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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435079	A. BUILDING _____ B. WING _____	C 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED LIVING COMMUNITY	405 FIRST AVE BROOKINGS, SD 57006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 5/20/24 through 5/23/24. United Living Community was found not in compliance with the following requirements: F625, F641, F657, F812, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 5/20/24 through 5/23/24. Areas surveyed included Quality of Care and Elopement. United Living Community was found in compliance.	F 000	F-625 Action Plan A Bed Hold form was created on 6.10.2024 by the Social Worker and Director of Nursing and reviewed and approved by Human Resources on 6.10.2024 and QAPI on 6.20.2024. The Checklist that Charge Nurses complete upon a resident transferring out of the facility or going on therapeutic leave was updated to include Bed Hold procedures. The checklist is in the Charge Nurse Book located in each Nurse station. Completed on 6.10.2024 by Director of Nursing.	
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and	F 625	Training on Bed Hold Policy and Procedures will be completed for all Nurses including Contract Nurses by 7.15.2024, by the Director of Nursing or designee. Following the training, the Nurses will complete a post test for competency and sign an attestation form stating they received, understand and had their questions answered.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Elizabeth Mosena DeBerg	Administrator	6/14/2024

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

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F 625	Continued From page 1 (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to provide bed-hold notices to the resident or resident's responsible party at the time of transfer to a hospital and ombudsman notification for four of four sampled residents (6, 4, 25 and 27). Findings include: 1. Review of resident 6's electronic medical record (EMR), revealed: *On 12/04/23, she had been transferred to the hospital at the request of her family representative due to her becoming shaky and she could not stand on her own. *There was no written notification to the resident or her responsible party regarding the Bed Hold policy, and no documented notification to the Ombudsman that resident 6 had been sent and admitted to the hospital. 2. Review of resident 4's EMR revealed: *On 2/29/24 at 10:30 p.m. resident 4 fell outside the restroom by the nurses' station. *He reported back pain. *Emergency medical services (EMS) was called and he remained on the floor while the staff waited for the ambulance. *Resident 4 was taken to the hospital and remained there until he returned on 3/2/24.	F 625	F 625 - Continued from page 1. Education will be tracked by the Nurse Educator or designee and reviewed in QAPI monthly. Bed Hold training will be added to the Nurse onboarding training checklist by 6.28.2024 by the Chief of Human Resources. The Bed Hold Policy and Procedures will be added to the Contract Resource binder by the Nurse Educator on 6.28.2024. Bed Hold forms will be completed by verbal consent with a witness or in writing within 24 hours or next business day of leaving the facility. Bed Hold form completion will be monitored by our Stand-Up team Monday through Friday. Director of Social Services or designee will monitor Bed Hold form completion per our policy monthly. Data will be monitored and reviewed monthly in QAPI. If we are at 100%for 12 consecutive weeks, we will move to monthly audits.	7.7.2024

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F 625	Continued From page 2 *There was no documentation the resident or his responsible party had received information about the bed-hold policy. 3. Review of resident 25's EMR revealed: *On 9/25/23 at 5:37 p.m. the hospital called to inform the nurse that resident 25 had a critical value blood glucose of 835. *Ecare (an online health service) called soon after with orders to send her to the emergency room. *A phone call was made to her husband who gave permission to send her to the hospital. *Resident 25 was transferred by ambulance to the hospital and remained there she returned on 9/29/23. *There was no documentation the resident or her responsible party had received information about the bed-hold policy. 4. Review of resident 27's EMR revealed: *A health status progress note (PN) on 3/21/24 at 11:52 a.m. indicated the resident "...transferred to the ER [emergency room] for further evaluation. Resident left [facility name] at 1130 via ambulance." *A PN on 3/21/24 at 1152 a.m. indicated her son was notified of the resident's transfer to the ER. *A PN on 3/22/24 at 4:04 p.m. indicated she had returned to the facility. *A PN on 4/7/24 at 12:30 p.m. indicated her son "... agree to transport patient to the hospital for evaluation." *A PN on 4/10/24 at 1:44 p.m. indicated she had returned to the facility. *There were no documentation the resident or her responsible party had received information about the bed-hold policy.	F 625		

