, provided, or on a reference chart by the pharmacy, or by contacting the pharmacist."	F0761		
F0880 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 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 §483.71 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	F0880	1. No immediate corrective action could be taken for the failure of LPN L storing her pulse oximeter in her smock pocket and clipping it to resident 44's finger without first cleaning it. No immediate corrective action could be taken for LPN L not practicing proper handwashing or glove use when placing the pulse oximeter on resident 44. No immediate corrective action could be taken for the failure of RN G not completing hand hygiene or practicing proper glove use prior to administering resident 65's eye drops. No immediate corrective action could be taken for the failure of dietary aide O touching resident 52's food without the use of gloves. No immediate corrective action could be taken for LPN L failing to remove personal protective equipment (PPE) after she performed resident cares and before she exited resident 73's room. No immediate corrective action could be taken for the failure of RN P and LPN L to use gloves while performing care with resident 73. No immediate corrective action could be taken for the failure of LPN L not bagging potentially contaminated wash cloth before she left resident 73's room. All residents are at risk for adverse effects related to failure to ensure appropriate infection prevention practices were followed. 2. The DON or designee will educate all licensed nurses, including LPN L, on the Cleaning and Disinfection of Equipment policy to prevent the spread of infection. The DON or designee will educate all staff, including RN G, LPN L, and Dietary Aide O, on the Hand Hygiene policy to include glove use to prevent the spread of infection. The DON or designee will educate all nursing staff, to include LPN L RN G, on the Enhanced Barrier Precaution (EBP) policy to ensure appropriate personal protective equipment (PPE) is donned and doffed appropriately to reduce transmission of multi-drug resistant organisms. The DON or designee will educate all staff, to include LPN L, on the Linen and Laundry handling policy to ensure linens are bagged in the resident room, then transported to the soiled linen receptacle to prevent the spread of potential infection. Education will be completed no later than August 1, 2026, and those not in attendance at education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 3. The DON or designee will complete 5 observations of nursing staff, including LPN L, to ensure that staff are disinfecting pulse oximeters before and after use. The DON or designee will audit 5 medication administrations, including LPN L and RN G, to ensure proper hand hygiene and glove use procedures are being followed by the nurse. The DON or designee will audit 5 staff members serving resident meal trays, including Dietary Aide O, to ensure staff are not touching food items with bare hands. The DON or designee	August 1, 2026

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F0880 SS = E	Continued from page 11 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. §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 the staff followed infection prevention and control practices regarding: The cleaning of a pulse oximeter (a device that clips onto a finger to measure blood oxygen saturation and pulse rate) by one of one licensed practical nurse (LPN) (L) after it was used by one of one sampled resident (44). Hand hygiene (handwashing with soap and water or a hand sanitizer) and glove use by one of one registered nurse (RN) (G) and one of one LPN (L) during medication administration for two of two sampled residents (65 and 44). One of one dietary aide (O) who touched ready to eat foods without the use of gloves. One of one LPN (L) who did not remove personal protective equipment (PPE) after she performed resident cares and before she exited the resident's room. One of one RN (P) and one of one LPN (L) who did not perform hand hygiene before and after the use of gloves while performing resident cares. One of one LPN (L) who did not bag a potentially contaminated wash cloth before she	F0880	will audit 5 nursing staff, including LPN L and RN P, while completing care for residents requiring EBP to ensure they are utilizing the appropriate PPE, appropriate hand hygiene and glove use, as well as doffing the PPE prior to leaving the resident's room. The DON or designee will audit 5 samples of staff handling and discarding soiled linens to ensure the appropriate procedure is utilized to prevent the spread of infection. Audits will be completed weekly for four weeks and then monthly for two months. Results of audits will be discussed by the Director of Nursing or designee at the monthly QAPI meeting with the IDT and Medical Director of analysis and recommendations for continuation/discontinuation/revision of audits based on audit findings.	

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

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F0880 SS = E	Continued from page 12 exited the resident's room. Findings include: 1. Observation on 6/29/26 at 3:50 p.m. in resident 44's room revealed that LPN L reached into her smock pocket and removed a pulse oximeter. Without first cleaning the device, she placed it on the resident's index finger. LPN L returned the oximeter to her smock pocket after the resident's oxygen saturation level and pulse rate were obtained. 2. Interview on 6/30/26 at 10:00 a.m. with LPN L regarding the above observation revealed that she acknowledged the pulse oximeter should have been cleaned before it was placed on resident 44's finger to mitigate the possibility of cross-contamination. 3. Observation on 7/1/26 at 8:15 a.m. of RN G preparing to administer resident 65's eye drops revealed she removed a pair of gloves from her smock pocket, and without performing hand hygiene, put on the pair of gloves. She then administered resident 65's eye drops, removed her gloves, discarded them, and performed hand hygiene. 4. Interview on 7/1/26 at 9:10 a.m. with RN G regarding the above observation revealed that she acknowledged that gloves should not be placed inside a potentially unclean smock pocket. She agreed that she should have completed hand hygiene before she put on a pair of gloves. 5. Interview on 7/1/26 at 11:20 a.m. with director of nursing (DON) B regarding the above observations revealed that after the oximeter was removed from a potentially unclean smock pocket, it should have been cleaned before it was placed on resident 44's finger and gloves should not be kept inside a smock pocket either. Hand hygiene was expected to be performed before putting on gloves. 6. Review of the provider's revised December 2019 Medication Administration Preparation and General Guidelines revealed, "9. Hands are washed before putting on examination gloves..." 7. Review of the provider's revised 2/20/24 Cleaning and Disinfection of Equipment policy revealed, "A. Supplies and equipment will be cleaned immediately after use."	F0880					

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F0880 SS = E	Continued from page 13 8. Observation on 6/29/26 at 11:57 a.m. in the dining room revealed dietary aide O brought resident 52 her noon meal. Dietary aide O removed the paper wrapper from a straw. A piece of that paper wrapper fell into resident 52's mashed potatoes and gravy. Dietary aide O touched resident 52's mashed potatoes and gravy with her ungloved hand as she removed the piece of paper from the mashed potatoes and gravy. Dietary O placed the piece of paper on the table beside resident 52's plate, returned to the kitchen service window, performed hand hygiene with alcohol-based hand sanitizer (ABHS), and continued to deliver meal trays to other residents. 9. Observation and interview on 6/30/26 at 2:28 p.m. of resident 73's medication administration and a nutritional supplement through his percutaneous endoscopic gastrostomy (PEG) tube (a tube surgically placed through the abdomen into the stomach to administer liquid nutrition, fluids and medications) revealed LPN L was standing at the medication cart positioned outside resident 73's room and removed resident 73's cyclobenzaprine 10 milligram (mg) tablet (a muscle relaxer) from the packaging, placed the tablet in a clear packet, and crushed the tablet. She placed that crushed tablet into a plastic cup of water, picked up that cup and took it into resident 73's room, and set it on his bedside table. There was a sign on resident 73's room door that indicated he was on enhanced barrier precautions (EBP; glove and gown use when providing contact care). In resident 73's room, LPN L washed her hands, put on a gown, and put on a pair of gloves. LPN L requested assistance from RN P to boost resident 73 up towards the head of the bed. Without performing hand hygiene, RN P put on a pair of gloves and did not put on a gown. After RN P repositioned resident 73, RN P with those same gloved hands, walked over to the other side of the room, and placed resident 26's fall mat (a padded mat on the floor beside the bed for residents who fall out of bed) on the floor beside his bed. With those same gloved hands, she picked a wet washcloth up from resident 73's bedside table, placed the washcloth in a plastic bag, removed her gloves and discarded them in the trash can, and did not perform hand hygiene. RN P then exited the room, opened the medication cart, removed a container of pH strips (strips to test for acidity) from the medication cart, brought the pH strips into		F0880				

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F0880 SS = E	Continued from page 14 resident 73's room, gave them to LPN L, and exited the room without performing hand hygiene. LPN L raised the head of resident 73's bed, positioned resident 73's shirt to expose his PEG tube, and placed a washcloth below his PEG tube. She used a syringe to withdraw a liquid from his stomach through his PEG tube and into the syringe. She put a pH test strip into the liquid she withdrew to confirm that the contents removed were acidic to verify that the PEG tube was in resident 73's stomach. LPN L reinserted the remaining liquid in the syringe back into resident 73's PEG tube. LPN L turned to resident 73's bedside table and stated the medication she had brought into the room was not on the bedside table where she had placed it. She looked around the room for the medication and could not locate it. She removed her gloves and discarded them in the trash can, did not perform hand hygiene, did not remove her gown, exited resident 73's room, and opened the medication cart. RN P was in the hallway, and when LPN L stated she could not find the cup with resident 73's medication in it. RN P stated she threw the cup that was on the bedside table away because she thought it was left in the room from earlier that day. LPN L did not perform hand hygiene, prepared another cyclobenzaprine tablet for administration, and went back into resident 73's room. Without performing hand hygiene, LPN L put on a pair of gloves, attached the syringe to resident 73's PEG tube, put water into the PEG tube, and then put the water with the cyclobenzaprine into the PEG tube. LPN L then flushed the PEG tube with more water, administered 250 milliliters of Nutren 1.5 (liquid nutrition), and flushed the PEG tube again with water. LPN L removed the syringe from resident 73's PEG tube, closed the PEG tube, and pulled his shirt down over his stomach. LPN L removed her gown and gloves, disposed of them in the trash can, and washed her hands. With her bare hands, LPN L removed the washcloth from below resident 73's PEG tube on his stomach, folded the washcloth, carried the washcloth into the hallway and set it on the medication cart. Without performing hand hygiene, gave a hug to a visitor, and then documented in resident 73's electronic medical record (EMR) on the computer that she had administered the cyclobenzaprine and Nutren 1.5. LPN L stated resident 73 was on EBP because he had a PEG tube. LPN L acknowledged she had worn	F0880					

