STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435029	A. BUILDING _____ B. WING _____	02/13/2025

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AVERA ROSEBUD COUNTRY CARE CENTER	126 S LOGAN AVE GREGORY, SD 57533

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F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/11/25 through 2/13/25. Avera Rosebud Country Care Center was found not in compliance with the following requirement: F582, F655, F658, F812 and F909.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide	F 582	The liability sheet was updated in all resident files on 3/7/2025. The policy - Notice of medicare provider non coverage from skill care was also updated on 3/7/2025 to reflect the correct form that is to be used when skilled care is discontinued. The resident files will be audited by the social services designee monthly for three months and then quarterly for one year to ensure that the proper form is being used. The results of these audits will be reported at the quarterly QA meeting to the QA manager. The next QA meeting is scheduled for 3/17/2025. The results of these audits will then be reported to the DON or administrator by the QA manager to ensure compliance.	3/17/2025 AT

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

Anthony Timanus | Administrator | 3/5/2025

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

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F 582	Continued From page 1 notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and interview the provider failed to ensure appropriate and timely Medicare notices had been provided for one of two sampled resident (20) who was discharged from skilled services. Findings include: 1. Review of resident 20's Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility (SNF) Beneficiary Notification Review form provided by social services designee D revealed: *His Medicare Part A Skilled Services Episode start date was 9/2/24. *His last covered day of Part A Service was	F 582		

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F 582	Continued From page 2 11/13/24. *He had not been given a SNF Advance Beneficiary Notice of Non-coverage (ABN) form and had remained in the facility. 2. Interview on 2/12/25 at 4:40 a.m. with social services designee D regarding Medicare non-coverage notices revealed: *He had been hired on 9/11/23. *He was not aware resident 20 should have been provided a SNF ABN form. *He believed he had completed the Notice of Medicare Non-coverage form for resident 20. 3. Interview on 2/13/25 at 9:13 a.m. with licensed social service consultant L revealed: *She met with social services designee D once a quarter to review items. *Her focus is on discharge planning when residents leave the facility. *She agreed the SNF ABN form was not provided to resident 20 and it should have been.	F 582		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident	F 655	The facilities policy - LTC Baseline/ Comprehensive Care Plans - System Standard Policy was updated on 3/7/2/205 to reflect the fact that baseline care plans must be provided to residents and families within 48 hours of admission to the facility, and that the appropriate signature page is included to document the discussion and distribution on this care plan. All baseline care plans will be redistributed to residents and families no later than 3/30/2025 to ensure compliance with this policy. New admissions will be audited and results will be presented at the 3/17/2025 quality meeting by the MDS Coordinator or her designee to the QA manager. They will then be audited and presented at the quarterly QA meetings every quarter for no less than one year. Results will then be presented to the DON or administrator by the QA manager to ensure compliance with this updated policy.	3/30/2025 AT

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F 655	Continued From page 3 including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, interview, policy review, the provider failed to ensure seven of twelve sampled residents (1, 22, 23, 26, 80, 81, and 130) or their representatives had received a summary of their baseline care plan within 48 hours. Findings include:	F 655		

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F 655	Continued From page 4 1. Record review of resident 22's paper medical record (PMR) revealed: *She had been admitted on 10/29/24. *She had a Brief Interview for Mental Status (BIMS) assessment score of 12 which indicated moderate cognitive impairment. *There was no documentation in her PMR that indicated a baseline care plan summary had been provided to the resident or the resident's representative. -Her current medication list was provided to her on 10/29/24. *Her representative was her son. 2. Record review of resident 130's PMR revealed: *She had been admitted on 2/7/25. *She had a BIMS score of 10 which indicated moderate cognitive impairment. *There was no documentation in her PMR that indicated a baseline care plan summary had been provided to the resident or the resident's representative. -Her current medication list was provided to her on 2/7/25. *Her interdisciplinary team members (IDT) did not sign her baseline care plan. 3. Review of resident 1's PMR revealed: *She had been admitted on 11/28/23. *She had a BIMS assessment score of 6 which indicated she had significant cognitive impairment. *She had a designated durable power of attorney (POA). *There was no indication resident 1 or her POA had been provided the summary of the baseline care plan.	F 655		

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F 655	Continued From page 5 4. Review of resident 26's PMR revealed: *She had been admitted on 11/25/24. *She had a BIMS assessment score of 10 which indicated she had moderate cognitive impairment. *Her representative/person to contact was her granddaughter. *There was no indication resident 26 or her representative had been provided the summary of the baseline care plan. 5. Record review of resident 23's PMR revealed: *She had been admitted on 7/11/24. *She had a BIMS assessment score of 7 which indicated severe cognitive impairment. *Her representative was her daughter. *A partially completed five-page baseline care plan form indicated: -Her admission date was 7/10/24. -Her current medication list had been provided to her daughter on 7/10/24. -Page five, which included a signature area for the team members who contributed to the baseline care plan was blank. -Page six, which included areas to document the baseline completion date, the date is was reviewed with the resident/representative, and the resident/representative signatures, was missing. -No documentation that indicated the baseline care plan summary had been provided to the resident or her daughter. *A "Care Plan Signature Page" indicated her daughter had signed and received resident 23's comprehensive care plan on the following dates: -On 7/23/24. -On 9/10/24. -On 12/10/24.	F 655		