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F 625	Continued From page 3 5. Interview on 5/23/24 at 10:22 a.m. with social service designee (SSD) C revealed: *The bed-hold information was located in the welcome book. *Residents signed an "Admission Acknowledgement" form, that acknowledged receipt of the "Welcome Handbook" upon admission. *She was not aware if a written form had been completed at the time of transfer. *She did not know it was her responsibility. 6. Interview on 5/23/24 at 10:52 a.m. with administrator A revealed: *She would have expected the nurse to notify the family verbally at the time of transfer and the social worker to follow up regarding the resident's return to the facility during a hospitalization. *A bed hold should have been completed at the time of transfer. *She stated, "We are not completing a written bed-hold form." 7. Review of the provider's undated Holding Bed Space policy revealed: *"Upon admission and when a resident is transferred for hospitalization or for therapeutic leave, a representative of the Social Services Department will provide information concerning our bed hold policy." *When emergency transfers are necessary, the facility will provide the resident or representative (sponsor) with information concerning our bed-hold policy. (Copy of Bed Hold Policy is mailed to resident or resident representative.)"	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		

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F 641	Continued From page 4 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview, observation, record review and policy review, the provider failed to ensure one of one sampled resident (115) was accurately assessed for appropriate and safe self-administration of a nebulized (converted from liquid to mist) medication. Findings include: 1. Interview on 05/21/24 at 09:25 a.m. with resident 115 revealed she: *Had a medication that was given through a nebulizer (neb) machine. *Was left alone by staff during her neb treatments. *Stated she had never been educated on using the neb machine and could not turn it on or off. *Would take the mask off before the neb treatment was done. *Wanted to self-administer her neb treatment. Observation and interview on 5/22/24 at 10:02 a.m. with registered nurse (RN) K while providing a neb treatment for resident 115 revealed: *She placed liquid Ipratropium (a med to open airways in the lungs) and Budesonide (a med to prevent swelling) in the neb reservoir, started the neb machine and placed the mask on resident 115's face. *She stated that she would set a timer on her watch for ten minutes and return to assist the resident and left the room. *She did not know if the resident had an orderto self-administer the neb treatment. *She was not sure of the facility policy on resident self-administration of medications.	F 641	F 641 Self-Administration of Medication Assessment will be completed upon admission by the Nurse Leader and quarterly thereafter or if a significant change occurs. This assessment will be added to the Admission Nurse Checklist and added to the 3-Day MDS assessment. This will be completed by the Director of Nursing on 6.28.2024. Existing residents will be assessed during their MDS review period by Nurse Leader. If a resident is able and willing to self-administer their medication(s), Nursing will receive consent from the resident or designee and a physician order for self-administration of medication and the MDS RN Coordinator will Care Plan. Education will be provided by the Director of Nursing to the Nurse Leadership team on July 15, 2024. Data will be collected upon each admission and reviewed monthly within QAPI.	7.7.2024

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F 641	Continued From page 5 *Review of the resident 115's electronic medical record (EMR) revealed: *An order on 05/13/24 for Budesonide (one vile via neb two times a day) and on 05/16/24 for Ipratropium (one vile by mouth three times a day). *There was no order for the self-administration of the Ipratropium or Budesonide . *There was no assessment to determine if she was able to self-administer the neb treatment safely. *Her care plan did not include her self-administration of the neb treatment. 2. Interview on 05/23/24 at 11:03 a.m. with RN I revealed: * There was no order for resident 115 to self-administer any medications. *Resident 115 had not been educated on using the nebulizer. *Self-administration was not included in resident 115's care plan. *She would have expected all education to have been conducted and documented in the resident's record. Review of the providers February 2021 Self-Administration of Medication policy revealed: *"3. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and their care plan. The decision that a resident can safely self-administer medications is reassessed periodically based on changes in the resident's medical and /or decision-making status."	F 641		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		

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F 657	Continued From page 6 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure resident care plans were revised to reflect the current needs for three of twenty-one sampled residents as follows: *Three of three sampled residents (6, 50, and 54) who had VirtuSense VSTAlert motion detection systems installed in their rooms. *One of one sampled resident (50) who had a	F 657	F 657 Residents who have a history of falls and/or are at risk of falling. Our Falls Committee includes the interdisciplinary team and meets weekly. During the meeting if a VST seems the best intervention for falls, the Director of Social Worker or designee will get consent, the Director of Nursing or designee will get the physician's order for a VST, and the MDS RN Coordinator will Care Plan. The Care Plan will include how often the VST is monitored to ensure it is working properly, the contact person for the VST machine, and the manufacturer. A VST policy was completed by Chief of Human Resources and approved by the QAPI Committee on 6.20.2024. Education on the VST machine and its functionality completed at an All Staff meeting on 4.23.2024, by the VST manufacturer.	