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F0880 SS = E	Continued from page 15 the gown into the hallway and did not perform hand hygiene before putting on a pair of gloves and after taking off the gloves. 10. Interview on 7/1/26 at 3:35 p.m. with DON B revealed she expected the staff to complete hand hygiene when the staff entered and exited the residents' rooms, before putting on and after removing gloves. She expected gloves to be worn any time a staff member touched a resident's ready to eat food. She expected the staff to wear a gown when providing direct care for a resident on EBP, including administering medications and nutritional supplements in PEG tubes. She expected gowns to be removed and disposed of in the resident's room and not to be worn into the hallway. She expected dirty laundry for a resident on EBP to be bagged prior to exiting the resident's room and not placed on the medication cart. 11. Review of the provider's 9/26/25 Enhanced Barrier Precautions policy revealed "Enhanced Barrier Precautions (EBP): refer to an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employs targeted gown and glove use during high contact resident care activities." "Enhanced Barrier Precautions (EBP) should be used for all residents with wounds or indwelling devices." "Gowns and Gloves should be used during high contact resident care activities that provide opportunities for transfer of MDROs [multi-drug resistant organisms] to staff hands and clothing." 12. Review of the provider's 5/11/26 Hand Hygiene policy revealed, "All personnel shall follow the hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors." "If hands are not visibly soiled, use an ABHR [alcohol based hand rub] containing 60-95% [percent] ethanol or isopropanol or 65% alcohol if hand wipes utilized, for all of the following situations: Before and after direct contact with residents, When entering and leaving a Resident care area/room, Before donning [putting on] and after removing gloves and other personal protective equipment (PPE)...Before preparing or handling medications...After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident." "Hand hygiene must be completed prior to and after removal of gloves."	F0880			

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F0880 SS = E	Continued from page 16 13. Review of the provider's 1/14/26 Linen and Laundry Handling policy revealed, "All laundry is considered potentially contaminated. Laundry and Nursing Healthcare Personnel (HCPs) will use Standard Precautions and use personal protective equipment (PPE), (e.g. gloves etc...) as appropriate while handling all these soiled items." "All soiled laundry will be placed directly into a bagged receptacle or bagged and transported to the bagged laundry receptacle." 14. Review of the provider's 1/14/26 Standard Precautions policy revealed, "PPE should be appropriately discarded prior to leaving the room after resident care and hand hygiene completed." "Gowns should be removed after resident care and disposed of in the resident [resident's] room." 15. Review of the provider's 4/15/20 Handwashing and Glove Use policy revealed, "Gloves may be used when working with food to avoid contact with hands. Gloves must be worn when touching any ready-to-eat food."	F0880		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F0550	1. The facility completed an inventory of all resident 17's clothing on July 24, 2026. The facility discarded all of resident 17's clothes that he had written on the outside of his clothing with a black marker. All of resident 17's clothes will be replaced, and the heat-activated device will be used to label resident 17's clothing with his name on the inside of his clothing items. Administrator will educate resident 17 to request assistance with labeling his clothing and to not use a black marker to write on the outside of his clothing. The above tasks will be completed no later than August 1, 2026. All residents are at risk for their dignity not being maintained due to their clothing not being labeled appropriately with the heat-activated label device resulting in residents writing their names on the outside of their clothing. 2. The Administrator or designee will educate all staff, including the Social Services Designee and laundry aide M, on the Resident Dignity and Privacy policy. The Administrator or designee will educate all staff, to include the Social Services Designee and laundry aide M, that no resident should have marker written on the outside of any clothing and that laundry staff is responsible to label resident clothing by using the heat-activated device or marking the inside of the clothing. Education will be completed no later than August 1, 2026, and those not in attendance at education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked.	August 1, 2026

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F0550 SS = D	Continued from page 17 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to protect the resident's right for dignity for one of one sampled resident (17) who was dressed in clothing that had his first name written in black marker on the top of his left pant leg and on the left side of his shirt. Findings include: 1. Observation and interview on 6/30/26 at 9:45 a.m. with resident 17 in his room revealed that he sat in his wheelchair watching television. His first name was written in black marker vertically, along the top of his left pant leg. His first name was also written vertically in black marker on the left side of his shirt. Resident 17 said he wrote his name on the clothes he was wearing with a black marker because sometimes his clothes were not returned from the laundry after they were washed. He indicated that his roommate's clothes had personalized labels affixed to the inside of them. Resident 17's clothes were not labeled like that. Resident 17 had other clothes that were not labeled with a black marker, but he did not wear them because he was concerned they would not be returned to him after they were washed. Resident 17 relied on donated clothes from the facility to wear. He had no local family support. Before he admitted to the facility, he had lived locally in his own apartment. He did not know what happened to his personal belongings he had in his	F0550	3. The Administrator or designee will complete an audit of 5 residents, including resident 17, to ensure the clothing residents are wearing is not marked on the outside of their clothing to ensure their dignity is maintained. Audits will be completed weekly for four weeks and then monthly for two months. Results of audits will be discussed by the Administrator or designee at the monthly QAPI meeting with the IDT and Medical Director of analysis and recommendations for continuation/discontinuation/revision of audits based on audit findings.		

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F0550 SS = D	Continued from page 18 apartment. 2. Interview on 6/30/26 at 10:45 a.m. with laundry aide M revealed she used a heat-activated device to affix name individualized labels to the residents' clothing. She was aware that not all of resident 17's clothing were labeled in that manner. Laundry aide M previously told the resident she would label his clothes, but she did not do that yet. 3. Interview on 6/30/26 at 1:30 p.m. with social services designee (SSD) E revealed that resident 17 admitted to the facility in October 2025. She confirmed that he lived in a local apartment before he admitted to the facility, and he had no local family support. SSD E did not contact the resident's former landlord to retrieve any of his personal belongings from the apartment after he admitted to the facility. SSD E confirmed that most of resident 17's clothing was donated to him by the facility. That clothing should have been labeled with the resident's name before they were provided to him to wear. She knew he had some clothing that was not returned to him after it was laundered because the facility had not labeled them. She agreed that having resident 17's first name printed with a black marker on his clothes was a privacy issue and compromised his self-esteem. Staff, other than those who worked in laundry, including herself, should have ensured resident 17's clothes were labeled in a dignified manner to mitigate the resident writing his name on them with a marker. 4. Review of the provider's revised 11/18/25 Resident Dignity and Privacy policy revealed, "It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity, as well as, care for each resident in a manner and in an environment, that maintains resident privacy."	F0550		
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by	F0554	1. No immediate corrective action can be taken for resident 54 being provided her medication through a nebulizer to self-administer without an assessment deeming her safe to self-administer and without a physician's order to self-administer her medications. Resident 54 has not requested to self-administer her medications. Resident 7's Symbicort inhaler and fluticasone nasal spray were removed from her room and	August 1, 2026

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F0554 SS = D	Continued from page 19 §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure residents were assessed for their ability to safely self-administer their medications, had a physician's order to self-administer their medications and store those medications in their room, according to the provider's policies for: *One of one sampled resident (54) observed self-administering a medication through a nebulizer (a device that converts liquid medication into an inhaled mist) in her room, who was not assessed for the ability to safely self-administer medications and did not have a physician's order to self-administer that medication. *One of one sampled resident (7) who self-administered her medications had her Symbicort inhaler (a medication to prevent and control inflammation in the lungs and open the airways) and a fluticasone nasal spray (allergy medication) securely stored when they were not being self-administered. Findings Include: 1. Observation on 6/30/26 at 9:50 a.m. in resident 54's room revealed she was sitting in her recliner, and coughing up phlegm and spitting it in the trash can next to her recliner. Resident 54 stated she did not received her 10:00 a.m. nebulizer treatment yet, did not refuse the nebulizer treatment, and believed registered nurse (RN) G was running late. 2. Review of resident 54's electronic medical record (EMR) revealed she admitted to the facility on 5/23/25. Her diagnoses included pneumonia (an infection that inflames the air sacs in the lungs and can fill with fluid), and chronic obstructive pulmonary disease (COPD a progressive incurable lung disease that restricts airflow causing difficulty to breathe). Her 5/29/26 Brief Interview of Mental Status (BIMS) assessment score was 9, which indicated her cognition was moderately impaired. She had a 12/29/25 physician's order for, "DuoNeb Solution 0.5-2.5 (3) MG [milligram]/3ML [milliliter] (Ipratropium-Albuterol) 3 ml inhale orally via nebulizer three times a day related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE." Resident			F0554	placed in a secured medication cart upon discovery during the annual recertification survey. All residents are at risk of being given medications to self-administer without being assessed as safe to self-administer with no physician's order to self-administer, as well as unsecured medications being left in their room with no order that they may be left at bedside. A full house audit will be completed in all residents' rooms to ensure no medications are being stored unsecured in resident rooms. 2. The DON or designee will educate all licensed nurses and the medication aide, including RN G and P, on the Self-Administration of Medications policy to ensure residents that have not been assessed safe to self-administer medications are not given their medications to self-administer, medications stored at bedside need to be store in a locked box, and a physician's order is required for self-administration of medications and to store medications at bedside. Education will be completed no later than August 1, 2026, and those not in attendance at education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 3. The DON or designee will audit 5 nebulizer medication administrations to ensure nurses do not leave residents to self-administer the nebulizer if not assessed as safe to self-administer medication and do not have a physician's order to self-administer medications. The DON or designee will audit 5 residents' rooms to ensure no medications are stored unsecured in their room and to ensure a physician's order has been received for any medications stored in resident rooms. Audits will be completed weekly for four weeks and then monthly for two months. Results of audits will be discussed by the DON or designee at the monthly QAPI meeting with the IDT and Medical Director of analysis and recommendations for continuation/discontinuation/revision of audits based on audit findings.		

