South Dakota De artment of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41884	A. BUILDING: _____ B. WING _____	C 08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAYBREAK VILLAGE, INC	956 E 7TH ST WINNER, SD 57580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance Statement	S 000	exhaust ventilation fan replaced on 9/11/24. Maintenance person will be in facility 8 hours a week to perform preventative maintenance and fix any ongoing issues. A preventative maintanance form/checklist was obtained from SD Dept of Health and will be utilized for maintenance person to follow. They will do monthly preventative checks of the facility, based off of the list and document via the checklist. A "repair log" will be utilized for staff to write any repairs that are needing done by the maintanence. This will be addressed on a weekly basis by maintanance. Any repairs will be documented by maintenence within this log sheet.. Monthly, the repair log and the preventatve checklist will be turned into the manager for review and documentation of completion on her audit form.Results will be shared with QAPI at the monthly meeting.	10/4/24

A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 8/20/24 through 8/22/24. Daybreak Village, Inc was found not in compliance with the following requirements: S145, S165, S166, S172, S173, S201, S295, S296, S305, S331, S337, S405, S477, and S685.

A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 8/20/24 through 8/22/24. The areas surveyed were pest control, resident rights, and staff availability during the overnight hours. Daybreak Village, Inc was found in compliance.

S 145 44:70:02:12 Ventilation

Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system.

This Administrative Rule of South Dakota is not met as evidenced by:
Based on observation and testing, the provider failed to maintain one of one exhaust ventilation fan in the laundry. Findings include:

1. Observation and testing on 8/20/24 at 10:45 a.m. of the ventilation fan in the laundry revealed:
*The switch to the ventilation fan was held in the on position by tape. 6899
*There was a note by the switch stating, "leave

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chelsey Moss, RN	Nurse-RN	9/25/24

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S 145	Continued From page 1 on". *The ventilation fan was not making any noise. *No air movement could be detected when a paper towel was placed on the surface of the vent.	S 145	*Audits will be completed monthly by the manager for six months and the results will be shared with QAPI. The QAPI committee will determine the ongoing need to continue, modify or conclude the audits at the conclusion of the six months.	
S 165	44:70:02:17 Occupant Protection Each facility must be constructed, arranged, equipped, maintained, and operated to avoid injury or danger to any occupant. The extent and complexity of occupant protection precautions are determined by the services offered and the physical needs of any resident admitted to the facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to maintain a safe, level walking surface for one of nine paths of egress (exit door 3) from the building. Findings include: 1. Observation on 8/20/24 at 11:27 a.m. outside of exit door 3 revealed: *The path of egress had cracked concrete creating an abrupt level change of greater than 1/4 inch within the path of egress. *Where the sidewalk met the landing, the sidewalk had settled approximately three inches along the south edge and one-half inch on the north edge. *The settling had caused the concrete on the edge of the landing to break and slope at about a forty-five-degree angle. Observation and interview on 8/20/24 at 2:30	S 165	Side walks have been repaired 9/24/24 Side walk checks will be part of the "preventative maintenance program". Maintenance will document completion of the checklist on the actual checklist form. The checklist will be turned into the manager each month for review and completion will be documented by the manager on her audit sheet. Results will then be shared with the QAPI at the monthly meeting	10/4/24

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S 165	Continued From page 2 p.m. with residents 2 and 3 revealed: *They were sitting outside of door 3 in chairs. *They used exit door 3 multiple times per day. *They had witnessed other residents' trip and stumble over the uneven surfaces. Interview on 8/21/24 at 4:45 p.m. with resident 5 revealed: *He had tripped on the uneven concrete by exit door 3 when trying to reenter the building during the afternoon of 8/20/24. -He was able to get up on his own after a short period of time. *He stated that he received several abrasions and hit his rib cage on the left side. -A half-dollar size abrasion to this left forearm and two pencil eraser sized abrasions were on his left pinky finger from the event. *He notified the staff when he re-entered the building that he had fallen. -He verbalized staff did not follow-up with him after he told them he tripped. Interview on 8/21/24 at 4:35 p.m. with administrator A revealed: *She was not aware the concrete outside of exit door 3 had settled and was uneven. *She guessed it had been that way for a couple of months.	S 165	Nursing staff assessed patient upon receival of this document(2 days after resident indicated to state of fall). Patient told staff that he had a fallen 2 days prior. Upon assessment, the nurse(who is no longer employed) indicated a small red sore on the patient's great toe. Nurse implemented a plan of care to monitor injury and to provide daily soaks. This was indicated within the patient's chart and also placed on the MAR for nursing staff to document. Resident was educated on the importance of reporting any incidents to the nursing staff as soon as possible for proper care and documentation. *Audits will be completed monthly by the manager for six months and the results will be shared with QAPI. The QAPI committee will determine the ongoing need to continue, modify or conclude the audits at the conclusion of the six months.	
S 166	44:70:02:17(1-2) Occupant Protection The facility shall: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by residents;	S 166		