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F 655	Continued From page 6 6. Interview on 2/11/25 at 9:43 a.m. with resident 80 revealed he could not recall his care plan having been discussed with him the first or second day when he was admitted to the facility about a week ago. Record review of resident 80's PMR revealed: *He had been admitted on 2/4/25. *He had a BIMS assessment score of 13 which indicated he was cognitively intact. *A partially completed five-page baseline care plan form indicated: -His admission date was 2/3/25. -His current medication list had been provided to the resident on 2/3/25. --Page five, which included a signature area for the team members who contributed to the baseline care plan was blank. -Page six, which included areas to document the baseline completion date, the date is was reviewed with the resident/representative, and the resident/representative signatures, was missing. -No documentation that indicated the baseline care plan summary had been provided to the resident or his representative. 7. Record review of resident 81's PMR revealed: *She had been admitted on 2/4/25. *She had a BIMS assessment score of 6 which indicated she had severe cognitive impairment. *A partially completed five-page baseline care plan form indicated: -Her admission date was 2/3/25. -Her current medication list had been provided to her "spouse", resident 80, with no date indicated. -Page five, which included a signature area for the team members who contributed to the baseline care plan had an illegible signature. -Page six, which included areas to document the	F 655		

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F 655	Continued From page 7 baseline completion date, the date is was reviewed with the resident/representative, and the resident/representative signatures, was missing. -No documentation that indicated the baseline care plan summary had been provided to the resident or her representative. 8. Review of the 2017 American Association of Nurse Assessment Coordination (AANAC)/American Association of Directors of Nursing Services (AADNS) baseline care plan form and interview on 2/12/25 at 10:55 a.m. with Minimum Data Set (MDS) Coordinator C revealed: *She had started working at the facility on 4/28/24. *She had "not had much training" regarding the baseline care plan and stated "I'm self-taught." *On the first day of a resident's admission, the admitting nurse would take the five-page AANAC/AADNS Baseline Care Plan form into the new resident's room and interview the resident and family to answer questions and fill out the form. -The completed form was to be kept in a Short Term Care Plan binder which were kept at each nurses station. *She stated they had not been providing a copy of the baseline care plan to the resident and/or the resident's family. *She was not aware of the form's sixth page which had sections to document completion dates and signatures. *She agreed the resident and representative, if applicable, were not receiving a written summary or a copy of the baseline care plan within 48 hours of a resident's admission. *She stated she was not aware of the requirements that the baseline care plan needed	F 655		

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F 655	Continued From page 8	F 655		

to be:
-Developed within 48 hours of a resident's admission.
-Provided to the resident and their representative that included:
--The initial goals of the resident.
--A summary of the resident's medications and dietary instructions.
--Services and treatments to be provided by the facility.
*She stated a copy of the comprehensive care plan was provided to the resident and family after the MDS assessment was completed at the resident's care plan conference which was from 14 to 21 days following the admission date.
*She confirmed a copy of the baseline care plan was not provided to the resident and/or family prior to receiving that comprehensive care plan.

Interview on 2/12/25 at 12:02 p.m. with director of nursing (DON) B revealed:
*The admitting nurse would use the five-page AANAC/AADNS Baseline Care Plan form to interview the resident and family.
*She confirmed a copy of the baseline care plan was not provided to the resident and/or family.
*She agreed they were not meeting the requirement to provide a written summary of the resident's baseline care plan to the resident and/or the resident's representative, if applicable.

9. Review of the provider's June 2023 LTC Baseline/Comprehensive Care Plans policy revealed:
*"Policy: The interdisciplinary team will develop a baseline and comprehensive care plan for each resident..."
*"Procedure:"
-"1. A baseline care plan will be developed within

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F 655	Continued From page 9 48 hours of a resident's admission to promote continuity of care and communication amount nursing home staff, increase resident safety and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative, if applicable are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan." -"2. Information for the baseline care plan will be based upon admission orders, information from the transferring provider and discussion with the resident and resident representative if applicable and the resident so chooses." -"3. The baseline care plan will include the minimum health care information necessary to properly care for a resident including, but not limited to: a. Initial goals based on admission orders, b. physician orders, c. dietary orders, d. therapy services, e. Social services, f. PASRR [Pre-Admission Screening and Resident Review] recommendations, if applicable, g. instructions needed to provide effective person-centered care that meets professional standards of quality of care, h. address resident and safety concerns to prevent decline or injury, i. identify needs for supervision, behavioral interventions and assistance with ADL's [Activities of Daily Living] as necessary." -"4. There will be documentation in the clinical record that the baseline care plan was given to the resident and/or representative..." 10. Review of the provider's September 2011 job	F 655		