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F0554 SS = D	Continued from page 20 54's did not have a self-administration of medication assessment completed or a physicians order to self-administer. A care conference note on 3/16/26 indicated that resident 54's power of attorney (POA- someone designated on a legal document to act on behalf of a resident) expressed concern that resident 54 was not receiving her full nebulizer treatments. Resident 54's medication administration record (MAR) indicated her nebulizer treatments were to be administered at 10:00 a.m., 4:00 p.m., and 9:00 p.m., and her that she had refused that morning nebulizer treatment. 3. Interview on 6/30/26 at 10:25 a.m. with RN G revealed that at 6:30 a.m. that day resident 54 stated she did not want the 10:00 a.m. nebulizer treatment. When RN G was informed that resident 54 was in her room waiting for her 10:00 a.m. nebulizer, RN G stated that resident 54 was forgetful and probably forgot she refused earlier, but that she could give resident 54 her 10:00 a.m. nebulizer treatment. 4. Observations on 6/30/26 from 10:47 a.m. to 11:22 a.m. in resident 54's room revealed that her nebulizer treatment was running and was alone in her room. She was fidgeting with the nebulizer mouthpiece and repeatedly removed it from her mouth and placed it back in. At 10:54 a.m., resident 54 then fell asleep, and the nebulizer mouthpiece fell out of her mouth and rested at her side away from resident 54's mouth. RN G walked past resident 54's room seven times without checking in on resident 54. At 11:22 a.m., RN G walked away from the medication cart positioned in the hallway, and resident 54's nebulizer treatment was on and still running. 5. Interview on 6/30/26 at 2:22 p.m. with RN G revealed that she was aware that resident 54 did not have a self- administration of medication assessment completed. She was not aware that she should have remained with resident 54 during her nebulizer treatment. 6. Interview and EMR review on 6/30/26 at 3:30 p.m. with director of nursing (DON) B revealed that she acknowledged that resident 54 did not have a self-administration of medication assessment completed or a physician's order to self-administer her nebulizer treatment.	F0554			

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F0554 SS = D	Continued from page 21 7. Review of the provider's revised January 2018 Medication Administration Preparation and General Guidelines policy revealed staff will, "Remain with the resident for the treatment unless the resident has been assessed and authorized to self-administer." 8. Observation and interview on 6/29/26 at 2:00 p.m. with resident 7 in her room revealed she had a Symbicort inhaler and a fluticasone nasal spray on her bedside table. Resident 7 stated she took those medications when she woke up in the morning. After she took the medications, she would tell the nurse she was done with them. Sometimes she forgot to tell the nurse she had taken them, and the inhaler and the nasal spray would stay on her bedside table for hours, and at times overnight. 9. Review of resident 7's electronic medical record revealed she admitted to the facility on 5/19/21. Her 5/21/26 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. Her diagnoses included chronic obstructive pulmonary disease (COPD; a group of lung diseases that block airflow and make it difficult to breathe) and allergic rhinitis (inflammation of the nasal passages). She had a 11/14/23 physician's order for fluticasone propionate suspension 50 micrograms per activation (MCG/ACT) two sprays to be administered in each nostril one time per day at 12:00 p.m. and a 3/1/24 physician's order for Symbicort Inhalation Aerosol 80-4.5 MCG/ACT two puffs to be administered orally two times per day at 12:00 p.m. and 8:00 p.m. A 4/23/25 physician's order indicated she, "May self administer medications as listed cough drops maybe [may be] kept at bedside. Fluticasone nasal spray and symbacort [Symbicort] inhaler may be self admin [self-administered] and return to [the] medication cart after use daily." Resident 7's 5/28/26 Medication Self-Administration Evaluation indicated that fluticasone nasal spray and the Symbicort inhaler were two of the medications she was evaluated for and found able to self-administer. The 5/28/26 Medication Self-Administration Evaluation form indicated, "No" to the question "Is there an order to keep medications at bedside (medications cannot be kept at bedside without an order)?" To the question, "Where will the medications be stored?" "Medication cart" was indicated as the locations of medication storage.			F0554			

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F0554 SS = D	Continued from page 22 10. Interview and review of resident 7's EMR on 7/1/26 at 10:23 a.m. with RN P revealed resident 7 self-administered her inhaler and nasal spray. On 6/29/26 her Symbicort inhaler was documented as administered at 12:18 p.m. and her fluticasone nasal spray was documented as administered at 12:15 p.m. by LPN L. RN P stated resident 7 liked to sleep in in the morning so the nurse would place the Symbicort inhaler and fluticasone nasal spray on her bedside table. After resident 7 woke up she was take her Symbicort inhaler and fluticasone nasal spray and then she would alert a certified nursing assistant (CNA) to bring the medication to the nurse, or she would tell the nurse that she had taken the Symbicort inhaler and the fluticasone nasal so the medications could be returned to the medication cart. RN P was not concerned that another resident could wander into resident 7's room and take her inhaler and nasal spray. She acknowledged there were residents who wander into other residents' rooms. 11. Observation on 7/1/26 at 2:02 p.m. of resident 7's room revealed the Symbicort inhaler and the fluticasone nasal spray were sitting on resident 7's bedside table. 12. Interview on 7/1/26 at 5:01 p.m. with director of nursing (DON) B revealed that residents' medications were stored in the medication carts. Resident 7 administered her own nasal spray and inhaler. Staff would leave at her bedside and when she woke up, she would take the nasal spray and inhaler and alert the staff when she had taken them. She was not aware her inhaler and nasal spray were left in her room for hours and overnight. She acknowledged resident 7 did not have a physician's order to store her medications in her room and her physician's order indicated the medications were to be returned to the medication cart after they were administered. 13. Review of the provider's January 2018 Self-Administration of Medications policy revealed, "Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the rooms of, or room with, residents who self-administer." "Then the interdisciplinary team determines that bedside or in-room storage of medications would be a safety risk to other			F0554			

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F0554 SS = D	Continued from page 23 residents, the medications of residents permitted to self-administer are stored in the central medication cart or medication room. The resident requests each dose from the medication nurse, who provides the medication to the resident in the unopened package for the resident to self-administer. The nurse then records each self-administration on the MAR by placing a check mark in the appropriate space and noting in the nursing comments the initials of the nurse who obtained the information from the resident."	F0554		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, observation, and interview, the provider failed to protect the resident's rights to be free from verbal, mental, or physical abuse for one of one sampled resident (28) who was verbally abused by one of one certified nurse aide (CNA) Q who called resident 28 a derogatory name, one of one sampled resident (58) who was emotionally and physically abused by one of one contracted travel CNA (Y) who had put her hand inside the residents brief to check if she was incontinent (involuntary urine or bowel leakage) and one of one sampled resident (58) by one of one contracted travel CNA (BB) who was rough while transferring resident 58 and two of two sampled residents (38 and 65) who were emotionally and physically abused by one of one contracted travel CNA (BB) who did not provide appropriate perineal care and who entered resident 38's room and with a	F0600	"Past Noncompliance - no plan of correction required"	

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

FORM APPROVED

OMB NO. 0938-0391

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F0600 SS = D	Continued from page 24 rude tone of voice told her that her room smelled. This citation is considered past non-compliance based on review of the corrective actions the provider implemented immediately following the incident. Findings Include: 1. Review of the provider's 5/11/26-submitted SD DOH FRI regarding resident 28 revealed that at 6:00 p.m. on 5/10/26, CNA Q approached resident 28, who had just returned to the facility with her family member, and said, "Midget is back." CNA Q then looked at resident 28's family member and said, "You look just like her." This information was reported to the staff by resident 28's family member on 5/11/26 at 1:30 p.m. Administrator A was notified at 1:50 p.m. that same day. CNA Q was suspended pending the outcome of the facility's investigation into the above incident. CNA Q provided a statement in response to the allegation, confirming that she had called resident 28 "midget" but did not intend to be mean. The facility verified the allegation of verbal abuse and decided to terminate her employment, but CNA Q self-terminated her employment with the facility on 5/14/26 in response to the allegation and investigation. The facility reported CNA Q to the South Dakota Board of Nursing. 2. Review of resident 28's electronic medical record (EMR) revealed she admitted to the facility on 2/27/24. Her diagnoses included recurrent major depressive disorder (a clinical mood disorder where a person experiences two or more distinct major depressive episodes, separated by at least two months of normal mood). Her 5/28/26 Brief Interview of Mental Status (BIMS) assessment score was 8, which indicated her cognition was moderately impaired. 3. Interview on 6/30/26 at 1:40 p.m. with resident 28 revealed that she did not recall the 5/10/26 incident. She denied any psychosocial impact from the incident and stated that she felt things were "going well" at the facility. 4. Interview on 6/30/26 at 3:07 p.m. with licensed practical nurse (LPN) L revealed that she received			F0600			

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F0600 SS = D	Continued from page 25 training on abuse identification, prevention, and reporting requirements "all the time." If she became aware of any allegation of abuse, she would report it immediately. "We report allegations even if we're not sure about them. It is not up to us to make that determination. The DON [director of nursing] will investigate." 5. Interview on 6/30/26 at 3:20 p.m. with contracted travel CNA N revealed that she had received training on abuse identification, prevention, and reporting requirements "many times because I've [I have] been a CNA for 10 years." There was "training and testing" when she started working at the facility. If she became aware of any allegations of abuse, she would report them to the nurse immediately. If she could not find the nurse, she would report them to DON B. 6. Review of CNA Q's personnel file revealed that she was hired at the facility on 4/23/25. She had completed training in abuse prevention, care for individuals with cognitive impairments, effective communication, resident rights essentials, and dementia care. CNA Q's CNA certification was current, and there were no known disciplinary actions associated with it. Her background check was completed and had no notable findings. 7. The providers' actions to mitigate the likelihood of the deficient practice recurring were verified on 7/1/26. A record review and an interview with DON B revealed that the facility had followed its Quality Assurance and Performance Improvement (QAPI) process regarding verbal abuse toward residents by interviewing resident 28 on 5/11/26 about the above incident. Resident 28 did not recall the incident and voiced no concerns regarding her care. Her psychosocial well-being was assessed and determined to be at her baseline, according to DON B and social services designee (SSD) E. They monitored and documented resident 28's behavior and psychosocial well-being following the incident. They ensured resident 28's care plan (personalized plan that addresses a resident's care needs, goals, and interventions) was reviewed in relation to her impaired cognition. Resident 28's family member participated in care plan meetings and denied any concerns regarding resident 28's care. In addition, 40 residents were interviewed about their sense of safety, whether they were addressed by any	F0600		