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S 166	Continued From page 3 This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, the provider failed to have an effective preventative maintenance plan. The provider failed to maintain: *One of one exhaust ventilation fan in the laundry. *A safe, level walking surface for one of nine paths of egress (exit door 3). *Shatter proof bulbs or a shield for one of two lights located in the clean linen folding area of the laundry room. *Proper ductwork installations (laundry dryer exhaust). *The proper function of multiple corridor doors. *The proper function of the cross-corridor smoke barrier doors located by the beauty shop. *A clear path of egress for exit door 2 which was obstructed by tables and chairs. The door would have been used in the event of a fire. Findings include: 1. Interview on 8/20/24 at 4:00 p.m. with administrator A revealed: *The facility did not have a maintenance person. *The administrator would make arrangements for maintenance when necessary. Interview on 8/21/24 at 4:35 p.m. with administrator A revealed: *She was not aware the concrete outside of exit door 3 had settled and was uneven. *She guessed it had been that way for a couple of months. Interview, testing, and observation on 8/21/24 from 1:30 p.m. to 2:00 p.m. with administrator A	S 166	-exhaust fan in laundry room fixed by owners on 9/10/24 -Side walks have been repaired on 9/24/24 -Light bulbs replaced and new shields placed by owner of facility on 9/10/24 -New metal ductwork installed in laundry dryer by owner of facility on 9/12/24 -Doors have been adjusted and lubricated by owner of facility. New doors have been ordered on 9/12/24 -Smoke barrier doors adjusted on 9/12/24 and are functioning -Tables and chairs have been moved on 9/12/24. No longer obstructing the exit door.	10/4/24

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S 166	Continued From page 4 revealed: *She was not aware the laundry room door was not latching. *The cross-corridor smoke barrier doors by the beauty shop worked sometimes and sometimes they did not. *She didn't know room 126 door would not close. -She thought it just had problems with the latch. *She stated the heat and humidity affected the doors and caused issues that changed with the seasons. Interview on 8/22/24 at 2:45 p.m. with administrator A revealed: *The dining room tables were put in front of exit door 2 during Covid to increase the distance between residents. *Exit door 2 was only used for fire drills. Refer to S145, S165, S172, S173, and S201.	S 166	*maintenence person will be in facility 8 hours per week to perform preventative maintenance, following our preventative maintenance checklist and addressing any repairs/ongoing issues. Preventative maintenance activities will be documented by maintenance on the checklist (charted weekly- repair log, charted monthly-preventative). The repair logs and preventative checklist will be turned into the manager monthly to audit completion. Results will be shared with QAPI on their montly meeting *Audits will be completed monthly by the manager for six months and the results will be shared with QAPI. The QAPI committee will determine the ongoing need to continue, modify or conclude the audits at the conclusion of the six months.	
S 172	44:70:02:17(6-7) Occupant Protection The facility shall: (6) Prohibit the use of a portable space heater, portable halogen lamp, household-type electric blanket, or household-type heating pad in a facility; (7) Ensure that any light fixture located over a resident bed, over a bathing fixture or treatment area, in a clean supply storage area, or in any medication set-up area be equipped with a lens cover or a shatterproof bulb; This Administrative Rule of South Dakota is not	S 172		