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F 657	Continued From page 7 side rail on her bed. Findings include: 1. Observation on 5/23/24 at 10:25 a.m. of resident 6's room revealed a VST motion sensor located on the far wall that had been directed at the residents' bed. 2. Review of resident 6's electronic medical record (EMR) revealed: *An order dated 05/17/24 indicated " Resident may use VST monitor per order received on 5/3/24." *There was no documentation of the use of the VST monitor in the resident care plan. *There was no consent documentation for the use of the VST monitor. 3. Observation on 5/20/24 at 2:27 p.m. of resident 50's room revealed: *A side rail on the left side of her bed. *A VST motion sensor located on the far wall that had been directed at the residents' bed. 4. Interview on 5/21/24 at 8:51 a.m. with an unidentified nurse revealed: *Resident 50 used the side rail to reposition herself. *The VST motion sensor alerted the nurses by phone when the resident attempted to get out of bed. 5. Review of resident 50's EMR revealed: *An order dated 12/28/23 indicated "Facility has added a bed monitor to patient room." *A fall progress note (PN) dated 1/4/24 at 4:10 p.m. indicated the resident fell in her room. -"Interventions added to care plan: use VST monitor." --This intervention had not been added to her	F 657	F 657 - Continued from page 7 Additional education will be completed on 7.15.2024, by the Director of Nursing or designee for all Nursing staff. VST training will be added to all staff onboarding checklists by the Chief of Human Resources by 6.28.2024. MDS Coordinator or designee will review all resident Care Plans that have a VST to ensure they are up to date by 7.15.2024. VST orders, consent and Care Plan will be audited monthly by the Director of Nursing in QAPI. Upon discharge the Facilities team will remove the VST device from the room.	7.7.2024

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F 657	Continued From page 8 care plan. *There was no documentation of the use of the side rail in her care plan. 6. Interview on 5/22/24 at 1:08 p.m. with director of nursing (DON) B revealed: *An order for the VST monitor for resident 50 was added by the Hospice physician on 1/3/24. -It had not been added to her medication administration record (MAR) or her care plan. --"The family is aware however we just didn't document it." *She would have expected the VST monitoring to have been added to the MAR and the care plan, and the resident's or resident's representative's consent to have been obtained and documented. *She stated the side rail documentation for resident 50 had not been completed because "the family wanted it so she could move in the bed." *She would have expected a quarterly side rail assessment for resident 50 to have been completed, a physician's order to have been obtained, and the side rail to have been added to her care plan. 7. Observation and interview on 5/22/24 at 12:46 p.m. with resident 54 while in her room revealed: *A VST motion sensor located on the far wall directed at her bed. -The sensor system announced "resuming" when the resident stepped near her bed. *The resident stated, "who said that?" -She indicated she did not know where the noise came from. 8. Review of resident 54's EMR revealed: *A PN dated 3/31/24 at 11:42 p.m. indicated "The resident's VST alarm is not working tonight." *There was no documentation of the use of the	F 657	F 657 Bed Rails. United Living Community refers to these as Assist Bars. Residents who my benefit from assist bars for transfers and/or repositioning, will be assessed by a Physical Therapist or designee. The Care Plan will be reassessed during the MDS assessment period or upon significant change by the MDS Coordinator. An Assist Bar policy was completed by Chief of Human Resources and approved by the QAPI Committee on 6.20.2024. Education on assist bars and their functionality will be completed at an All Staff meeting on 7.15.2024 by the Physical Therapist or designee. Assist Bar training will be added to all staff onboarding checklists by Chief of Human Resources by 6.28.2024. MDS Coordinator or designee will review all resident Care Plans that have Assist Bars to ensure they are up to date by 7.15.2024.	

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F 657	Continued From page 9 VST monitor in her care plan. 9. Interview on 5/22/24 at 3:40 p.m. with administrator A revealed: *The VST system was used for fall prevention for residents at the highest risk of falls. *She confirmed a physician's order and the resident's representative's consent should have been obtained and the use of the VST monitoring system should have been added to the care plan. * They did not have a specific policy regarding the VST monitoring system. Review of the providers' 2016 Proper Use of Side Rails policy revealed, "The use of side rails as an assistive device will be addressed in the resident care plan." Review of the providers' undated Care Plan Policy revealed: *"The purpose of the care plan is to provide a centralized coordination of the services that will be provided to each resident, based on his or her individual needs, abilities, and preferences." *"The care plan should address, but is not limited to the following: -"Fall history and/or risk.	F 657	F 657 Continued from page 9 Assist Bar orders, consent and Care Plan will be audited monthly by the Director of Nursing or designee in QAPI. Upon discharge the Facilities team will remove assist bars from the bed.	7.7.2024
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812		