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F0600 SS = D	Continued from page 26 term other than their name, and whether they had observed the staff calling other residents inappropriate names. No concerns were identified. The facility interviewed 23 staff members about whether they had witnessed the staff calling residents terms other than their names, whether they had witnessed the staff being mentally or verbally abusive toward residents, and whether they knew whom to report allegations or observations of verbal or mental abuse to. No concerns were identified. All staff were reeducated to ensure they call residents by their name and do not use terms or names that may be perceived as derogatory. The incident was brought to the facility's QAPI meeting for further review and recommendations. Based on the above information, non-compliance at F600 occurred on 5/10/26, and based on the provider's corrective action plans that were initiated on 5/11/26 and implemented for the deficient practice confirmed on 7/1/26, this occurrence of non-compliance is considered past non-compliance. 8. Review of the provider's 3/12/26 submitted SD DOH FRI report regarding resident 58 revealed that at approximately 1:00 p.m. on 3/12/26, SSD E informed administrator A that resident 58 reported to CNA V that contracted travel CNA Y had come into her room and stated that her room "stunk" and asked resident 58 if her incontinence (involuntary urine or bowel leakage) brief was soiled and when resident 58 replied "no", contracted travel CNA Y put her hand inside of resident 58's brief and rubbed her buttocks up and down twice then proceeded to the front and rubbed up and down twice checking to see if her brief was soiled. Resident 58 reported that incident happened on 3/12/26 at approximately 7:00 a.m. Contracted travel CNA Y was suspended on 3/12/26 pending the facility's investigation. During the facilities investigation they interviewed LPN Z and resident 99, who was resident 58's roommate at that time, and both confirmed seeing contracted travel CNA Y in the room with resident 58 that morning. LPN Z completed skin assessments on resident 58 on 3/16/26 and 3/18/26 with no skin concerns found. 9. Review of resident 58's EMR revealed she admitted to the facility on 3/3/26. Her diagnoses included cerebral palsy (a disorder that affects a			F0600			

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F0600 SS = D	Continued from page 27 person's ability to move and maintain balance and posture), and the need for assistance with personal care. Her 5/27/26 BIMS assessment score was 15, which indicated her cognition was intact. 10. Resident 58 was out of the facility and was not available for interview during the time of the survey. 11. Review of contracted travel CNA Y's personnel file revealed she had completed education for abuse, and neglect on 12/23/25. Her certification was current, and there were no known disciplinary actions associated with that certification. Her background check was completed on 7/12/25 and had no remarkable findings. 12. Interviews with contracted travel CNA N and CNA AA confirmed they had received education regarding perineal care, and the facility abuse and neglect policy. 13. Record review confirmed that the staff were educated about perineal care, and the facility's abuse and neglect policy. 14. The providers implemented actions to mitigate the likelihood of the deficient practice from reoccurring were verified on 6/29/26 after record review, and interview with DON B revealed that the facility had followed its QAPI process regarding mental and emotional abuse towards a resident. Clinical staff received education on perineal care and the facility's abuse and neglect policy. Resident 58's well-being was monitored and documented by SSD E visits conducted twice weekly for two weeks. Resident 58 was offered counseling services but declined. Both the resident and the medical provider were notified of the investigation's findings. In addition, a sample of residents were interviewed regarding any care concerns they had, how to report allegations of abuse, and whether residents felt safe in the facility. A sample of the staff were interviewed regarding any observations of inappropriate staff behavior toward residents and their understanding of the facility's abuse reporting procedures. Contracted travel CNA Y was permanently removed from eligibility to work in the facility. The incident was brought to the facility's QAPI meeting for further review by the interdisciplinary team.	F0600		

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F0600 SS = D	Continued from page 28 Based on the above information, non-compliance at F600 occurred on 3/12/26, and based on the provider's corrective action plans that were initiated on 3/12/26 and implemented for the deficient practice confirmed on 6/29/26, this occurrence of non-compliance is considered past non-compliance. 15. Review of the provider's 4/17/26 submitted SD DOH FRI report regarding resident 65 revealed that at 2:00 p.m. on 4/17/26, CNA V notified DON B that resident 65 had expressed concerns about contracted travel CNA BB. DON B interviewed resident 65 who reported that contracted travel CNA BB assisted her to the bathroom and contracted travel CNA BB handed resident 65 the wipes to clean herself. When resident 65 stated she needed assistance, contracted travel CNA BB discarded the wipes and pulled up resident 65's pants without providing the necessary perineal care. Contracted travel CNA BB was suspended pending the facility's investigation. During the facility's investigation, DON B interviewed resident 65 as well as additional staff members. Their statements corroborated the resident 65's allegations of abuse from contracted travel CNA BB. The resident's medical provider and her power of attorney (POA someone designated on a legal document to act on behalf of a resident) were notified of the incident and the investigation findings. 16. Review of resident 65's EMR revealed she admitted to the facility on 8/3/22. Her diagnosis included the need for assistance with personal care. Her 4/30/26 BIMS assessment score was 15, which indicated her cognition was intact. 17. Interview on 6/29/26 at 2:05 p.m. with resident 65 regarding the abuse incident on 4/17/26 revealed that she and contracted travel CNA BB were in the hallway bathroom when contracted travel CNA BB handed her the wipes. Resident 65 told contracted travel CNA BB that she could not wipe herself. At that point, contracted travel CNA BB threw the wipes away without cleaning her, pulled up resident 65's pants, and took her back to her room without speaking to her during the interaction.	F0600		

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F0600 SS = D	Continued from page 29 18. Review of the provider's 4/17/26 SD DOH FRI report regarding resident 38 revealed that at 2:00 p.m. on 4/17/26 resident 38 reported to CNA V that on the evening of 4/16/26 contracted travel CNA BB entered her room and stated that her room "stinks". Resident 38 reported feeling upset by the tone used by contracted travel CNA BB. CNA V reported the concern to DON B, who then notified administrator A. Contracted travel CNA BB was suspended pending the facility's investigation. During the facility's investigation, administrator A assisted resident 38 in completing a grievance form regarding the incident involving contracted travel CNA BB. Based on witness statements from other staff members, the facility was able to confirm the allegations of abuse from contracted travel CNA BB. Resident 38's medical provider and POA were notified of the incident and the investigation findings. 19. Review of resident 38's EMR revealed she admitted to the facility on 3/5/24. Her diagnosis included heart failure, and multiple sclerosis (disabling disease of the central nervous system where the immune system attacks the protective sheath covering the nerve fibers.) Her 5/20/26 BIMS assessment score was 15, which indicated her cognition was intact. 20. Interview on 6/29/26 at 2:50 p.m. with resident 38 revealed she did not remember the 4/17/26 incident above. 21. Review of the provider's 4/17/26 submitted SD DOH FRI report regarding resident 58 revealed that at 2:00 p.m. on 4/17/26 CNA V informed DON B that resident 58 reported contracted travel CNA BB was rough and rushing during her transfer the previous evening o 4/16/26. DON B interviewed resident 58, who stated that contracted travel CNA BB had raised the bed too high, nearly causing her leg to fall out of the bed. LPN Z assessed resident 58 and noted no injuries. Contracted travel CNA BB was suspended pending the facility's investigation. During the facility's investigation DON interviewed additional staff members, and based on their statements, the facility was able to confirm the allegations of physical abuse by contracted travel CNA BB. Resident 58 and her medical provider were			F0600			

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F0600 SS = D	Continued from page 30 notified of the incident and the investigation findings. 22. Review of resident 58's EMR revealed she admitted to the facility on 3/3/26. Her diagnoses included cerebral palsy (disorder that affects a person's ability to move and maintain balance and posture), and the need for assistance with person care. Her 5/27/26 BIMS assessment score was 15, which indicated her cognition was intact. 23. Resident 58 was out of the facility and was not available for interview during the time of the survey. 24. Review of contracted travel CNA BB's personnel file revealed her certification was current, and there were no known disciplinary actions associated with that certification. Her background check was completed on 4/4/26 and had no remarkable findings. 25. The providers implemented actions to mitigate the likelihood of the deficient practice from reoccurring were verified on 6/29/26 after record review, and interview with DON B revealed that the facility had followed its QAPI process regarding mental, emotional, and physical abuse towards the residents. Monitored and documented the well-being of all three residents, with SSD E completing two visits per week for two weeks for each resident. Weekly audits were initiated to observe the staff performing residents' transfers. In addition, a sample of residents were interviewed regarding whether they feel safe in the facility, whether the staff listen to and meet their toileting needs, whether any staff members were verbally or mentally abusive, whether any staff members had made inappropriate comments regarding odors in their rooms, and whether any staff member were rough during transfers. A sample of staff members were interviewed regarding whether they had witnessed staff members refusing to meet residents' toileting needs, making inappropriate comments to a resident about their room odors, or being rough during resident transfers. Contracted travel CNA BB was permanently removed from eligibility to work in the facility. The incident was brought to the facility's QAPI meeting for further review by the interdisciplinary team.	F0600		

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F0600 SS = D	Continued from page 31 Based on the above information, non-compliance at F600 occurred on 4/17/26, and based on the provider's corrective action plans that were initiated on 4/17/26 and implemented for the deficient practice confirmed on 6/29/26, the 4/17/26 occurrences of non-compliance are considered past non-compliance.	F0600		
F0658 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 follow professional standards of nursing by one of one licensed practical nurse (LPN) (L) who did not assess and document one of one sampled resident's (44) pain level before she administered that resident a pain medication, and did not document that pain medication administration on the resident's medication administration record (MAR). Findings include: 1. Observation and record review on 6/29/26 at 3:50 p.m. with LPN L revealed she responded to resident 44's request to be seen by a nurse. The resident complained of a cough and a headache. She thought she had a "slight stroke" because she felt unable to control her mouth secretions. Resident 44 sat calmly in a chair in her room. She was alert, oriented, and able to answer LPN L's questions. The resident's vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) were within normal limits (WNL). Resident 44 winced when the blood pressure cuff inflated around her arm, but she demonstrated no other verbal or non-verbal indications of pain. The resident's pulse and oxygen saturation levels (the percentage of hemoglobin in the blood carrying oxygen) were WNL. LPN L completed a stroke assessment that included evaluating the resident's arm strength, her vision,	F0658	1.No immediate correction action can be taken for LPN L failing to assess and document resident 44's pain level before she administered her a pain as needed (prn) pain medication and did not document that pain medication administration on the resident's medication administration record (MAR). All residents are at risk of their pain not being assessed and pain level documented prior to being administered, as well as their prn pain medication administration not being documented on their MAR. 2.The DON or designee will educate all licensed nurses, including LPN L, on the Pain Management and Medication Administration - General Guidelines policies to ensure residents' pain is assessed and pain level is documented prior to administration of a prn pain medication and that all medication administrations are documented on the resident's MAR. Education will be completed no later than August 1, 2026, and those not in attendance at education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 3. The DON or designee will audit 5 medication passes to ensure the nurse assessed the resident's pain, documented their pain level, and documented the administration of prn pain medication. Audits will be completed weekly for four weeks and then monthly for two months. Results of audits will be discussed by the DON or designee at the monthly QAPI meeting with the IDT and Medical Director of analysis and recommendations for continuation/discontinuation/revision of audits based on audit findings.	August 1, 2026