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S 172	Continued From page 5 met as evidenced by: Based on observation, the provider failed to supply shatter proof bulbs or a shield for one of two lights located in the clean linen folding area of the laundry room. Findings include: 1. Observation on 8/20/24 at 10:55 a.m. in the laundry room revealed: *There were two lights in the clean linen folding area. *Both were fluorescent style lights. *Neither light had shields. *The light towards the middle of the room had shatter resistant LED light bulbs. *The light over the white plastic table had unprotected fluorescent bulbs. -Those bulbs were flickering and dark and appeared to be burnt out. Observation on 8/21/24 at 3:30 p.m. revealed there was unfolded clean linen laying on the table under the unprotected fluorescent bulbs.	S 172	light bulbs have been replaced and shields are in place on 9/12/24. Maintenance person will be in facility 8 hours per week to perform preventative maintenance and fix any ongoing issues. Light bulb checks will be included on the "preventative maintenance program/checklist that the maintenance person will monitor on a monthly basis. Completion will be documented on the checklist by the maintenance person and he will turn his sheets into management montly for review. Management will document completion on her auditing form and results will be shared with QAPI at the monthly meeting. *Audits will be completed monthly by the manager for six months and the results will be shared with QAPI. The QAPI committee will determine the ongoing need to continue, modify or conclude the audits at the conclusion of the six months.	10/4/24
S 173	44:70:02:17(8-9) Occupant Protection The facility shall: (8) Ensure that any clothes dryer must have a galvanized metal transition duct for exhaust or flexible transition duct listed and labeled in accordance with UL 2158A; and (9) Ensure that the storage and transfilling of oxygen cylinders or containers meet the requirements of the NFPA 99 Health Care Facilities, 2012 Edition, chapter 11. A resident may store in the resident's room a maximum of three E-cylinders or seventy-two cubic feet, or 2.040 cubic meters of oxygen on an as-needed basis, in addition to oxygen in use by the resident.	S 173		

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S 173	Continued From page 6 If a facility admits or retains a resident not capable of self-preservation, the facility must meet NFPA 101 Life Safety Code, 2012 edition, health care occupancy standards in chapter 18 or 19, or equip the facility with complete automatic sprinkler protection. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, the provider failed to maintain proper ductwork installations (laundry dryer exhaust) for one of two dryers. Findings include: 1. Observation on 8/20/24 at 10:45 a.m. revealed: *There were two dryers in the laundry room. *One dryer had metal exhaust ducting. *The Samsung laundry dryer had foil paper exhaust ductwork installed. The dryer exhaust ducting must be metal.	S 173	Laundry duct replaced with new metal exhaust on 9/12/24 Maintenance person will be in facility 8 hours per week to perform preventative maintenance and fix any ongoing issues. Laundry duct checks will be included on the "preventative maintenance program/checklist that the maintenance person will monitor on a monthly basis. Completion will be documented on the checklist by the maintenance person and he will turn his sheets into management monthly for review. Management will document completion on her auditing form and results will be shared with QAPI at the monthly meeting. *Audits will be completed monthly by the manager for six months and the results will be shared with QAPI. The QAPI committee will determine the ongoing need to continue, modify or conclude the audits at the conclusion of the six months.	10/4/24
S 201	44:70:03:02 General Fire Safety Each facility must be constructed, arranged, equipped, maintained, and operated to avoid undue danger to the lives and safety of occupants from fire, smoke, fumes, or resulting panic during the period of time reasonably necessary for escape from the structure in case of fire or other emergency. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, the facility must conduct monthly drills to provide training for all personnel.	S 201		

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S 201	Continued From page 7 This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain fire safety related to the following: *The latching feature for one of one corridor door to the laundry was not working properly. *One of three cross corridor smoke barrier doors (by the beauty shop) would not close to resist the passage of smoke. *One of two paths of egress (Exit 2) in the dining room was obstructed by a table and chairs. *One of one exit sign located at exit 2 would not light when tested. *One of one interior side hinged door to resident room 126 would not open with less than five pounds of force. *One of one door to the oxygen room rubbed on the frame and could not close without assistance. *The sheet rock ceiling for one of one mechanical room/break room had a hole in it and would not resist the passage of smoke or fire. Findings include: 1. Observation and testing on 8/20/24 at 10:45 a.m. of the laundry room door in the corridor revealed: *The laundry room door into the corridor was not latched. *Opening the door and letting it close with the self closing feature brought the door closed but it would not latch into the frame. *The door would latch into the frame if additional force was applied to pull the door closed. 2. Observation and testing on 8/20/24 at 11:17 a.m. of the cross corridor smoke barrier door by the beauty shop revealed: *The west door would meet the east door and	S 201	doors have been adjusted and lubricated by owner of facility on 9/12/24 New doors have been ordered. Doors will be monitored on a monthly basis according to the preventative maintenance checklist. Tables have been moved on 9/12/24 and there are no longer obstructions to exits. Door in room 126 has been adjusted and lubricated by owner of facility 9/12/24 Exit light fixed by owner of facility and now lights up 9/12/24 A leak in the ceiling was the cause for the sheet rock issue in the break room. Maintenance fixed leak on the roof and replaced sheetrock on 9/18/24	10/4/24