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F 655	Continued From page 10 description for MDS Specialist revealed: *"Essential functions" included: -"Completes initial admission care plan on each resident." *"Responsibilities, expectations, and standards" included "Comply with safety principles, laws, regulations and standards associated with, but not limited to CMS [Centers for Medicare and Medicaid Services], ..."	F 655		
F 658 SS=E	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, and policy review, the provider failed to ensure proper medication preparation for three of three residents (13, 19, and 21) by one of one licensed practical nurse (LPN) (I) who prepared their medications and stored them to administer to the residents later. Findings include: 1. Observation and interview on 2/12/25 at 11:27 a.m. with LPN I at a medication (med) cart revealed: *He had dispensed resident 13, 19, and 21's medications into white paper medication cups and did not label them to identify which resident's meds were in each cup. *He left resident 13's medications on top of the med cart and then placed resident 19 and 21's medications in the top drawer of the cart and shut	F 658	All RNs, LPNs, and Medication Aides will be retrained on medication administration competencies no later than 3/30/2025. Medication administration will be observed and audited at least monthly for three months and then quarterly for one year to ensure staff who distribute medication are doing so in accordance of the written policy. This audit will be conducted by the DON or her designee. The results of these audits will be reported at the quarterly QA meeting on 3/17/2025 and then every quarter for one year. These results will be reported by the DON to the QA manager or administrator to ensure compliance.	3/30/2025 AT

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F 658	Continued From page 11	F 658		

the drawer.
*He confirmed he did not dispense and prepare residents' medications individually.
*He stated he had a system and "that's the way I do it."
*He stated he did not get confused when he administered residents' medications that he placed in unlabeled cups to be given later.

2. Interview on 2/12/25 at 3:26 p.m. with LPN I about the provider's medication policy revealed:
*He knew it mentioned the five rights of medication administration.
*He could not clarify any other information in the policy.

3. Interview on 2/13/25 at 8:31 a.m. with director of nursing (DON) B revealed:
*She had previously spoken to LPN I about setting up (placing meds in cups to be given later) resident medications and he knew he was not supposed to do that.
*She was not aware that he did not label the paper medication cups to identify which resident's meds were in the cups.
*She agreed setting up and storing meds to administer to residents later was not an acceptable practice for medication administration.
*She had provided education regarding correct medication administration processes in the past.

4. Review of the provider's revised 10/2023 Medication Policy revealed:
*"Once the resident is identified, the medication needs to be delivered to the resident. Once the medication is administered, the nurse will document as appropriate in the Mar.
*"All medications will be given according to the 5 rights: right medication, right resident, right time,

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F 658	Continued From page 12 right dose/amount, and right route." *"Medications are not allowed to be routinely "set up" in cups and stored to give later. If a resident wants their medications later than when prepared, the med cup must be dated and timed with the resident's name on the med cup, another med cup placed on top to prevent contamination and stored in the med cart."	F 658		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to ensure one of two mechanical dishwashers that used high temperature sanitizing met the required minimum wash and rinse temperatures. Findings include:	F 812	On 2/20/25 the incoming water to the dishwasher was found to be at 42 degrees. Our maintenance staff identified this as the primary reason that the dishwasher was not consistently meeting required minimum temperatures as outlined. We purchased a new mixing value for the incoming water and installed on 2/20/2025 to the incoming water would reach the minimum temperature of 55 degrees but not more than 90 degrees. We then ran multiple cycles to test and ensure that the unit was meeting minimum rinse and wash cycle temperatures. This repair has corrected the water temperature issue. Daily tests will be conducted per our policy to ensure that the dishwasher continues to function at the proper required minimum temperature for all cycles. These results will be logged and the dietary manager will notify the environmental services manager if any results are reported outside of the required minimum or maximum temperature. These logs will be reviewed quarterly at our quarterly QA meeting for one year starting on 3/17/2025. Log results will be reported to the DON or administrator to ensure compliance.	3/17/2025 AT

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F 812	Continued From page 13 1. Observation on 2/11/25 at 8:36 a.m. of the long-term care (LTC) kitchenette revealed: *The mechanical dishwashing machine had a label that revealed "HOT WATER SANITIZING": -"WASH TEMPERATURE 150° [degrees] F [Fahrenheit] MIN [minimum]. -"RINSE TEMPERATURE 180° F MIN. *Posted on the door of the reach-in refrigerator was the February 2025 Dishmachine Temperature Record that included: -Columns to record the "Start Wash/rinse" and "Finish Wash/rinse" for each of the three mealtimes "Breakfast", "Lunch", and "Supper". -Each column had two recorded temperatures. The wash temperature was separated by a dash from the rinse temperature. -The wash temperatures recorded ranged from 142 to 160 degrees F. --Twelve of those recorded wash temperatures were not at the minimum wash temperature of 150 degrees F. -The rinse temperatures recorded ranged from 172 to 184 degrees F. --Twenty-eight of those recorded rinse temperatures were not at the minimum rinse temperature of 180 degrees F. 2. Interview on 2/11/25 at 8:56 a.m. with food service manager (FSM) F in the main kitchen revealed: *She had worked at the facility for 12 years. *The LTC kitchenette's mechanical dishwasher was used to clean and sanitize the dishes used to serve meals to the residents of the nursing home. *The LTC kitchenette's mechanical dishwasher was a high temperature dishwasher that used heat for sanitization.	F 812		