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F0658 SS = D	Continued from page 32 speech, facial symmetry, and orientation. That assessment was negative for any remarkable findings. LPN L failed to assess the resident's headache pain by not asking questions such as the location of the headache pain, the type of headache she had, how long she had the headache, if anything helped to relieve the headache, or how intense her headache pain was. After exiting the resident's room and reviewing resident 44's MAR, LPN L prepared a 5 milligram (mg) oxycodone (controlled pain medication) tablet to administer to resident 44. The oxycodone was scheduled to be administered PRN (as needed) every four hours for pain. LPN L returned to the resident's room and administered the oxycodone to the resident. 2. Review of resident 44's June 2026 MAR revealed that the resident was expected to assign a numerical value between 0 and 10 (0 being no pain and 10 being excruciating pain) to her pain level that the nursing staff were to document on the MAR before administering the resident's PRN oxycodone. There was no pain level or PRN oxycodone administration documented on her MAR for the PRN oxycodone that was administered to the resident by LPN L on 6/29/26. 3. Record review and interview on 6/30/26 at 10:00 a.m. with LPN L revealed that she acknowledged failing to assess, identify, or document resident 44's pain level on 6/29/26, before she administered the resident's PRN oxycodone. She also did not document the PRN oxycodone administration on the resident's MAR after it was given on 6/29/26 at 4:00 p.m. 4. Interview on 6/30/26 at 5:20 p.m. with director of nursing (DON) B revealed that LPN L was expected to complete and document resident 44's pain assessment score on the resident's MAR before she administered the resident her PRN oxycodone. LPN L was also expected to document on resident 44's MAR the PRN oxycodone administration immediately after that administration was completed. 5. Review of the provider's revised 4/28/25 Pain	F0658		

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F0658 SS = D	Continued from page 33 Management policy revealed-"5. Conduct a comprehensive pain assessment upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain." 6. Review of the provider's revised December 2019 Medication Administration Preparation and General Guidelines policy regarding medication administration documentation revealed: "The individual who administers the medication dose records the administration on the resident's MAR/eMAR [electronic MAR] directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR/eMar to ensure necessary doses were administered and documented."		F0658				
F0699 SS = D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to complete a trauma informed care assessment for two of two sampled residents (5 and 6) with a post-traumatic stress disorder (PTSD)-a disorder in which an individual has difficulty recovering after experiencing or witnessing a traumatic event) diagnosis. Finding included: 1. Review of resident 5's electronic medical record (EMR) revealed she admitted to the facility on 11/18/25. Her diagnoses included PTSD, major depressive disorder (a mental health condition that causes persistent feelings of sadness, hopelessness, and a total loss of interest in activities), and anxiety disorder (a mental health condition characterized by excessive, persistent, and uncontrollable worry or fear). Her 7/1/26 Brief Interview for Mental Status (BIMS) assessment score was 5, which indicated her cognition was severely impaired. Her revised		F0699	1. The care plan for resident 5 will be updated to include her goals and interventions related to her post traumatic stress disorder (PTSD) no later than August 1, 2026. A trauma screening will be completed for residents 5 and 6 no later than August 1, 2026. Resident 6 has been referred for counseling services. All residents are at risk of not having a trauma screening completed upon admission. The Administrator or designee will complete a full house audit to ensure all residents have a trauma screening completed, and any trauma identified will be addressed and care planned with interventions implemented no later than August 1, 2026. 2. The Administrator or designee will educate the Social Services Designee on the Mental Health Adjustment Difficulties Related to Trauma, PTSD, or Other Mental Health Issues policy. The Administrator or designee will educate the Social Services Designee to ensure all residents have a trauma screening completed upon admission and residents with a diagnosis of PTSD require goals and interventions included in their care plan related to their PTSD. Education will be completed no later than August 1, 2026, and those not in attendance at education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 3. The Administrator or designee will complete an audit of 5 newly admitted residents to ensure they have a trauma screening completed upon admission. The Administrator or designee will complete an audit to ensure residents with diagnoses of PTSD have goals and interventions included in their care plan. Audits will be completed weekly for four weeks and then monthly for two months. Results of audits will be discussed by the Administrator or designee at the monthly QAPI meeting with the IDT and Medical Director of analysis and recommendations for continuation/discontinuation/revision of audits based on audit findings.		August 1, 2026	

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F0699 SS = D	Continued from page 34 4/20/26 care plan did not include goals or interventions identified related to her PTSD. Resident 5 had no documentation indicating that a trauma informed care assessment was completed to identify her related needs or that behavioral health counseling was offered. 2. Observation on 6/29/26 at 2:20 p.m. of resident 5 in her room revealed she was in her bed with the television on and unable to be interviewed as she was nonverbal when questioned. 3. Interview on 6/29/26 at 5:02 p.m. with resident 5's emergency contact revealed that staff updated him with any information or changes in resident 5's care. He attended resident 5's care meetings and visited resident 5 twice a month. Resident 5's emergency contact voiced no concerns regarding her care and services. He stated that resident 5 was in a good place, she was doing well at the facility, and that the facility provided her with good care. 4. Review of resident 6's EMR revealed he admitted to the facility on 10/27/25. He had a diagnosis of PTSD. His BIMS assessment score was 15, which indicated his cognition was intact. His 3/18/26 care plan indicated he had altered mood and behaviors related to his PTSD. The interventions identified in the care plan related to his PTSD were to allow him to choose his activities, stop and talk to him as the staff were passing by, and allow positive interactions. Resident 6 had no documentation indicating that a trauma informed care assessment was completed to identify his related needs, or that behavioral health counseling was offered. 5. Interview on 6/29/26 at 1:52 p.m. with resident 6 revealed he had PTSD from combat. He stated the facility did not offer him much support regarding his PTSD, he was not offered any counseling services, and he would like to be referred for counseling services. 6. Interview on 6/30/26 at 4:00 p.m. with social services designee (SSD) E revealed she was the SSD for three years at the facility. She was unaware she was responsible for completing the resident's trauma informed care assessments until approximately three months ago. 7. Interview on 6/30/26 at 4:16 p.m. with director of	F0699		

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F0699 SS = D	Continued from page 35 nursing (DON) B revealed that she acknowledged residents 5 and 6 did not have trauma informed care assessments completed in their EMRs and that they were not offered any counseling services for their PTSD. She expected staff to follow the provider's policy and complete a trauma informed care assessment for residents diagnosed with PTSD to identify the residents' needs and to offer them counseling services. 8. Review of the provider's revised 9/30/24 Mental Health Adjustment Difficulties Related to Trauma, PTSD, or Other Mental Health Issues policy revealed staff, "Assess the resident to determine if services are needed"	F0699		
F0740 SS = D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure continued behavioral health services to treat a diagnosed mental illness were provided and to identify and implement interventions and effective communication processes with other healthcare entities for one of one sampled resident (10) with depression symptoms and suicidal thoughts. Findings include: 1. Interview on 6/30/26 at 7:56 a.m. with resident 10 revealed she felt like she wanted to "give up." She did not have an interest in participating in activities anymore. She worried about her finances. She received counseling in the past, but she no longer did. She did not know why those counseling sessions stopped. She thought the counseling helped her when she had counseling sessions.	F0740	1. Resident 10 completed a follow-up visit with her psychiatric provider on July 21, 2026. The psychiatric provider referred resident 10 for counseling services. The provider also evaluated resident 10 for suicidal risk and completed a new risk assessment. Resident 10's care plan has been updated with non-pharmacological interventions to meet her behavioral health needs. All residents that require behavioral health services are at risk for not being offered counseling services. All residents that require behavioral health services are at risk for their care plans not being updated with non-pharmacological interventions. The DON or designee will complete a full house audit on all residents that receive behavioral health services to ensure counseling services have been offered, and non-pharmacological interventions are care planned to meet their behavioral health needs. 2. The DON or designee will educate all licensed nurses and Social Services designee E to ensure all residents that require behavioral health services have non-pharmacological interventions included in their care plan and have been offered counseling services. Education will be completed no later than August 1, 2026, and those not in attendance at education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 3. The DON or designee will complete an audit of 5 residents' requiring behavioral health services to ensure counseling services have been offered, resident is receiving counseling services if they choose to receive services, and their care plan has non-pharmacological interventions in place to meet their behavioral health needs. Audits will be completed weekly for four weeks and then monthly for two months. Results of audits will be discussed by the Administrator or designee at the monthly QAPI meeting with the IDT and Medical Director of analysis and recommendations for continuation/discontinuation/revision of audits based on audit findings.	August 1, 2026