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S 201	Continued From page 8 could not slide by it to close. *A dent on the face of the east door caused a protrusion that would not allow the west door to slide past. *Those doors would not close tight enough to resist the passage of smoke. 3. Observation on 8/20/24 at 11:25 a.m. in the dining room revealed: *There were two tables and eight chairs placed approximately ten inches from exit door 2. *Exit door 2 could not be used without first moving the tables and chairs. 4. Testing on 8/20/24 at 11:26 a.m. of the emergency exit light located above exit door 2 revealed it would not light when tested. 5. Interview, observation, and testing on 8/20/24 at 11:33 a.m. of the door to resident room 126 revealed: *The resident of room 126 stated he could not close his door. *The door rubbed against the frame and could not be closed easily. *The door could be forced closed but then it could not open with less than 5 pounds of force. 6. Observation and testing on 8/20/24 at 11:38 a.m. of the oxygen room door revealed: *The door had to be forced open. *When the door was allowed to close with the self closing device the door would rub against the top frame and would not close. *The door could be forced closed and latched, but not without assistance. 7. Interview, testing, and observation on 8/21/24 from 1:30 p.m. to 2:00 p.m. with administrator A revealed:	S 201	Maintenance person will be in facility 8 hours per week to perform preventative maintenance and fix any ongoing issues. Completion will be documented on the checklist by the maintenance person and he will turn his sheets into management monthly for review. Management will document completion on her auditing form and results will be shared with QAPI at the monthly meeting. *Audits will be completed monthly by the manager for six months and the results will be shared with QAPI. The QAPI committee will determine the ongoing need to continue, modify or conclude the audits at the conclusion of the six months.	

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S 201	Continued From page 9 *She was not aware the laundry room door was not latching. *The cross corridor smoke barrier doors sometimes worked and sometimes they did not. *She did not know room 126's door would not close. -She thought it just had problems with the latch. *She stated the heat and humidity affected the doors and caused issues that changed with the seasons. 8. Observation on 8/21/24 at 4:30 p.m. of the ceiling in the mechanical room/break room revealed: *There was a right triangle shaped hole in the sheet rock. The hole was approximately three inches wide and six inches long. *There was approximately two feet of sheet rock tape missing along the joint to the south of the hole in the ceiling. 9. Interview on 8/22/24 at 2:45 p.m. with administrator A revealed: *The dining room tables were put in front of exit door 2 during Covid to increase the distance between residents. *Exit door 2 was only used for fire drills.	S 201	Existing staff will need to watch the same videos as the New Hire Staff are watching-"Mandatory Extravaganza". They also will take the post test after completing all the videos. A log in sign up sheet will be utilized to keep track of their hours for payment and a checklist system in place to ensure they are completing every video. The manager will be monitoring that this is completed by every employee by Oct 31st,2024 and documented within every employees personal chart. Results will be shared with QAPI at the monthly meeting in November.	10/4/24
S 295	44:70:04:04 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. Ongoing education programs must cover the required subjects annually. This Administrative Rule of South Dakota is not met as evidenced by:	S 295		

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S 295	Continued From page 10 Based on personnel file review and interview, the provider failed to ensure one of two sampled employees (G) had completed all the required annual training topics. Findings include: 1. Review of employee G's personnel file revealed: *She was hired 8/27/16 as a caregiver. *She had completed the annual personnel training on 5/10/23. -This training occurred fifteen months ago. *She had not completed the required annual training for the following topics: -Fire prevention and response. -Emergency procedures and preparedness. -Infection control and prevention. -Accident prevention and safety procedures. -Resident rights. -Confidentiality. -Incidents and diseases subject to mandatory reporting and the facility's reporting mechanism. -Nutritional risks and hydration. -Abuse, neglect, and misappropriation of resident property and funds. -Problem solving and communication techniques related to residents with cognitive impairment or challenging behaviors. -Education based on resident care needs. Interview on 8/22/24 at 1:00 p.m. with administrator A regarding annual education revealed: *The facility utilized a program that covered the annual training topics by viewing a DVD and completing a multiple-choice test. *That test was completed on an annual basis every May. -She had not had the opportunity to conduct the annual training that had been due in May 2024.	S 295	New Hire packets have been made with a checklist for the manager to document completion, and to ensure all employees receive proper initial training within 30 days of hire and follow up competency yearly, in October and on a PRN basis. Initial and folow up competency training will be provided by the manager and results shared with the nurse and QAIP at the monthly meetings. Initial training includes watching the "Mandatory Extravaganza annual training video-2022 version from Avera. -New Hire checklist will ensure that all employees receive required TB testing as well.	