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F 812	Continued From page 14 3. Observation and interview on 2/11/25 at 1:50 p.m. in the LTC kitchenette with food service worker (FSW) J and FSW K revealed: *FSW J rinsed dishes under hot running water and placed those dishes in a rack which she then pushed into the mechanical dishwasher to be cleaned and sanitized. *FSW K removed the rack from the dishwasher and placed the clean dishes on the shelves in the kitchenette. *FSW K stated she had let the dishwasher run three or four cycles before she documented the wash and the rinse cycle temperatures before she sent the loads of dishes through the dishwasher. *The 2/11/25 dinner start wash/rinse temperatures on the Dishmachine Temperature Record posted on the door of the reach-in refrigerator were documented as: -A wash cycle temperature of 154 degrees F. -A rinse cycle temperature of 180 degrees F. *FSW K stated the wash cycle temperature should have been at the minimum 160 degrees F or above and the rinse cycle temperature was at the minimum 180 degrees F. *FSW K stated if the dishwasher readings were not reaching the minimum temperatures she would notify FSM F or maintenance. *The following random observations on 2/11/25 were made of the above mechanical high temperature dishwasher: -At 1:52 p.m. the wash cycle reached 149 degrees F and the rinse cycle reached 178 degrees F. -At 1:54 p.m. the wash cycle reached 145 degrees F and the rinse cycle reached 178 degrees F. -At 2:00 p.m. the wash cycle reached 144	F 812		

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F 812	Continued From page 15 degrees F and the rinse cycle reached 178 degrees F. -At 2:02 p.m. the wash cycle reached 145 degrees F and the rinse cycle reached 178 degrees F. -At 2:11 p.m. the wash cycle reached 145 degrees F and the rinse cycle reached 176 degrees F. -At 2:14 p.m. the wash cycle reached 147 degrees F and the rinse cycle reached 178 degrees F. -During those observations: --FSW J had the hot water running and was rinsing dishes under that hot running water. --The wash cycle ran between 30 to 33 seconds. --The rinse cycle ran for approximately 10 seconds. *On 2/11/25 at 2:16 p.m. FSW K recorded the dinner finish wash/rinse temperatures on the Dishmachine Temperature Record as: -A wash cycle temperature of 147 degrees F. -A rinse cycle temperature of 178 degrees F. -FSW K agreed those temperatures did not meet the minimum temperatures for hot water sanitizing. -FSW K reported to FSM F on 2/11/24 that the LTC kitchenette's mechanical dishwasher had not reached the minimum temperatures required. Interview on 2/11/25 at 2:24 p.m. with FSM F regarding the observations above of the LTC kitchenette's high temperature mechanical dishwasher's temperatures revealed: *She stated "Why hasn't anyone said anything." *The following were requested: -The Dishwasher Temperature Records for November 2024, December 2024, and January 2025. -The LTC kitchenette's mechanical dishwasher's	F 812		

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F 812	Continued From page 16 manufacturer's manual. 4. Observation and interview on 2/12/25 at 9:35 a.m. in the LTC kitchenette revealed: *The "Supper Start Wash/rinse" temperatures for 2/11/25 were documented as: --A wash cycle temperature of 151 degrees F. --A rinse cycle temperature of 178 degrees F. --The rinse cycle temperature did not meet the minimum temperature of 180 degrees F required for hot water sanitizing. -The "Supper Finish Wash/rinse" temperatures for 2/11/25 were documented as: --A wash cycle temperature of 147 degrees F. --The wash cycle temperature did not meet the minimum temperature of 150 degrees F required for hot water sanitizing. --A rinse cycle temperature of 178 degrees F. --The rinse cycle temperature did not meet the minimum temperature of 180 degrees F required for hot water sanitizing. -The documented 2/12/25 breakfast start wash/rinse temperatures met the required temperatures for sanitizing. *On 2/12/25 at 9:35 a.m. FSW J and FSW K were in LTC kitchenette area and preparing to wash and sanitize the breakfast dishes through the mechanical dishwasher. *FSW K stated maintenance tech E had been in and out of the LTC kitchenette working on the mechanical dishwasher that morning, 2/12/25. *The following random observations on 2/12/25 were made of the mechanical high temperature dishwasher: -At 9:37 a.m. the wash cycle reached 158 degrees F and the rinse cycle reached 176 degrees F.	F 812		