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F 812	Continued From page 10 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review the provider failed to ensure food items were appropriately labeled, stored, handled, prepared, and served in a safe and sanitary manner in one of one kitchen and one of four kitchenettes for the following: *One of one commercial refrigerator that contained food items that were not labeled, dated, or discarded by the use-by date, *One of one commercial freezer that contained food items that were not labeled or dated. *One of one kitchen and one of four kitchenettes that contained dry food items that were not labeled or dated. *Appropriate glove use and hand hygiene by cook G while preparing food. *Appropriate glove use and hand hygiene by dietary aide F and by unlicensed assistive personnel (UAP) H while handling food. Findings include: 1. Observation on 5/20/24 at 1:11 p.m. of the kitchen revealed: *A commercial refrigerator contained: -One container of pickles that was not covered or dated.	F 812	F 812 The Dietary Manager or designee will conduct the education for the dietary staff by 7.15.2024. Weekly audits will be completed by the Dietary Manager or designee for correct food labeling and storage after 7.15.2024. Competency tests will be conducted by the Dietary Manager or designee monthly thereafter July 15th, 2024. All Dietary Staff re-trained by 7.15.2024. Audits for proper food labeling and storage will be completed weekly by the Dietary Manager or designee. If at 90% accuracy or above for 12 consecutive weeks, then audits will move to monthly. Reported and monitored in QAPI by the Dietary Manager monthly. Hand hygiene and glove use for all dietary staff was completed on 6.27.2024 by the Dietary Manager and Assistant Dietary Manager. Competency and compliance audits will be done weekly by the Nurse Educator or designee and reviewed monthly in QAPI.	7.7.2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 11 -One jar of barbecue sauce that was opened and not dated. -One bottle of ranch dressing marked as opened on 7/17/23. --There was no expiration date found. -A container labeled "broccoli broth use by 5/15." -A sliced onion in a plastic bag that was not labeled or dated. -A flour tortilla labeled "use by April 25, 2024." -A package of deli pepper jack cheese labeled "use by Feb 26, 2024"." -A tub of palmetto cheese spread labeled "use by date April 4, 2024." -Two heads of lettuce in a plastic bag that had browned in areas. -Several stacks of sliced cheese, wrapped in plastic wrap, one with what appeared to be a spot of mold, that were not labeled or dated. -Two apple pies on a tray covered with plastic that were not labeled or dated. *A commercial freezer contained: -At least 10 packages of opened frozen meat items that were not labeled or dated. *Two open bags of puffcorn that were not dated. *An open bag of shredded coconut labeled "sell by date 1/1/24." -There was no open or use-by date. *An open bag of cereal that was not labeled or dated. 2. Observation on 5/20/24 at 2:1p.m. in the 500-hall kitchenette revealed: *A package of what appeared to be French Toast in the freezer that was not labeled or dated. *A bottle of liquid that appeared to be pancake syrup that was not labeled or dated. *Three containers of dry cereal that were not labeled or dated *An open plastic bag of what appeared to be	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435079	A. BUILDING _____ B. WING _____	C 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED LIVING COMMUNITY	405 FIRST AVE BROOKINGS, SD 57006

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F 812	Continued From page 12 pancake mix dated "3/18." 3. Observation and interview on 5/20/24 at 3:51 p.m. with cook G revealed he: *Wore gloves to place raw chicken on a pan, removed those gloves, seasoned the chicken- without washing his hands, and then put on a new pair of gloves. *Checked the temperature of the lasagna while wearing those gloves, removed those gloves, and without washing his hands put on a new pair of gloves and then touched the ready-to-eat garlic bread with those gloved hands. 4. Observation on 5/21/24 10:38 a.m. with dietary aide F in the main kitchen revealed: *While wearing gloves, he opened the walk-in cooler door, took two containers from the cooler, and set them on the cart. *With those same gloved hands, he picked up a lid to a coffee pot, set it on the counter, filled it, picked up a lid, and screwed it on the coffee pot. *With those same glove hands he delivered the cart to the kitchenette on Morningview hallway and came back to the main kitchen. *He continued to move between the main kitchen and the Morningview kitchenette while he touched several surfaces and resident food items (silverware, BBQ sauce, straws, beverage cans and water glass rims) with those same gloved hands. *At 11:18 a.m. he removed those gloves, did not wash his hands and put on a new pair of gloves and again touched several surfaces and resident food items (utensils, buns, plates, and cupboards) while he served lunch. *He picked up a clipboard and documented resident meal intakes with those same gloves on. *At 11:50 a.m. he removed those gloves and did	F 812		