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S 295	Continued From page 11 A policy regarding annual personnel training was requested from administrator A on 8/22/24 at 1:10 p.m. but not provided by the end of the survey.	S 295		
S 296	44:70:04:04(1-11) Personnel Training These programs must be completed within thirty days of hire for all healthcare personnel and must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness, including responding to resident emergencies and information regarding advanced directives; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Resident rights; (6) Confidentiality of resident information; (7) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (8) Nutritional risks and hydration needs of residents; (9) Abuse and neglect; (10) Problem solving and communication techniques related to individuals with cognitive impairment or challenging behaviors if admitted and retained in the facility; and (11) Any additional healthcare personnel education necessary based on the individualized resident care needs provided by the healthcare personnel to the residents who are accepted and retained in the facility. Any personnel whom the facility determines will have no contact with residents are exempt from the training required by subdivision (8).	S 296	New hire staff will be required to watch, within 30 days of hire, the 2022 version of Mandatory Extravaganza Annual Training DVD that is from AVERA. A competency test will follow. Topics include: Safety first(44min), Infection Prevention(20min), Workplace environment(34min), Resident rights and Compliance(44min), Resident Care(52min). All caregivers will also watch: Resident Care(78min), caregiver well-being(60min), Health conditions(82min).	10/4/24

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S 296	Continued From page 12 This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel file review and interview, the provider failed to ensure the required training was completed within 30 days of hire for three of three recently (B, C, and E) hired employees. Findings include: 1. Review of the personnel files for employees B, C, and E revealed: *Employee B had been hired as a registered nurse (RN) on 4/5/24. *Employee C had been hired as a RN on 5/16/24. *Employee E had been hired as a cook and caregiver on 3/18/24. *There was no documentation they had received training on: -Fire prevention and response. -Emergency procedures and preparedness. -Infection control and prevention. -Accident prevention and safety procedures. -Resident rights. -Confidentiality. -Incidents and diseases subject to mandatory reporting and the facility reporting mechanism. -Nutritional risks and hydration. -Abuse, neglect, and misappropriation of resident funds. -Problem solving and communication techniques related to residents with cognitive impairment or challenging behaviors. -Education based on resident care needs. Interview on 8/22/24 at 2:00 p.m. with employees B and C revealed: *They both had been hired as an RN within the last 3-4 months.	S 296	New hire education will be provided by the manager and results will be shared with the nurse and QAPI at the monthly meetings. Each new -hire "training completion day" will be added to the "training calender" and looked at daily by the manager, to ensure all training is done within the proper time frame. Annual competency training will be provided by manager in October of each year and results shared with nurse and QAPI at the monthly meeting. Fire Drills will also be performed on each shift quarterly. The manager will audit that each fire drill was performed quarterly and results will be shared with QAPI at the monthly meeting. This will be done indefinetly. Audits will be conducted weekly by the nurse x4 weeks, bi-weekly x4weeks, and monthly x4 months. The results will be shared with QAPI at the monthly meeting. The QAPI committee will determine the need to continue, modify, or conclude the audits at the conclusion of the six months.	