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F 812	Continued From page 17 -At 9:40 a.m. the wash cycle reached 144 degrees F and the rinse cycle reached 176 degrees F. -At 9:43 a.m. the wash cycle reached 144 degrees F and the rinse cycle reached 180 degrees F. -At 9:50 a.m. the wash cycle reached 144 degrees F and the rinse cycle reached 176 degrees F. *At 9:50 a.m. FSW J stated she thought that running the hot water to rinse the dishes prior to placing them in the dishwasher may have affected the hot water temperature. 5. Observation on 2/12/25 at 10:05 a.m. of the main kitchen revealed: *The mechanical dishwashing machine had a label that revealed "HOT WATER SANITIZING": -"WASH TEMPERATURE 160° F MIN." -"RINSE TEMPERATURE 180° F MIN." *At 10:13 a.m. the mechanical dishwasher reached: -A wash cycle temperature of 167 degrees F. -A rinse cycle temperature of 195 degrees F. -Those temperatures were above the minimum temperatures required for hot water sanitizing. 6. Interview on 2/12/25 at 10:20 a.m. with FSM F regarding the observations made above of the LTC kitchenette mechanical dishwasher's temperatures revealed she stated they could transport, wash, and sanitize the nursing home dishes in the main kitchen's mechanical dishwasher. 7. Interview on 2/12/25 at 1:44 p.m. with FSW K revealed she and FSW J had brought the dishes used to serve the dinner meal in the nursing home to the main kitchen to be washed in that	F 812		

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F 812	Continued From page 18 mechanical dishwasher. 8. Interview and observation on 2/12/25 at 2:09 p.m. in the LTC kitchenette with maintenance tech E revealed: *He thought the incoming water temperature for the mechanical dishwasher should be between 55 and 60 degrees F. *He turned on the water faucet, placed a digital thermometer in the running water coming out of the faucet and noted the temperature of the incoming water was at 47 degrees F. -He stated that was ten degrees colder than what it should be. *He had called the mechanical dishwasher's servicing dealer and had discussed what needed to be done to ensure the mechanical dishwasher met the minimum temperatures required for hot water sanitizing. -He stated the dishwasher had been set at "Cycle 1 which was a one-minute cycle." *At 2:12 p.m. he changed the dishwasher to "Cycle 4" and stated that was a four-minute cycle: -The wash cycle then reached 156 degrees F which was above the required minimum temperature of 150 degrees F. -The rinse cycle then reached 180 degrees F which was the minimum temperature required. *At 2:18 p.m. he changed the dishwasher to "Cycle 2" and stated that was a two-minute cycle: -The wash cycle then reached 156 degrees F. -The rinse cycle then reached 181 degrees F. -Both of these temperatures were above the minimum temperatures required for hot water sanitizing. -Maintenance tech E confirmed the mechanical dishwasher used hot water sanitization. 9. Interview on 2/12/25 at 2:49 p.m. with FSM F	F 812		

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F 812	Continued From page 19	F 812		

regarding the requested policy on the mechanical dishwasher revealed she:
*Provided a February 2025 Dishwasher Temperature policy.
*Had revised the policy that day, 2/12/25.
*Stated the previous policy was "very vague" and did not contain the mechanical dishwasher's minimum temperatures.
-She had not kept a copy of that previous policy.

10. Observation and interview on 2/13/25 at 8:44 a.m. with FSW K in the LTC Kitchenette revealed:
*The current Dishmachine Temperature Record had recorded:
-The 2/12/25 "Dinner Start Wash/rinse" area had noted "dishes at Hosp [hospital main kitchen]".
-The 2/12/25 "Dinner Finish Wash/rinse" area had noted "done dishes @ [at] H [hospital main kitchen]".
*The documented 2/12/25 supper start and finish wash/rinse temperatures met the required temperatures for sanitizing.
-No wash or rinse cycle temperatures for 2/13/25 had been recorded.
*At 8:50 a.m. FSW K stated:
-The mechanical dishwasher temperatures for the 2/13/25 breakfast start were:
--The wash cycle had reached 153 degrees F.
--The rinse cycle had reached 180 degrees F.
-She confirmed both of those temperatures met the minimum temperatures required for hot water sanitizing and recorded those temperatures.

11. Interview on 2/13/25 at 9:04 a.m. with FSM F revealed FSW K had reported to her on 2/11/24 and 2/12/24 that the LTC kitchenette's mechanical dishwasher had not reached the minimum temperatures required.

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F 812	Continued From page 20 12. Observation on 2/13/25 at 9:33 a.m. in the LTC Kitchenette with FSW J and FSW K while operating the mechanical dishwasher revealed: *The mechanical dishwasher was set at "Cycle 2". *At 9:34 a.m. the wash cycle reached 151 degrees F which was above the required minimum temperature of 150 degrees F. -The rinse cycle reached 180 degrees F which was the minimum temperature required. *At 9:37 a.m. FSW J turned on the hot water to rinse the dishes: -The wash cycle reached 149 degrees F. -The rinse cycle reached 180 degrees F. -The wash cycle temperature did not meet the minimum temperature of 150 degrees F required for hot water sanitizing. *At 9:40 a.m. FSW J shut off the hot water she had been running to rinse dishes. *At 9:44 a.m. the wash cycle reached 151 degrees F and the rinse cycle reached 180 degrees F. *At 9:47 a.m. FSW J turned on the hot water to rinse the dishes: -The wash cycle reached 149 degrees F. -The rinse cycle reached 180 degrees F. -The wash cycle temperature did not meet the minimum temperature of 150 degrees F required for hot water sanitizing. 13. Interview on 2/13/25 at 9:55 a.m. with FSM F regarding the above observations and the mechanical dishwasher's temperatures revealed she: *Confirmed some of the dishwasher temperatures were under the minimum temperature required. -Stated she would discuss with maintenance tech E what needed to be done to raise the hot water	F 812		