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F0740 SS = D	Continued from page 36 2. Review of resident 10's electronic medical record (EMR) revealed she admitted to the facility on 2/12/25. Her 5/22/26 Brief Interview for Mental Status (BIMS) assessment score was 12, which indicated her cognition was moderately impaired. Her diagnoses included major depressive disorder. Resident 10's 3/4/25 PHQ-9 (a tool used to assess for depression) assessment score was 00, which indicated she did not have any depression symptoms. On 11/18/25 her PHQ-9 assessment score was 5, which indicated she had mild depression symptoms. She reported feeling down, depressed, or hopeless for two to six days in the past fourteen days. She had trouble falling asleep or staying asleep for seven to eleven of the past fourteen days. She felt tired or had little energy for seven to eleven of the past fourteen days. Resident 10's 2/18/26 PHQ-9 assessment score was 9, which indicated she had mild depression symptoms. She reported feeling down, depressed, or hopeless for seven to eleven of the past fourteen days. She felt tired or had little energy for two to six of the past fourteen days. She felt bad about herself for two to six of the past fourteen days. She had trouble concentrating on things for two to six of the past fourteen days. Resident 10's 5/22/26 PHQ-9 assessment score was 5, which indicated she had mild depression symptoms. She reported that she had felt down, depressed, or hopeless for seven to eleven of the past fourteen days. She felt tired or had little energy for seven to eleven of the past fourteen days. She felt bad about herself for two to six of the past fourteen days. Her 7/1/26 care plan had a focus area of "I receive an antidepressant medication related to Depression." The interventions for that focus area were, "Attempt gradual dose reductions (GDR) for me for anti-depressant medications based on my progress and stability", "Give antidepressant medications ordered by my attending physician. Observe me for any side effects every shift. Antidepressant side effects: dry mouth, dry eyes, constipation, urinary retention, suicidal ideations." "Observe for and report to my physician any ongoing s/sx [signs and symptoms] of depression unaltered by antidepressant meds [medications]: Sadness, irritability, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideation, neg. [negative] mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, doesn't enjoy	F0740			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435047	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/01/2026
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F0740 SS = D	Continued from page 37 usual activities, changes in condition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, & [and] concern with body functions." Her 7/1/26 care plan did not indicate any non-pharmacological interventions (treatments and preventative measures that do not rely on medication) that staff could use if resident 10 expressed symptoms of depression. 3. Review of resident 10's 2/24/26 and 3/24/26 paper psychiatry notes revealed she was being seen by a psychiatrist for psychiatric evaluation and medication management. During her 2/24/29 initial visit, it stated that resident 10, "whimpers throughout the visit stating she needs a mom and is lonely." Her mood was described as "Down", her appetite and energy were "Poor", and she had anxiety "Daily, related to losing family members and grief." Her suicidal risk assessment indicated she was at moderate risk for suicide due to suicidal thoughts without a plan or intent. Resident 10 indicated she had little interest or pleasure in doing things nearly every day. She felt down, depressed, or hopeless nearly every day. She had trouble falling or staying asleep, or sleeping too much, nearly every day. She had trouble concentrating on things, such as reading a newspaper or watching television more than half the days. She either moved or spoke slowly, or was so fidgety and restless that she was moving around more than usual nearly every day. She indicated there were several days when she had thoughts that she would be better off dead or had thoughts of hurting herself. Her PHQ-9 score was 18, which indicated she had moderately severe depression symptoms. During the 2/24/26 psychiatry visit, anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability) was added to her diagnoses. Her sertraline (an antidepressant medication) was changed to duloxetine (an antidepressant medication) to help her mood and her chronic pain. A plan was made for a follow-up appointment in one month, and a referral was made for mental health therapy. Resident 10's 3/24/26 psychiatry visit notes revealed she had continued depression, grief, and pain. Her sleep was described as "poor" and her interests were "low". She had continued thoughts of	F0740		

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F0740 SS = D	Continued from page 38 suicide without a plan or intent. Her PHQ-9 score was 19, which indicated moderately severe depression symptoms. Resident 10 had been previously referred to therapy and the psychiatrist felt that it would be beneficial due to resident 10's depression. Resident 10's duloxetine was stopped, and she started on Prozac (an antidepressant medication). The plan was made for a follow-up appointment in one month. There were no paper psychiatry visit notes after 3/24/26. 4. Interview on 7/1/26 at 2:04 p.m. with licensed practical nurse (LPN) L revealed resident 10 was a "very emotional" person. Resident 10 did not express to LPN L that she felt depressed. LPN L stated resident 10 could be "down" one minute and then be rearranging things in her room the next. 5. Interview and review of resident 10's EMR on 7/1/26 at 2:34 p.m. with social service designee (SSD) E revealed she completed the resident's PHQ-9 assessments. She thought she offered resident 10 counseling services but indicated that there was no documentation in resident 10's EMR to support that counseling services were offered to her, or that she declined counseling. Resident 10 would come into her office when she was feeling "down" and they would talk. SSD E did not document any of those visits with resident 10 in her EMR. SSD E verified there were no non-pharmacological interventions identified for resident 10's depression in her care plan. 6. Interview on 7/1/26 at 3:18 p.m. with assistant director of nursing (ADON) U revealed she was responsible for setting up and attending the residents' psychiatry appointments with the residents. She would request the visit notes from the psychiatrist because they did not get sent to the provider automatically. Resident 10's psychiatry notes were not in her EMR or reviewed by ADON U before the notes were requested by the surveyor for review on 6/30/26 and were received by the provider from the psychiatrist on 7/1/26. ADON U was not aware that resident 10 had additional diagnoses identified in her psychiatry visit notes. She was not aware that resident 10 had expressed suicidal thoughts, that her PHQ-9 assessments indicated moderately severe depression, or that resident 10 was referred to			F0740			

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F0740 SS = D	Continued from page 39 therapy due to her depression. She acknowledged that not having all the information related to resident 10's current mental health status and needs had the potential for a decline in resident 10's mental health and quality of life. 7. Interview on 7/1/26 at 5:01 p.m. with ADON U revealed resident 10 did not have a follow-up appointment scheduled with psychiatry, and she was not scheduled with the therapist she was referred to on 2/24/26. 8. Review of the provider's 11/18/25 Mental Health Adjustment Difficulties Related to Trauma, PTSD or Other Mental Health Issues policy revealed, "To ensure appropriate treatment and services are provided to all residents with adjustment difficulties to achieve the highest practicable mental and psychosocial well-being. "Appropriate' means based upon assessment and care plan, should be person-centered, and the facility must make attempts to provide the services or assist residents with accessing such services." "Assess the resident to determine if services are needed. Services Provided need to address individualized approaches that address the assessed needs of the resident. Care Plan should address the individualized emotional and psychosocial needs of the resident. Staff must consistently implement the care approaches identified in the Care Plan."	F0740		
F0755 SS = D	Pharmacy Svcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must	F0755	1. No immediate corrective action can be taken for 2 nurses failing to complete controlled medication counts together at change of shift on several dates from January 2026 through June 2026. No immediate corrective action can be taken for RN G administering the incorrect dose of a prescribed dose of antihistamine medication for resident 66 resulting in a medication error. A medication error report for the antihistamine medication error was completed on 7/24/26. Additionally, the provider and family were notified of the medication error. All residents are at risk of missing controlled medications resulting from failing to complete controlled medication counts by 2 nurses at shift change to ensure accountability of medications and are at risk for adverse effects of medication errors. 2. The DON or designee will educate all licensed nurses, including LPNs L, J, and K, RN W, and RN/MDS coordinator, and the medication aide on the Control Substances policy to ensure accurate accountability of the inventory of all controlled drugs is maintained by 2 nurses completing controlled medications counts at shift change and both nurses signing the Shift Verification of Controlled	August 1, 2026

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F0755 SS = D	Continued from page 40 employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), observation, interview, record review, and policy review, the provider failed to ensure: The staff completed and documented controlled medications (medications at risk for abuse and addiction) supply counts for two of two medication carts (East and West), and one of one sampled resident (24) who had one tablet of oxycodone (a controlled pain medication) unaccounted for. The residents were safe from medication errors for one of one sampled resident (66) who was not administered the prescribed dose of antihistamine medication by one of one RN (G). Findings include: 1. Review of the provider's 5/5/26 SD DOH FRI revealed that on 5/5/26 at approximately 5:19 a.m. licensed practical nurse (LPN) J notified director of nursing (DON) B that when LPN J checked her controlled medication at approximately 3:45 a.m. that morning she noticed resident 24 was missing one oxycodone 5 milligram (mg) tablet. LPN J counted the controlled medications on the East medication cart with registered nurse (RN) W, and verified that resident 24 was missing one tablet of oxycodone 5 mg. The evening of 5/4/26, LPN L and LPN J completed the controlled medication count, and that count was accurate. LPN J and RN W checked the locked drawer on the medication cart together and searched the hallway near where LPN J was when she last administered a			F0755	Substances Count sheets for both the East and West medication carts following completion of the counts. The DON or designee will educate all licensed nurses, including RN G, and medication aide on the Medication Administration - General Guidelines policy that addresses the Five Rights - right resident, right drug, right dose, right route, and right time, are applied for each medication being administered, as well as a triple check of the five Rights to ensure three steps in the process of preparation of a medication for administration. Additionally, the DON or designee will ensure RN G completes a medication administration competency. Education and competency will be completed no later than August 1, 2026, and those not in attendance at education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 3. The DON or designee will complete an audit of 5 shift change controlled medication counts to ensure 2 nurses count the controlled medications and and both nurses sign the Shift Verification of Controlled Substances Count sheets following completion of the counts. The DON or designee will complete an audit of 5 medication passes to ensure the nurse follows the five rights of medication administration and triple check of the five rights to prevent medication errors. Audits will be completed weekly for four weeks and then monthly for two months. Results of audits will be discussed by the Administrator or designee at the monthly QAPI meeting with the IDT and Medical Director of analysis and recommendations for continuation/discontinuation/revision of audits based on audit findings.		