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S 296	Continued From page 13 *They had not not completed the eleven required training topics identified above. *There was no orientation for a new nurse at this facility. -Employee B had not not started employment until the day after the former nurse left employment. -A binder was available in the nurse's office with examples of several forms utilized at the facility. Interview on 8/22/24 at 1:00 p.m. and again at 3:00 p.m. with administrator A revealed education had not been completed within thirty days of hire for the above listed employees. An employee training policy was requested from administrator A on 8/22/24 at 1:10 p.m. but was not provided by the end of the survey.	S 296	New hire packets are made with a checklist ensuring all employees receive proper training within 30 days of hire and immunizations within 14 days of hire. Each employee will have their own folders to help organize our staff. Each new hire employee will receive an initial employee health screen(utilizing our employee health screen form) within 30 days of hire and annually thereafter in October along with the annual competency training. All Training and immunizations will be provided by manager and documentation will be within each employees chart. The nurse will cosign all checklist post completion. Results shared with nurse and QAPI at monthly meetings. The nurse will cosign indefinitely and results will be shared with QAPI indefinatley.	10/4/24
S 305	44:70:04:05 Personnel Health Program The facility shall have a personnel health program for the protection of the residents. All personnel must be evaluated by a licensed health professional for a reportable communicable disease that poses a threat to others before assignment to duties or within fourteen days after employment including an assessment of previous vaccinations and tuberculin skin tests. This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel record review, interview, and policy review, the provider failed to ensure three of five sampled employees (B, C, and E) were evaluated by a licensed health professional within 14 days from hire date. Findings include: 1. Review of the employee personnel records	S 305		

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S 305	Continued From page 14 revealed the following: *Employee B was hired on 4/5/24. -There was no employee health record documented in her file. *Employee C was hired on 5/16/24. -There was no employee health record documented in her file. *Employee E was hired on 3/18/24. -There was an employee health record document in her file but it was not signed that she had been evaluated by a licensed health professional. Interview on 8/22/24 at 3:00 p.m. with administrator A revealed: *Employee B and C were nurses. -She was not aware newly hired nurses should have had an employee health screening done by a licensed health professional. *Employee E had an employee health record document in her file. -The screening questions had been answered by the employee and tuberculin screening tests had been completed. -The form had not been evaluated and signed by a licensed health professional. An employee health screening policy was requested from administrator A on 8/22/24 at 1:10 p.m. but was not provided by the end of the survey.	S 305	Every new hire employee will be given a 2 step TB test by the manager, within 14 days of hire. (TB testing form will be utilized and this is kept in the new hire packets. Documentation by the manager will be kept in every employee's individual file and cosigned by the nurse for completion. Every new resident will also receive a 2 step TB test within 14 days of admittance into this facility. TB testing will be performed by the manager and documented within each residents chart. Completion will be cosigned by the nurse. This will be done indefinitely. Results shared with QAPI at monthly meetings. Indefinitlely	10/4/24
S 331	44:70:04:10(1) Tuberculin Screening... Requirements Tuberculin screening requirements for healthcare personnel and residents are as follows: (1) Each healthcare personnel or resident shall receive an initial individual TB risk assessment	S 331		

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S 331	Continued From page 15 that is documented and the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within twenty-one days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of admission or employment are considered two-step. A TB blood assay test completed within a twelve-month period prior to the date of admission or employment is an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare personnel or resident transfers from one licensed healthcare facility to another licensed healthcare facility within this state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin or blood assay TB testing having been completed within the prior twelve months. Skin testing or TB blood assay tests are not necessary if documentation is provided by the transferring healthcare facility, healthcare personnel, or resident, of a previous positive reaction to either test. Any healthcare personnel or resident who has a newly recognized positive reaction to the skin or TB blood assay test must have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure two of three recently hired sampled employees (B and C) had received the two-step tuberculin (TB) skin test within twenty-one days of their employment. Findings include:	S 331		

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S 331	Continued From page 16 1. Review of employee B's personnel record revealed: *She was hired on 4/5/24. *There was no documentation of the completion of a TB screening. Review of employee C's personnel record revealed: *She was hired on 5/16/24. *There was no documentation of the completion of a TB screening. Interview on 8/22/24 at 3:00 p.m. with administrator A revealed: *There was not a TB screening test completed or obtained from a previous employer for the above employees. *She was not aware that the facility nurses also needed to complete the TB screening process. A TB screening policy was requested from administrator A on 8/22/24 at 1:10 p.m. but was not provided prior to the end of the survey.	S 331	Care Plans will be initiated by nursing staff upon admission and PRN thereafter to ensure that the residents "plan of care" meets each individual diagnosis. Nurse will monitor careplans on a weekly basis. Results shared with manager and QAPI at monthly meeting. Care Plans will be accessible to caregiving staff/medication aides within the Communication book as a reference to provide individualized care as needed. Special instruction/restrictions will also be indicated in the Nursing Communication Book as a reference for caregivers. (ex: fluid restrictions etc) A handout from the Avera Dialysis Dept will be accessible within the nursing communication book as a reference for caregivers and med aides to follow in regards to fistula monitoring. Med aides will document within the MAR, fistula "thrill" checks daily. Oxygen parameters will also be listed within the communication book for caregiver and med-aides to reference, indicating when PRN oxygen is indicated and when to notify nursing staff.	10/4/24
S 337	44:70:04:11 Care Policies Each facility shall establish and maintain policies, procedures, and practices that follow accepted standards of professional practice to govern care, and related medical or other services necessary to meet the residents' needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and record review, the provider failed to develop and implement procedures for staff to follow related to two of two sampled residents (1 and 9) who had unique care	S 337		