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F 812	Continued From page 21 temperature. 14. Review of the provider's November 2024 Dishmachine Temperature Record for the LTC kitchenette's mechanical dishwasher revealed: *There were 31 out of 180 recorded wash temperatures that did not meet the minimum required wash temperature of 150 degrees F which was 18 percent of the recorded temperatures. *There were 36 out of 180 recorded rinse temperatures that did not meet the minimum required rinse temperature of 180 degrees F which was 20 percent of the recorded temperatures. 15. The provider's December 2024 Dishmachine Temperature Record for the LTC kitchenette's mechanical dishwasher was requested on 2/11/25 at 2:24 p.m. from FSM F but was not received by the end of the survey. 16. Review of the provider's January 2025 Dishmachine Temperature Record for the LTC kitchenette's mechanical dishwasher revealed: *There were 40 out of 180 recorded wash temperatures that did not meet the minimum required wash temperature of 150 degrees F which was 23 percent of the recorded temperatures. -Six wash temperatures were not recorded on the form. *There were 69 out of 180 recorded rinse temperatures that did not meet the minimum required rinse temperature of 180 degrees F which was 39 percent of the recorded temperatures. -Six rinse temperatures were not recorded on the form.	F 812		

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F 812	Continued From page 22 Review of the provider's February 2025 Dishwasher Temperature Policy revealed: *"Purpose: To assure that temperatures in the dishwasher remains at the proper temperatures to clean and sanitize the dishes." *The "Information and Procedure" section included; -"1. ...NURSING HOME wash temperatures should remain at a MINIMUM of 150 degrees and rinse temperatures at a MINIMUM of 180 degrees. --The policy did not indicate if the minimum temperature readings were Fahrenheit (F) or Celsius (C). -"2. After turning on dishwasher and filling, it should be run through three cycles to assure [sic] that the water reaches the highest possible temperature before inserting dirty dishes. -"3. At the time that the dishes are washing, the temperature should be recorded." -"4. At the final rinse the temperature should also be recorded." -"5. This should be done with BREAKFAST, LUNCH AND DINNER dishes each day. -"6. If a temperature does not reach the designated numbers, the problem should be reported to the supervisor or the maintenance person so it can be monitored/addressed and adjusted." -"7. If maintenance is unable to fix immediately, the dishwasher company will be called to repair, and dishes transported to alternative kitchen to be washed or disposable [dishes] will be utilized." *The policy did not indicate it had been approved. Review of the provider's June 2021 AM16 Dishwasher's instructions manual revealed: *The model "AM16VL-BAS" was circled indicating	F 812		

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F 812	Continued From page 23 that was the model number of the LTC kitchenette's mechanical dishwasher. *The "Water Supply Requirements" for Model AM16VL-BAS Hot Water Sanitizing indicated: -The recommended cold water temperature was 65 degrees F. -The minimum cold water temperature was 55 degrees F. *"Operating temperatures for all models are as follows:" -"Sanitizing Mode: Hot Water." --"Wash Temperature Minimum Wash" indicated "150° F (66° C [Celsius])". --"Rinse Temperature Minimum Rinse" indicated "180° F (82° C)". Review of the provider's 12/31/24 job description for a Food Service Worker revealed the essential job functions included: *"Cleans and sanitizes equipment, utensils, dishes, pot/pans, floor mats, floors, and work areas following proper procedure." *"Operates dish machine and kitchen equipment safely and efficiently." Review of the provider's 11/22/24 job description for a Food Service Manager revealed: *The Job Summary included "Ensures that all standards and regulations concerning dietary services are met and maintained." *The Essential Job Functions included: -"Ensures that all standards of cleanliness and quality are maintained in the dietary department." -"Directs activities and collects data to demonstrate a safe and sanitary food service operation to meet state health department, and federal regulations."	F 812		
F 909 SS=E	Resident Bed	F 909		

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F 909	Continued From page 24 CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to assess grab bars for safety for four of four sampled residents (8, 26, 1, and 15) who had grab bars on their beds. Findings include: 1. Observation on 2/11/25 at 8:53 a.m. of resident 8's room revealed grab bars were on both sides of the bed. Review of resident 8's electronic medical record (EMR) revealed: *She had a Brief Interview for Mental Status (BIMS) assessment score of 5 which indicated she had severe cognitive impairment. *A device evaluation for her use of grab bars was last completed on 8/1/2024. -She utilized the right and left grab bars for turning and repositioning while in bed. *There was no documentation that an assessment on the grab bars had been completed to determine safe use or measurment of the grab bars. 2. Observation and interview on 2/11/25 at 10:04 a.m. of resident 26 in her room revealed:	F 909	The policy Restraints Policy 7802B.100 will be updated by 03/07/2025. This policy revision will reflect that all beds will be assessed by the facilities bed rail safety assessment at least annually, on admission, and whenever the mattress is changed on a bed. These assessments will be documented in the MDS summary note of the appropriate resident. All beds will be reviewed and assessed by 3/30/2025. Results of these assessments will be reported at the quarterly QA meeting by the DON or her desingee to the QA manager at the quarterly QA meeting on 3/17/2025 and every quarter thereafter quarterly for one year. Results will then be reported by the QA manager to the administrator to ensure compliance.	3/30/2025 AT