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F0755 SS = D	Continued from page 41 dose of oxycodone to resident 24. Resident 24's room and surrounding areas were searched for the missing oxycodone tablet. The oxycodone tablet was not found. Resident 24's medication administration record (MAR) indicated he had received all of his scheduled doses of oxycodone, and he did not have a physician's order for an as needed (PRN) oxycodone dose. DON B interviewed resident 24 on 5/5/26 at 8:20 a.m. and but he did not recall receiving an extra dose of oxycodone after his 4:00 p.m. dose on 5/4/26 or being given two tablets of oxycodone. 2. Observation, interview, and review of the East medication carts controlled substances binder on 6/30/26 at 11:08 a.m. with LPN L revealed the 6/30/26 day to evening Shift Verification of Controlled Substances Count was signed by LPN L as the off-going nurse. There was no signature for the on-coming nurse. LPN L stated the controlled medications were to be counted by the on-coming and the off-going nurse at each shift change. The signatures on the Shift Verification of Controlled Substances Count form indicated the controlled medications were counted and the count was accurate. LPN L verified it was her signature in the off-going nurse count column. She did not count the controlled medications with the on-coming nurse because that would happen at change of shift and the change of shift would not happen until that evening. She acknowledged she documented with her signature that the controlled medications were counted and the count was accurate before having counted the controlled medications. 3. Review of resident 24's electronic medical record (EMR) revealed he admitted to the facility on 5/13/25. His Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact. He had a 5/13/25 physician's order for oxycodone 5 mg one tablet to be administered four times a day at 4:00 a.m., 10:00 a.m., 4:00 p.m., and 10:00 p.m. 4. Interview on 6/30/26 at 2:45 p.m. with LPN L revealed she worked the night before (5/4/26) and the morning after resident 24's oxycodone tablet was found to be missing on 5/5/26. LPN L counted	F0755		

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F0755 SS = D	Continued from page 42 the controlled medications the evening of 5/4/26 with LPN J. During that controlled medication count, LPN L noticed she had forgotten to document that she removed resident 24's 4:00 p.m. oxycodone on his Controlled Drug Receipt/Record/Disposition Form. After she documented that she had removed it from the locked drawer for administration, the controlled medication count was accurate. The next morning, when LPN L returned for her scheduled shift, she was informed that resident 24 was missing one oxycodone tablet. LPN L counted the controlled medications with LPN J and verified that resident 24 was missing one oxycodone tablet. 5. Observation on 7/1/26 at 10:00 a.m. of the East medication cart controlled substance binder revealed there was a signature on 7/1/26 for the off-going nurse on the Shift Verification of Controlled Substances Count sheet, but there was no signature for the on-coming nurse. LPN L was preparing medications on the East medication cart during the observation. 6. Observation and interview on 7/1/26 at 2:04 p.m. of LPN L documenting on a Controlled Drug Receipt/Record/Disposition Form revealed that she administered resident 24's oxycodone at 10:00 a.m. She tried to document on the Controlled Drug/Receipt/Record/Disposition Form at the time she removed the controlled medication from the medication cart, but after the medication pass was completed she went back through the Controlled Drug/Receipt/Record/Disposition Forms to be sure she documented that she had removed the controlled medications that she administered to each resident. She rounded the time she documented the removal of the controlled medication to the hour, not the actual time she removed the controlled medication to be administered. 7. Review of the East medication cart Shift Verification of Controlled Substance Count sheets from January 2026 through June 2026 revealed two nurses did not sign that the controlled medication count was completed and accurate on 2/16/26 for the night to day shift change and the day to evening shift change, on 2/19/26 for the night to day shift change or the day to night shift change, on 2/25/26 for the night to day shift change, on 3/22/26 for the night to day shift change, on 3/23/26 for the day to			F0755			

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F0755 SS = D	Continued from page 43 night and the night to day shift change, on 3/31/26 for the day to night shift change, and on 4/19/26 for the day to night shift change. 8. Review of resident 24's Controlled Drug Receipt/Record/Disposition Form for his oxycodone 5 mg tablets from January 2026 through June 2026 revealed there were three doses of oxycodone not accounted for on 6/24/26. There was no oxycodone 5mg Controlled Drug Receipt/Record/Disposition Form from 6/1/26 through 6/8/26. 9. Review of resident 24's May 2026 and June 2026 MAR and Controlled Drug Receipt/Record/Disposition Form revealed that on 5/1/26 at 10:00 a.m. resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart and documented in his MAR as being administered at 11:39 a.m. On 5/4/26 at 10:00 a.m. resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart and documented in his MAR as being administered at 11:16 a.m. On 5/7/26 at 10:00 a.m. resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart and documented in his MAR as being administered at 11:21 p.m. On 5/10/26 at 4:00 p.m. resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart and documented in his MAR as being administered at 5:11 p.m. On 5/11/26 at 4:00 p.m. resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart and documented in his MAR as being administered at 5:44 p.m. On 5/14/26 at 10:00 a.m. resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart and documented in his MAR as being administered at 11:04 a.m. On 5/15/26 at 10:00 a.m. resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart and documented in his MAR as being administered at 11:17 a.m. On 5/18/26 at 10:00 a.m. resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart and documented in his MAR as being administered at	F0755			

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F0755 SS = D	Continued from page 44 11:56 a.m. On 5/19/26 at 10:00 a.m. resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart and documented in his MAR as being administered at 11:27 a.m. On 5/19/26 at 4:00 p.m. resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart and documented in his MAR as being administered at 5:07 p.m. On 5/22/26 at 10:00 a.m. resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart and documented in his MAR as being administered at 11:04 a.m. On 5/22/26 at 4:00 p.m. resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart and documented in his MAR as being administered at 6:15 p.m. On 5/23/26 at 10:00 a.m. resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart and documented in his MAR as being administered at 11:37 a.m. On 5/23/26 resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart at 4:00 p.m. and documented in his MAR as being administered at 5:45 p.m. On 5/27/26 resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart at 9:00 a.m. and documented in his MAR as being administered at 11:04 a.m. On 6/15/26 resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart at 4:00 p.m. and documented in his MAR as being administered at 6:30 p.m. On 6/17/26 resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart at 10:00 a.m. and documented in his MAR as being administered at 11:36 a.m. On 6/20/26 resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart at 10:00 a.m. and documented in his MAR as being administered at 11:17 a.m. On 6/22/26 resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart at 10:00 a.m. and documented in his MAR as being administered at 11:34 a.m. On 6/22/26			F0755			

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F0755 SS = D	Continued from page 45 resident 24's oxycodone tablet was documented on the Controlled Drug form as being removed from the locked drawer on the medication cart at 4:00 p.m. and documented in his MAR as being administered at 6:09 p.m. On 6/25/26 resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart at 4:00 p.m. and documented in his MAR as being administered at 5:06 p.m. On 6/30/26 resident 24's oxycodone tablet was documented on the Controlled Drug form as removed from the locked drawer on the medication cart at 10:00 a.m. and documented in his MAR as being administered at 11:15 a.m. 10. A phone interview on 7/1/26 at 3:05 p.m. with LPN J was attempted and she did not return the call by the end of the survey. 11. Phone interview on 7/1/26 at 3:28 p.m. with RN W revealed she had removed five tablets of oxycodone from the Nexsys (an automated medication dispensing machine used for single doses or emergency medication dispensing) on 6/24/26 to administer resident 24's 4:00 a.m. dose because his bubble packed (presorted medication cards where doses are organized into sealed, clear compartments by day and time) supply from the pharmacy had run out. DON B informed her on 7/1/26 that she was supposed to initiate a Controlled Drug Receipt/Record/Disposition Form to document when each dose oxycodone was removed from the locked drawer on the medication cart for administration and to document the number of pills that remained in the locked drawer when she removed the oxycodone from the Nexsys. RN W did not know she was supposed to do that. RN W did not work the night resident 24's oxycodone tablet was discovered to be missing. 12. Interview and review of resident 24's EMR, resident 24's oxycodone Controlled Drug/Receipt/Record/Disposition forms and the Shift Verification of Controlled Substance Count Sheet on 7/1/26 at 3:35 p.m. with DON B revealed she expected the on-coming nurse and the off-going nurse to count the controlled medications at each change of shift. When the nurse signed the Shift Verification of Controlled Substance Count Sheet it indicated that the controlled medications	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435047	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/01/2026
NAME OF PROVIDER OR SUPPLIER AVANTARA PIERRE			STREET ADDRESS, CITY, STATE, ZIP CODE 950 EAST PARK STREET , PIERRE, South Dakota, 57501	
(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
F0755 SS = D	Continued from page 46 were counted and the count was accurate. She acknowledged there were missing signatures in May and June on the Shift Verification of Controlled Substances Count sheets for the East and West medication carts. She expected the nurse to sign out controlled medications on the Controlled Drug Receipt/Record/Disposition Form with the time the medication was administered, not the scheduled time or a rounded time. She acknowledged that the times documented on the Controlled Drug Receipt/Record/Disposition form did not match the times the controlled medications were documented in resident 24's MAR as administered. She expected the nurse to initiate a Controlled Drug Receipt/Record/Disposition form when removing a controlled medication from the Nexsys. She was not aware that the nurses had removed oxycodone from the Nexsys for resident 24 and did not document it on a Controlled Drug Receipt/Record/Disposition Form. Once all the controlled medications were used or destroyed from a medication bubble pack, she expected the Controlled Drug Receipt/Record/Disposition Form to be placed in a basket to be scanned into that resident's EMR. She was not aware that resident 24's Controlled Drug Receipt/Record/Disposition Form was not scanned into his EMR for 6/1/26 through 6/8/26. She verified that the form was unable to be found in the EMR, on the medication cart, or in the basket to be scanned into the EMR. She acknowledged that on 6/24/26 there was no documentation on resident 24's Controlled Drug/Receipt/Record/Disposition Form that his oxycodone was removed from the locked drawer on the medication cart to be administered at 4:00 a.m., 10:00 a.m., and 4:00 p.m., but it was documented on resident 24's EMR that he was administered his oxycodone at those times. She stated the oxycodone was removed from the Nexsys by RN W. RN W administered resident 24's 4:00 a.m. oxycodone from the supply she removed from the Nexsys. His 10:00 a.m. dose was administered by RN/minimum data set (MDS) coordinator D from the supply that was removed from the Nexsys, and LPN K administered his 4:00 p.m. dose of the oxycodone removed from the Nexsys because he had run out of his oxycodone that was dispensed from the pharmacy.	F0755		