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S 337	Continued From page 17 needs to ensure they received safe and effective care with adequate follow up. Findings include: 1. Review of resident 1's care record revealed: *She was admitted to the facility on 10/12/21. *Has diagnoses of type II diabetes mellitus, diabetic retinopathy, diabetic neuropathy, history of stroke, and end stage renal disease and on dialysis. *The weekly nursing assessments indicated she had dialysis every Monday, Wednesday, and Friday in a neighboring town. Review of resident 1's undated care plan revealed no information related to her being on dialysis. 3. Review of resident 9's physician orders and medication administration record revealed: *Oxygen was to be used at two liters by nasal cannula during the night. *Oxygen was to be used at two liters by nasal cannula as needed for shortness of breath. Review of resident 9's care record revealed: *He was admitted to the facility on 10/5/23. *Has diagnoses of chronic obstructive pulmonary disease, anxiety, congestive heart failure, and osteoporosis. *The resident's oxygen saturation during weekly nursing assessment ranged from 85 -96% on room air. -He would be encouraged by the nurse to wear his oxygen as needed when he was short of breath. Review of resident 9's undated care plan revealed the section for oxygen was not addressed and had been left blank.	S 337	Education was given to staff by the nurse at nursing meeting on 9/26/24 Nursing care plans will be monitored and adjusted on a weekly basis by the nurse. This will be done indefinetely. No specific auditing will take place for this procedure.	

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S 337	Continued From page 18 4. Interview on 8/21/24 at 12:00 p.m. with administrator A regarding communication between disciplines revealed: *The direct care staff did not document in the care record. *If they had any concerns they would visit with the nurse directly if she was in the facility or they would let administrator A know to pass on the information. -The nurse was in the facility one day a week. Interview on 8/22/24 at 2:00 p.m. with registered nurse (RN) B and RN C regarding resident 1 and resident 9 revealed: *For resident 1: -They acknowledged that the dialysis component was not on her care plan. -They relied on resident 1 to let staff know if there were any issues. -There was no guidance for direct care staff regarding what to be alert for with a dialysis resident or how she could potentially feel after treatment. --They acknowledged that resident 1 was weaker after dialysis. *For resident 9: -They acknowledged the oxygen component was not on his care plan. -The resident applied his oxygen when he felt short of breath. -There was no guidance or parameters provided to the direct care staff regarding his shortness of breath or oxygen use. *They verbalized there was no written communication between direct care staff and nursing. -The direct care staff did not document in the care record if a task/treatment was completed or if the resident had any issues affecting their care, including behaviors.	S 337		

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S 337	Continued From page 19 -They acknowledged these residents were at a higher risk for issues related to their physical health conditions. Interview on 8/22/24 at 3:00 p.m. with administrator A revealed: *The nurses were able to look at the "jot" or report sheets that had been filled out by the direct care staff to find out information related to the residents. -They were not a part of the medical record. *This information was not shared when she was interviewed by the surveyor on 8/21/24 at 12:00 p.m. Review of the report sheets from 8/15/24 through 8/21/24 revealed: *They had each residents name listed on a sheet of paper *"Ok" was marked next to most residents. *Occasionally information such as when a resident went to the bathroom during the night was included. Interview on 8/22/24 at 4:05 p.m. with RN B revealed: *She was aware of the use of the report sheets by direct care staff. *This was not a tool that she found helpful in communicating resident issues. *It was her expectation that there be enhanced written communication between the direct care staff and nursing to ensure that safe and effective care was delivered and continuity of care was followed. A policy related to documentation was requested from administrator A on 8/22/24 at 9:15 a.m. but was not provided prior to the end of the survey.	S 337		