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F 909	Continued From page 25 *She used a walker for ambulation. *Grab bars were on both sides of her bed. *She stated the grab bars had been there since she arrived at the facility. *She used the grab bars to get up and out of bed. Review of resident 26's EMR revealed: *She was admitted on 11/25/24. *She had a BIMS assessment score of 10 which indicated she had moderate cognitive impairment. *A device evaluation for her use of grab bars was last completed on 12/8/24 which indicated she was safe to use them. *There was no documentation that an assessment on the grab bars had been completed to determine safe use or measurement of the grab bars. 3. Observation and interview on 2/11/25 at 1:31 p.m. with resident 1 in her room revealed: *She had grab bars on both sides of her bed. *She stated she used them to help her reposition. Review of resident 1's EMR revealed: *She had a BIMS assessment score of 6 which indicated she had severe cognitive impairment. *A device evaluation for her use of grab bars was last completed on 1/17/25. -She utilized the grab bars to assist her in sitting up, sitting down, rolling side to side, and repositioning in bed. *There was no documentation that an assessment on the grab bars had been completed to determine safe use or measurement of the grab bars. 4. Observation and interview on 2/11/25 at 1:49 p.m. with resident 15 in her room revealed:	F 909		

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F 909	Continued From page 26 *Grab bars were on both sides of her bed. *She stated she did not turn in bed due to her right arm immobility, but she would grab one of them to hold onto occasionally. Review of resident 15's EMR revealed: *She had a BIMS assessment score of 12 which indicated she had moderate cognitive impairment. *A device evaluation for her use of grab bars was completed on 2/11/25. -She utilized the right and left grab bar for bed mobility and positioning. *There was no documentation that an assessment on the grab bars had been completed to determine safe use or measurement of the grab bars. 5. Interview on 2/12/25 at 1:52 p.m. with director of nursing (DON) B and registered nurse (RN) G revealed: *They were to complete the device evaluation for the residents' safe use of grab bars every 90 days. *They had not completed measuring assessments to ensure safety requirements for the use of the grab bars had been met. 6. Interview on 2/13/25 at 9:21 a.m. with administrator A revealed maintenance had not completed measurement assessments for the safe use of the grab bars for any resident. 7. Observation on 2/13/25 at 10 a.m. revealed 27 out of 30 observed resident beds had grab bars in the up position on their beds. 8. Review of the provider's revised 7/2015 Restraints and Entrapment policy revealed:	F 909		

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F 909	Continued From page 27 *"The term entrapment describes an event in which a resident is caught, trapped, or entangled in the open space of side rails, grab bars, or in gaps around mattresses." 9. Review of the provider's revised 6/2016 Preventative Maintenance policy revealed: *"All equipment and building service is to be in satisfactory working condition for the safety and wellbeing of patients, residents, visitors, employees, and volunteers."	F 909		

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 2/14/25. Avera Rosebud Country Care was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at E004 in conjunction with the provider's commitment to continued compliance with the fire safety standards..	E 000		
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:	E 004	It was discovered after consulting with the facility emergency preparedness manager that the plan had been reviewed and updated in 02/2024. During the survey our DON gave the surveyor and outdated form and did not know the location of the correct documentation. The outdated documentation was removed from our emergency preparedness materials and the correct documentation was included on 03/04/2025. The bi-annual review will be discussed and checked at our quarterly quality meeting on 03/17/2025, and reviewed quarterly for one year to ensure that the materials are being reviewed within the required window. The results of this audit will be reported by the QA nurse to the emergency preparedness manager, the DON, and the administrator to ensure compliance.	3/17/2025 AT

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Anthony Timanus	Administrator	3/4/2025

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E 004	Continued From page 1 * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to update the emergency preparedness program plan annually (the last review was done in October 2023). Findings include: Record review on 2/14/25 at 10:50 a.m. revealed no documentation the provider's current emergency preparedness program plan was updated annually. The plan had last been revised and reviewed in October 2023. The plan had been scheduled for review again in October 2024 but there was no documentation the review had been performed.	E 004		

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E 004	Continued From page 2 Interview with the administrator on 2/14/25 at 11:45 a.m. confirmed that finding. He indicated revisions and review of the emergency plan were a continual process, and that the revision documentation had not been logged into the report.	E 004		