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NAME OF PROVIDER OR SUPPLIER AVANTARA PIERRE			STREET ADDRESS, CITY, STATE, ZIP CODE 950 EAST PARK STREET , PIERRE, South Dakota, 57501		
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F0755 SS = D	Continued from page 47 13. Review of the provider's January 2018 Controlled Substances policy revealed, "Accurate accountability of the inventory of all controlled drugs is maintained at all times. When a controlled substance is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): Date and time of administration (MAR , Accountability Record). Amount administered (Accountability Record). Remaining quantity (Accountability Record). Initials of the nurse administering the dose, completed after the medication is actually administered (MAR, Accountability Record)." 14. Observation on 7/1/26 at 8:20 a.m. of RN G revealed that after she reviewed resident 66's medication administration record (MAR), she removed a stock bottle (a supply of over-the-counter medications kept on hand by the facility) of 60 milligram (mg) fexofenadine (an antihistamine medication) tablets from her medication cart. She placed one 60 mg fexofenadine tablet, a multivitamin tablet, and an 81 mg tablet of aspirin into a medication cup. The cup was taken into resident 66's room, and those medications were administered to the resident. 15. Interview and review of resident 66's MAR on 7/1/26 at 9:10 a.m. with RN G revealed that the physician's order read- "Fexofenadine HCl [hydrochloride] Oral Tablet, 180 MG. Give 1 tablet by mouth one time a day related to seasonal allergic rhinitis [inflammation of the mucous membrane inside the nose]." RN G had read only the medication administration instructions and not the entire fexofenadine medication order when she prepared that medication for administration. Based on the above physician's order, she should have prepared and administered three 60 mg tablets (180 mg) to resident 66. 16. Interview on 7/1/26 at 2:00 p.m. with DON B revealed that RN G should have compared the fexofenadine stock bottle label to the MAR, and the medication administration instructions for accuracy. Any identified discrepancy was expected to be reconciled with the resident's physician before that medication was administered. 17. Review of the provider's revised December 2019 Medication Administration Preparation and General Guidelines policy revealed: "4). Five Rights-Right resident, right drug, right dose, right route, and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container,	F0755			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435047	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/01/2026
NAME OF PROVIDER OR SUPPLIER AVANTARA PIERRE			STREET ADDRESS, CITY, STATE, ZIP CODE 950 EAST PARK STREET , PIERRE, South Dakota, 57501	
(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
F0755 SS = D	Continued from page 48 and finally (3) just after the dose is prepared and the medication put away."	F0755		
F0919 SS = D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure an in-room call light (a device activated by a resident to alert staff for assistance) was accessible for one of one sampled resident (2) to use. Findings include: 1. Observation and interview on 6/29/26 at 5:00 p.m. with resident 2 in his room revealed that he sat in his wheelchair near the television. The resident's hands had a tremor. The television was on the west wall of his room. There was a red mat on the floor on the exit side of the resident's bed. The head of the resident's bed was on the east wall of the room. The resident stated that the non-skid red mat was used to steady his feet and reduce his risk of falling when he stood up from his bed. He was not supposed to stand up without having staff with him. He had Parkinson's disease (a progressive neurological disorder that primarily affects movement). The resident's call light was wrapped around and secured with medical tape to the top of a positioning pole near the head of his bed. The call light was attached to the call light cord. The part of that cord near where it was attached to the call light device was taped to the center of the positioning pole. The remainder of the call light cord was tucked behind the resident's bedside table against the wall. The resident confirmed he had no access to his call light when he sat in his wheelchair watching television.	F0919	1. The medical tape that held the call light for resident 2 to the positioning pole near the head of his bed has been removed. All residents are at risk for their call light being secured to equipment which does not allow residents to easily access their call light if it is not within reach. A full house audit will be completed to ensure no other residents' call lights are secured to any equipment in their room. 2. The Administrator or designee will educate all staff, including CNA V, on the Call Lights policy. The Administrator or designee will educate all staff that call lights must be placed within reach of residents. Education will be completed no later than August 1, 2026, and those not in attendance at education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 3. The Administrator or designee will complete an audit of 5 residents' rooms, including resident 2, to ensure no residents' call lights are secured and immobile on any facility equipment and to ensure the resident's call light is within reach upon observation. Audits will be completed weekly for four weeks and then monthly for two months. Results of audits will be discussed by the Administrator or designee at the monthly QAPI meeting with the IDT and Medical Director of analysis and recommendations for continuation/discontinuation/revision of audits based on audit findings.	August 1, 2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435047		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/01/2026	
NAME OF PROVIDER OR SUPPLIER AVANTARA PIERRE				STREET ADDRESS, CITY, STATE, ZIP CODE 950 EAST PARK STREET , PIERRE, South Dakota, 57501			
(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
F0919 SS = D	Continued from page 49 He would have to turn his wheelchair around and move it towards his bed to activate the call light for staff assistance. 2. Observation on 6/30/26 at 10:15 a.m. of resident 2 in his room revealed that he sat in his wheelchair watching television. He had no access to his call light that was taped to the positioning pole near the head of his bed. 3. Review of resident 2's electronic medical record (EMR) revealed he had a revised 8/11/25 activities of daily living (basic self-care tasks) care plan that indicated the resident had self-care deficits related to unsteadiness on his feet, dementia, and Parkinson's disease diagnoses, and needed the staff's assistance with his personal care. A revised 6/16/25 intervention read, "Encourage me to use my call light to call for assistance." A revised 8/11/25 fall risk care plan revealed that resident 2 was at risk for falling related to a history of falling. Interventions included, "I have been educated by [the] nurse to call for assistance." Date Initiated: 12/19/2025. "Please make sure that my call light is within my reach and encourage me to use it to call for assistance." Date Initiated: 06/16/2025. 4. Interview on 6/30/26 at 4:15 p.m. with certified nursing assistant V revealed that she knew that resident 2's call light was secured to the positioning pole on his bed. She stated that that was where the resident wanted it. She agreed that securing the call light to that pole prevented it from being accessible to the resident when he sat in his wheelchair to watch television. 5. Interview on 6/30/26 at 5:15 p.m. with director of nursing (DON) B revealed that resident 2 was able to access the call light taped to his positioning pole only if he was in his bed or able to move his wheelchair to the bed to activate the call light. She agreed that in the event the resident fell out of his wheelchair and onto the floor in his room while watching television, he would not be able to summon staff assistance without access to a call light. 6. Review of the provider's revised 9/30/24 Call Lights policy revealed, "4. Ensure call lights are placed within reach of residents."			F0919			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESFORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435047	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/30/2026
NAME OF PROVIDER OR SUPPLIER AVANTARA PIERRE			STREET ADDRESS, CITY, STATE, ZIP CODE 950 EAST PARK STREET , PIERRE, South Dakota, 57501	
(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
E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 6/30/26. Avantara Pierre was found in compliance.	E0000		August 1, 2026

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Chase Watson	TITLE Administrator	(X6) DATE 7/22/2026
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435047		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 06/30/2026	
NAME OF PROVIDER OR SUPPLIER AVANTARA PIERRE				STREET ADDRESS, CITY, STATE, ZIP CODE 950 EAST PARK STREET , PIERRE, South Dakota, 57501			
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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 6/30/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avantara Pierre was found in compliance.			K0000			August 1, 2026

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Chase Watson		TITLE Administrator	(X6) DATE 7/22/2026
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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10663	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/01/2026
NAME OF PROVIDER OR SUPPLIER AVANTARA PIERRE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 E PARK PIERRE, SD 57501			
(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) COMPLETE DATE	
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 6/29/26 through 7/1/26. Avantara Pierre was found not in compliance with the following requirement: S236.	S 000			
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare personnel or residents are as follows: (1) Each new healthcare personnel or resident shall receive an initial individual TB risk assessment and the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within twenty-one days of employment or admission to a facility. The qualified personnel must record the assessment and the test in the employee's record or the resident's medical record. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of admission or employment is considered a two-step test. A TB blood assay test completed within a twelve-month period prior to the date of admission or employment is an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare personnel or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin testing having been completed within the prior twelve months. Skin testing or a TB blood assay test is not necessary if documentation is provided by the transferring healthcare facility, healthcare personnel, or resident, of a previous	S 236	1. A new two-step TB skin test for licensed practical nurse (LPN J) was initiated by the facility on July 17, 2026. All employees are at risk for the facility not providing a two-step TB skin test upon hire. A full house audit of all employee files will be completed no later than August 1, 2026 to determine if any other staff do not have required TB skin test documentation in place. If staff do not have required TB skin test documentation in place, a new two-step TB skin test will be started by August 1, 2026. 2. The Administrator or designee will educate all management licensed nurses and the Human Resources Director on the Tuberculosis Prevention and Control policy to ensure a two-step TB skin test is fully completed for all employees within the required 21-day period. Education will be completed no later than August 1, 2026 and those not in attendance at education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 3. The Administrator or designee will complete an audit of all new hire employees to ensure a two-step TB skin test was initiated upon hire. Audits will be completed weekly for four weeks and then monthly for two months. Results of audits will be discussed by the Administrator or designee at the monthly Quality Assurance Performance Improvement (QAPI) meeting with the IDT and Medical Director of analysis and recommendations for continuation/discontinuation/revision of audits based on audit findings.	August 1, 2026	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Chase Watson

Administrator

7/24/2026

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10663	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/01/2026
NAME OF PROVIDER OR SUPPLIER AVANTARA PIERRE			STREET ADDRESS, CITY, STATE, ZIP CODE 950 E PARK PIERRE, SD 57501		
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S 236	Continued From page 1 positive reaction to either test. Any new healthcare personnel or resident who has a newly recognized positive reaction to the skin test or TB blood assay test must have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure one of four reviewed employees (J) had her two-step tuberculin (TB) skin test completed within 21 days after her hire to determine if she was a positive TB reactor. Findings include: 1. Review of licensed practical nurse (LPNJ) J's employee record revealed she was hired on 2/3/26. She had received the first dose of her TB skin test on 9/29/25 at another health care facility, and the results were read within the required time frame of 48 to 72 hours. There was no documentation of the second dose of the two-step TB skin test being administered within the required 21-day period. 2. Interview on 7/1/26 at 2:30 p.m. with director of nursing (DON) B revealed that any newly hired staff member who did not have a documented two-step PPD would be required to have one, and it would be completed at the facility. The completion of employees' TB screening test was assigned to infection preventionist (IP)/LPN F. Additional management licensed nurses, including DON B and registered nurse (RN)/minimum data set (MDS) coordinator D, were also able to administer or read the TB skin test. DON B tried to keep the administration and reading of the TB tests to one person for ease of	S 236			

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10663	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/01/2026
NAME OF PROVIDER OR SUPPLIER AVANTARA PIERRE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 E PARK PIERRE, SD 57501		
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S 236	Continued From page 2 tracking the tests' completion. She was not aware that there was no documentation that LPN J did not have the second step of the TB skin test completed. 3. Interview on 7/1/26 at 2:41 p.m. with administrator A regarding LPN J's second-step TB skin test revealed he was unable to find documentation for the test being completed. He acknowledged that it did not meet the requirement of a two-step TB skin test.	S 236		