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F 812	Continued From page 13 not wash his hands. 5. Interview on 5/21/24 at 11:52 a.m. with dietary aide F regarding glove use and handwashing revealed he stated: *"Gloves are to be worn whenever handling food or beverages. *If he left the serving area and changed gloves, he would wash his hands before putting on the new gloves." 6. Observation on 5/21/24 at 11:18 a.m. with UAP H revealed: *She wore gloves while serving a resident meal plate in the 500-hall dining room, without changing those gloves she took a bottle of ketchup out of the refrigerator, then served the next plate while wearing those same gloves. *While wearing those same gloves she left the dining room and delivered a meal tray to resident room 513. *She returned to the serving area, removed those gloves, did not wash her hands, put on a new pair of gloves and delivered a meal tray to resident room 516. *She removed those gloves as she walked to the serving line, discarded them in the trash, did not wash her hands and put on a new pair of gloves. *She then stated, "We don't have to, but I like to wear gloves when I serve food." 7. Interview on 5/23/24 at 9:00 a.m. dietary manager (DM) D regarding glove use, hand hygiene, and food storage, handling, preparation, and serving revealed: *Food items were labeled with a black marker that indicated an "intake date." *The manufactured date was the date used for the expiration date.	F 812		

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F 812	Continued From page 14 *Prepared or leftover food was to have been labeled with a sticker that identified the food, the date it was placed in the refrigerator, and the date it should have been discarded. *She would have expected expired food to have been thrown away. *Dry cereal, once removed from the box, should have been labeled with a sticker indicating what kind of cereal it was, and when it was to have been discarded. *She would have expected gloves to have been worn when touching ready-to-eat foods. *She stated gloves needed to be changed when "moving on to a new task." *She would have expected staff to wash their hands when they arrived at work, before starting a task, before putting on gloves, after removing gloves, and when their hands were soiled. *Gloves were not to have been worn while delivering food to residents at the table or to their rooms. *Hand sanitizer should have been used in the dining room between each task. 8. Interview on 5/22/24 at 3:10 p.m. with registered dietitian E, by email, , regarding food handling, glove use, and hand hygiene revealed: *"I expect that staff will use gloves whenever handling ready-to-eat foods that are not going to be cooked further." *"They should be washing hands before putting [on] the gloves." *"Hand washing needs to be done frequently and often between tasks and after breaks ..." *"I expect dining room staff to wash [their] hands prior to serving." -"I don't expect them to wear gloves when serving meals unless they are touching a ready to eat item like a roll or bun."	F 812		

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F 812	Continued From page 15 Review of the provider's 2017 Food Receiving and Storage policy revealed: *"Dry foods that are stored in bins will be removed from original packaging, labeled and dated ("use by" date)." *"All food stored in the refrigerator or freezer will be covered, labeled and dated ("use by" date)." Review of the provider's 2017 Preventing Foodborne Illness- Employee Hygiene and Sanitary Practices policy revealed: *"Employees must wash their hands: ..whenever entering or re-entering the kitchen; before coming into contact with any food surfaces; during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks ..." *The use of disposable gloves does not substitute for proper hand washing." Review of the provider's 2009 Personal Protective Equipment - Gloves policy revealed: *"Wash your hands after removing gloves or use alcohol hand rinse if appropriate."	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program 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.	F 880		

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F 880	Continued From page 16 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the 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	F 880	F 880 Education for all staff on the following topics and demonstration with a competency test will be completed by 7.15.2024. The Nurse Educator or designee will complete this training: - Hand Hygiene; - When to wash hands vs when to use gel; and - Glove Use. Weekly audits will be completed by the Nurse Educator or designee and reported in QAPI monthly.	7.7.2024

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F 880	Continued From page 17 (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, and policy review, the provider failed to ensure: *Licensed practical nurse (LPN) O and certified nursing assistant (CNA) P had performed hand hygiene and glove use according to the provider's policy during a dressing change for sampled resident (164). *Registered nurse (RN) K had performed hand hygiene and glove use according to the provider's policy during a nebulizer treatment with resident (115). Findings include: 1. Observation and interview on 5/22/24 at 12:30 p.m. with LPN O and CNA P during a dressing change for resident 164 revealed: *LPN O entered the resident's room and into the bathroom. *Then CNA P entered the room. *Both LPN O and CNA P put on gloves without washing their hands. *LPN O:	F 880		

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F 880	Continued From page 18 -Removed the soiled wound dressings from the residents buttock and removed her gloves. -Put on clean gloves without washing her hands. -Placed some paper towels at the head of the bed. -Placed the resident's new dressings on top of those paper towels and opened the dressings. -Took her gloves off and put clean gloves on without washing her hands or using hand sanitizer. -With those gloved hands she reached into her pocket, removed a pen and dated the new dressings with the pen. *LPN O placed two new dressings on resident 164's buttock. *CNA P had assisted with repositioning the resident, the bedding, clothes, and incontinence brief. -She removed her soiled gloves and without washing her hands she put clean gloves on. *A large bottle of hand sanitizer was on top of the medication cabinet in the room. *LPN O and CNA P confirmed: -There was hand sanitizer available for use in the room. -They should have used hand sanitizer or soap and water each time they changed their gloves. 2. Interview on 5/24/24 at 1:00 p.m. with the RN infection preventionist I and RN staff development coordinator L regarding the above observed lack of hand hygiene revealed the staff had received repeated hand hygiene education. 3. Observation and interview on 5/22/24 at 10:02 a.m. with RN K while providing a nebulizer treatment for resident 115 revealed: *She did not perform hand hygiene before taking the nebulizer equipment out of the packaging.	F 880		