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K 000	INITIAL COMMENTS A recertification survey was conducted on 2/14/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avera Rosebud Country Care was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K363, K712, and K923 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and plan review, the provider failed to ensure staff were familiar with the provider's fire drill procedures (removal of the resident or closing the fire location corridor door). Findings include: 1. Observation on 2/14/25 at 11:00 a.m. revealed a simulated fire was discovered in resident room	K 712	All staff will be reeducated on proper actions during fire drills and actual emergencies during the week of 3/10/2025 - 3/14/2025. Fire drills will be conducted once per month in the following rotation to ensure all departments and shifts are covered; month 1 day hospital, month 2 day long term care, month 3 night hospital and nursing home. Results of these fire drills will be reported by the environmental services manager to the QA manager at the QA meeting on 3/17/205 and quarterly thereafter for one year. The QA manager will report the results of these drills to the DON or administrator to determine if further reeducation is required.	3/17/2025 AT

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K 712	Continued From page 1 RC211. The staff person responding to the simulated fire did not initially remove the resident or close the corridor door to the room after discovery of the fire. The first respondent to the simulated fire with a fire extinguisher did not check the door and door handle for heat prior to entering the room to fight the fire. Interview with the maintenance supervisor at the time of the observations confirmed those findings. He stated the provider had many new workers that were not completely sure of the fire drill procedures. The deficiency had the potential to affect 100% of the occupants.	K 712		
K 923 SS=B	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient	K 923	Oxygen concentrators where removed from the location on 2/14/2025. Location was rechecked on 3/3/2025 to ensure compliance and no concentrators where found at the location. This location will be audited monthly for three months and then quarterly for one year to ensure compliance. Results of this audit will be reported by the environmental services manager to the QA manager at the quarterly QA meeting on 3/17/2025 and then quarterly thereafter for one year. Results of this audit will be reported to the DON or administrator to ensure compliance.	3/17/2025 AT

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K 923	Continued From page 2 care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to protect medical gas storage as required. Oxygen concentrators were kept with the oxygen bottles (empty and full cylinder storage locations). Findings include: 1. Observation on 2/14/25 at 9:35 a.m. revealed combustible materials (oxygen concentrators) were found to be stored adjacent to and within five feet of oxygen cylinders in the empty and full oxygen cylinder storage locations. Four oxygen concentrators were kept in the empty oxygen bottle storage location and six oxygen concentrators were kept with 89 oxygen e cylinders in the full oxygen storage location. Interview with the maintenance supervisor at the time of the observations confirmed those findings. The oxygen concentrators were removed at the time of the observations.	K 923		

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K 923	Continued From page 3 The deficiency affected one of four smoke compartments.	K 923		

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K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and plan review, the provider failed to ensure staff were familiar with the provider's fire drill procedures (removal of the resident or closing the fire location corridor door). Findings include: 1. Observation on 2/14/25 at 11:00 a.m. revealed a simulated fire was discovered in resident room	K 712	All staff will be reeducated on proper actions during fire drills and actual emergencies during the week of 3/10/2025 - 3/14/2025. Fire drills will be conducted once per month in the following rotation to ensure all departments and shifts are covered; month 1 day hospital, month 2 day long term care, month 3 night hospital and nursing home. Results of these fire drills will be reported by the environmental services manager to the QA manager at the QA meeting on 3/17/205 and quarterly thereafter for one year. The QA manager will report the results of these drills to the DON or administrator to determine if further reeducation is required.	3/17/2025 AT

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K 923 SS=B	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient	K 923	Oxygen concentrators where removed from the location on 2/14/2025. Location was rechecked on 3/3/2025 to ensure compliance and no concentrators where found at the location. This location will be audited monthly for three months and then quarterly for one year to ensure compliance. Results of this audit will be reported by the environmental services manager to the QA manager at the quarterly QA meeting on 3/17/2025 and then quarterly thereafter for one year. Results of this audit will be reported to the DON or administrator to ensure compliance.	3/17/2025 AT

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA ROSEBUD COUNTRY CARE CENTER	**126 S LOGAN AVE** **GREGORY, SD 57533**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 2 care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to protect medical gas storage as required. Oxygen concentrators were kept with the oxygen bottles (empty and full cylinder storage locations). Findings include: 1. Observation on 2/14/25 at 9:35 a.m. revealed combustible materials (oxygen concentrators) were found to be stored adjacent to and within five feet of oxygen cylinders in the empty and full oxygen cylinder storage locations. Four oxygen concentrators were kept in the empty oxygen bottle storage location and six oxygen concentrators were kept with 89 oxygen e cylinders in the full oxygen storage location. Interview with the maintenance supervisor at the time of the observations confirmed those findings. The oxygen concentrators were removed at the time of the observations.	K 923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435029	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/14/2025**

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K 923	Continued From page 3 The deficiency affected one of four smoke compartments.	K 923		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10625	A. BUILDING: _____ B. WING _____	02/13/2025

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/11/25 through 2/13/25. Avera Rosebud Country Care Center was found in compliance.	S 000		
S 000	Compliance/noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 2/11/25 through 2/13/25. Avera Rosebud Country Care Center was found in compliance.	S 000		3/3/2025 AT

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anthony Timanus — TITLE: Administrator — (X6) DATE: 3/3/2025