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F 880	Continued From page 19 *She did not perform hand hygiene before putting gloves on or after taking them off. *She admitted she did not perform hand hygiene and stated she should have sanitized her hands before touching the equipment. Review of the provider's January 2023 Nebulizer Treatments policy revealed: *" Procedure: 1. Wash or sanitize hands." Review of the provider's Handwashing/Hand Hygiene Policy revealed: *All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. *All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. *Hand hygiene products and supplies (sinks, soap, towels, alcohol-based rub) would be readily accessible and convenient for staff use to encourage compliance with hygiene policies. *Wash hands with soap and water for the following: -When the hands were visibly soiled; and -After contact with a resident with infectious diarrhea. -Before and after coming on duty. -After personal use of the toilet or conducting your hygiene. *Use an alcohol-based hand rub containing at least 62% alcohol or soap and water for the following situations such as: -Before and coming on duty. -Before and after direct contact with residents. -Before preparing or handling medications. -Before and after handling invasive devices such	F 880		

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F 880	Continued From page 20 as a catheter and IV access sites. -Before handling used dressings and contaminated equipment. -Before moving from a contaminated body site to a clean body site during resident care. -After contact with blood or bodily fluid. -Before assisting residents with eating. *Hand hygiene is the final step after removing and disposing of protective equipment. *The use of gloves does not replace hand washing or hand hygiene. *Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.	F 880		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435079	A. BUILDING _____ B. WING _____	05/23/2024

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 5/20/24 through 5/23/24. United Living Community was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elizabeth Mosena DeBerg

TITLE: Administrator

(X6) DATE: 6/19/2024

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435079	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/24/2024**

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 5/24/24. United Living Community was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K222, K353, K918, and K923 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 353 SS=C	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 353	K 353 What: Sprinkler system quality flow systems will be checked and audited for completion. Audit will include, date of sprinkler system last checked; who provided the system check, and water system supply source. Who: Director of Facilities and Services or designee. When: Quarterly How: QAPI Plan K 353 What: Sprinkler system internal obstruction inspection every 5 years. Will be completed in 2024. Who: Director of Facilities and Services How: QAPI data and place the last inspection in the survey entrance book, with who completed, their findings and the date.	June 20, 2024 and quarterly there after

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elizabeth Mosena DeBerg
TITLE: Administrator
(X6) DATE: 6/14/2024

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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	435079	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/24/2024**

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K 353	Continued From page 1 Based on record review, observation, and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition (quarterly flow test not done in the third quarter of 2023 and 5 year internal obstruction inspection not done since 2016). Findings include: 1. Record review on 5/24/24 at 8:45 a.m. revealed the required quarterly flow tests had not been performed in the third quarter of 2023. Flow tests in the past twelve months had been performed on 12/5/22, 4/26/23, 8/4/23, and 2/27/24. Observation of the sprinkler system maintenance tags placed by the contractor revealed there was not a tag for the third quarter 2023 flow testing. A quarterly flow test had not been performed in November 2023. 2. Record review on 5/24/24 at 8:50 a.m. revealed there had not been a required 5 year internal obstruction inspection performed for the sprinkler riser and valves since 3/22/16. Observation of the sprinkler system maintenance tags placed by the contractor revealed there was not a tag for the 5 year internal obstruction inspection since 3/22/16. The pressure guages had been marked 3/22/16. Interview with maintenance supervisor at the time of the record review confirmed those conditions. Failure to continuously maintain the automatic sprinkler system as required increases the risk of death or injury due to fire. The deficiency affected two of numerous required tests on the automatic sprinkler system.	K 353		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435079	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING	DATE SURVEY COMPLETE: 5/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED LIVING COMMUNITY	405 FIRST AVE BROOKINGS, SD

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 222	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to provide egress doors as required at one of seven exit door locations. Findings include: 1. Observation beginning on 5/24/24 at 7:15 a.m. revealed the main entrance exit door was equipped with a magnetic lock that prevented egress. Testing of the door by applying force in the direction of the path of egress revealed that action would initiate an irreversible process to unlock the magnet and release the door after a 30 second delay. That indicated the magnetically locked door was functioning as a delayed egress locked door. There was not the required signage mounted on the door indicating it was delayed egress and

K-222

What: Create a new sign stating the delay of 30 seconds and place it at the main entrance.

When: by June 14, 2024.

Who: Director of Facilities and Services or designee

How: Ensure sign is at main entrance with the proper delay time monthly.

Policy updated and approved by QAPI June 20, 2024.

Elizabeth Mosena DeBerg Administrator 6/14/2024

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435079	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING	DATE SURVEY COMPLETE: 5/24/2024
NAME OF PROVIDER OR SUPPLIER: UNITED LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE: 405 FIRST AVE BROOKINGS, SD		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 222	Continued From Page 1 how to exit. Interview at the time of the observation with the maintenance director confirmed that condition. He stated the delay was changed from 15 seconds to 30 seconds in the past year and the required signage with the 15 second delay information was removed. A new sign with the required information on how to egress with the 30 second delay information was required but not installed. Failure to provide egress doors as required increases the risk of death or injury due to fire. The deficiency affected 100% of the building occupants. Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6.2(3)(a)
K 918	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to perform generator maintenance as required (monthly load runs) for the Onan 400 kW diesel generator for 2023 and 2024. Findings include: 1. Record review on 5/24/24 at 8:45 a..m. revealed documentation of weekly automatic generator runs for thirty minutes (0.5 hours with 10 minute cooldown) each month. The generator runs were not performed under load. Monthly load runs were required. If monthly load runs could not carry at least 30% of the nameplate value of the generator every month in a year, annual load banking was required. Record review revealed annual load banking was being performed.

K-918

What: We will return to the monthly kW testing June 10, 2024. Weekly and monthly generator maintenance will be completed as outlined in regulations.

When: Start June 10th, 2024 and ongoing.

How: QAPI

Policy will be reviewed and approved by QAPI on June 20, 2024.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435079	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING	DATE SURVEY COMPLETE: 5/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED LIVING COMMUNITY	405 FIRST AVE BROOKINGS, SD

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES

K 918

Continued From Page 2

Interview with the maintenance supervisor at the time of the record review confirmed that finding. The monthly load runs must be for thirty minutes (0.5 hours) plus a minimum five minute (0.1 hour) cool down time delay. Further interview with the maintenance supervisor revealed he had been advised to performed load banking yearly in lieu of monthly load runs..

Interview with the maintenance supervisor at the time of the record review confirmed that finding. He stated the generator had required a load bank test in the past.

The deficiency affected one of numerous generator maintenance requirements.

K 923

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 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.
Combustible items were stored on racks within five feet of the oxygen cylinders in room 126. Findings include:

1. Observation on 5/24/24 combustible materials were found to be stored adjacent to and within five feet of 29 oxygen 'e' cylinders in the 126 oxygen storage room. The minimum 5 feet of separation between combustibles and oxygen storage was not maintained as required in this area.

K-923

What: All flammables and combustibles will be removed from Oxygen room.

All empty cylinders will be moved away from full cylinders.

We will store 20 cylinders.

When: June 10, 2024.

Who: Director of Facilities and Services or designee

How: Audit the room weekly for 4 consecutive weeks. If at 100% compliance will move to monthly audits ongoing. This data will be recorded within the QAPI plan.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435079	MULTIPLE CONSTRUCTION A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	DATE SURVEY COMPLETE: **5/24/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED LIVING COMMUNITY	**405 FIRST AVE BROOKINGS, SD**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 923	Continued From Page 3 The deficiency affected one of eight smoke compartments.

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
	10601	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED LIVING COMMUNITY	405 1ST AVE BROOKINGS, SD 57006

(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 5/20/24 through 5/23/24. United Living Community was found not in compliance with the following requirement: S115.	S 000		
S 115	44:73:01:07 Reports Each facility shall fax, email, or mail to the department the pertinent data necessary to comply with the requirements of all applicable administrative rules and statutes. Any incident or event where there is reasonable cause to suspect abuse or neglect of any resident by any person shall be reported within 24 hours of becoming informed of the alleged incident or event. The facility shall report each incident or event orally or in writing to the state's attorney of the county in which the facility is located, to the Department of Social Services, or to a law enforcement officer. The facility shall report each incident or event to the department within 24 hours, and conduct a subsequent internal investigation and provide a written report of the results to the department within five working days after the event. Each facility shall report to the department within 24 hours of the event any death resulting from other than natural causes originating on facility property such as accidents. The facility shall conduct a subsequent internal investigation and provide a written report of the results to the department within five working days after the event. Each facility shall report a missing resident to the	S 115	S-115 What: Re-education will be done with nurses regarding state reporting, falls and reporting possible injuries to families. Who: Director of Nursing and / or Nurse Educator. When: June 26, 2024 and quarterly thereafter. How: Auditing data will be added to our QAPI plan.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elizabeth Mosena DeBerg

TITLE: Administrator

(X6) DATE: 6/14/2024

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
	10601	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED LIVING COMMUNITY	405 1ST AVE BROOKINGS, SD 57006

(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 115	Continued From page 1 department within 48 hours. The facility shall conduct a subsequent internal investigation and provide a written report of the results to the department within five working days after the event. Each facility shall also report to the department as soon as possible any fire with damage or where injury or death occurs; any partial or complete evacuation of the facility resulting from natural disaster; or any loss of utilities, such as electricity, natural gas, telephone, emergency generator, fire alarm, sprinklers, and other critical equipment necessary for operation of the facility for more than 24 hours. Each facility shall notify the department of any anticipated closure or discontinuation of service at least 60 days in advance of the effective date. Each facility shall report to the department any unsafe water samples for pools or spas. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to report to the South Dakota Department of Health (SD DOH) two of three sampled residents (35 and 4) who had a fall with an injury that required medical evaluation and intervention at a healthcare setting outside of the facility. Findings include: 1. Review of resident 35's electronic medical record (EMR) revealed: *She had a recent history of falls and right knee pain.	S 115		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10601	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED LIVING COMMUNITY	405 1ST AVE BROOKINGS, SD 57006

(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 115	Continued From page 2 *On 5/8/24 at 9:35 a.m. she fell in the Sunshine dining room. *She landed on her right side. *She had right knee pain. *She had been complaining of right knee pain off and on for the past few days before this fall. *Her right knee was noted to be mildly swollen. *She stated "ow" at times when she needed to stand and bear weight on it. *She was able to bend her knee. *On 5/8/24 at 12:19 p.m. Ecare (an online health service) was consulted due to increased right knee pain and mild swelling. *A video camera assessment was completed, and orders were received for: -Physical Therapy. -Voltaren gel (topical pain medication). -An x-ray of the right knee. *A call was placed to notify her daughter and plan for the x-ray. *Her daughter was out of town, so a ride was arranged with the community bus service. *On 5/8/24 at 1:26 p.m. resident 35 was transported to a local provider for an x-ray. *On 5/8/24 at 5:51 p.m. a call was placed to Ecare for follow up on the x-ray. -The on-call certified nurse practioner (CNP) stated her knee was likely fractured. -She recommended no weight bearing as able and an Ace wrap to the right knee as tolerated. *A health status note on 5/9/24 at 9:55 a.m. confirmed the resident had a right patella (knee) fracture. *An email on 5/22/24 to SD DOH complaint department confirrned the provider had not notified the SD DOH of the fall and injury that required medical evaluation at a healthcare setting outside of the facility.. Interview on 5/23/24 at 10:00 a.m. with registered	S 115		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10601	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED LIVING COMMUNITY	405 1ST AVE BROOKINGS, SD 57006

(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 115	Continued From page 3 nurse (RN) I and administrative consultant J regarding resident 35's fall with a fracture revealed: *They did know all resident incidents had to be reported to SD DOH if outside medical attention was sought. *They confirmed her fall was not reported to SD DOH. *It was their expectation it would have been reported. Interview on 5/23/24 at 2:35 p.m. with administrator A regarding resident 35's a fall with a fracture revealed: *She confirmed the incident was not reported to SD DOH. *Every incident where a resident seeks outside medical attention needed to be reported. *She agreed the provider's fall policy did not clarify to notify SD DOH for incidents where residents seek outside medical evaluation or treatment. 2. Review of resident 4's medical record revealed: *On 2/29/24 at 10:30 p.m. resident 4 fell outside the restroom by the nurses' station. *He reported back pain. *Emergency medical services (EMS) was called and he remained on the floor while the staff waited for the ambulance. *He was taken to the hospital and remained there until he returned on 3/2/24. *There was no documentation the SD DOH had been notified of his fall that required hospitalization. *A phone call on 5/22/24 to SD DOH complaint department confirmed the provider had not notified the SD DOH of the fall and hospitalization.	S 115		

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
	10601	A. BUILDING: _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED LIVING COMMUNITY	405 1ST AVE BROOKINGS, SD 57006

(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 115	Continued From page 4 Review of the provider's revised March 2018 Assessing Falls and Their Causes policy revealed: *"1. Notify the following individuals when a resident falls: -a. The resident's family. -b. The attending physician (timing of notification may vary, depending on whether injury was involved). -c. The director of nursing services. -d. The nursing supervisor on duty. 2. Report other information in accordance with facility policy and professional standards of practice."	S 115		