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S 405	Continued From page 20 44:70:05:02 Resident Care Plans, Service Plans, And Progr The facility shall provide safe and effective care from the day of admission through the development and implementation of a written care plan or service plan for each resident. The care plan or service plan must address personal care, and the medical, physical, mental, and emotional needs of the resident. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview the provider failed to: *Execute a 2000 ml (milliliters) fluid restriction for one of one sampled discharged resident (4) on a physician ordered fluid restriction. *Develop and revise individual resident care plans to reflect the unique needs of two of two sampled residents (1 and 9). Findings include: 1. Review of resident 4's discharge summary from the hospital on 2/14/24 revealed he was on a 2000 ml fluid restriction. Review of the 2/14/24 admitting orders for resident 4 signed and dated by the physician revealed: *A 2000 ml fluid restriction. *The fax was received on 2/14/24 at 10:00 a.m. *The fax orders were noted by previous nurse with her signature. Review of resident 4's admission nursing questionnaire and resident care plan revealed: *His dietary needs were a no added salt diet and a fluid restriction of 2000 ml in 24 hours.	S 405 S 405	Upon admission, each resident will have an initial assessment/screening performed by nursing staff as a baseline. Care Plans will be developed on an individualized basis in regards to each resident's personal diagnosis(personal care, medical, physical, mental and emotional needs). Care Plans will be updated and added, as needed, based on residents' personal needs. Care Plans will also be reviewed on an annual basis by nursing staff and updated as needed. Care Plans will be accessible to all Caregiving staff and Medication aids as a reference to provide care. Copies of care plans will be kept in the nursing communication book and in each residents individual files. Staff was education at the nursing meeting on 9/26/24 by the nurse, on where to find the care plans and encouraged to read them and utilize the information as a reference for providing care.	10/4/24

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S 405	Continued From page 21 *His care plan had a handwritten note below the diet stating, "fluid restrictions." Review of resident 4's weekly nurses' notes revealed: *On 2/14/24 a lengthy note described the resident's condition and vitals. -Last notes from the above description "Fluid restriction 2000 ml/24 hrs. No edema noted ACE wraps in place. Appetite good wt [weight] 186# [pounds]" signed by the nurse. *On 2/22/24 "No change in plan of care wt [up arrow] 1# this week VS [vital signs] WNR [within normal range] BP [blood pressure] 106/48 Encouraged to drink H2O [water] in room. Ace wraps ..." *On 2/28/24 "No change in plan of care. Wt [up arrow] 1#. *On 3/6/24 resident had seen a physician on 2/29/24. Nurse notes indicated changes in physician orders. There were no changes or notes regarding the fluid restriction. *A second entry on 3/6/24 "No change in plan of care. Wt [down arrow] 2# this wk [week] VS WNL [within normal limits] ..." *On 3/14/24, 3/19/24, and 3/27/24 all notes started with "No change in plan of care ..." *On 3/30/24 Nurse notes included a treatment to a superficial open area on lower right leg. *On 4/3/24 Nurse faxed to a physician regarding the open area on lower right leg. Notes about residents' condition, resident was developing a pressure sore on buttock from sleeping in the chair. *All notes made from 2/14/24 to 4/3/24 were made by the admitting nurse who no longer worked at the facility. *All notes made from 4/10/24 to close of his record on 5/22/24 were made by registered nurse (RN) B.	S 405	Jot sheets will be accessible, within the Nursing Communication Book, to caregivers/med aids on each shift that indicate any specific orders/needs that a patient might have. Example: diet restrictions, fluid restrictions, s/s to watch for post dialysis etc. Any restrictions/ special care needs will also be indicated within the careplans that are in the Nursing communication book; available for access to all med aids and caregivers. For example: fluid restriction monitoring, oxygen use.. Documentation on these restrictions/ specific needs will be done within the MAR/communication book. Caregiving staff and medication aids will be educated upon hire, and PRN therafter, what information to chart within this communication book and what information requires immediate nursing notification. Every patient will have their own file within this book to ease transition of notes into their individual files. On 9/26/24, the nurse educated the staff of this information at the nursing meeting	

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S 405	Continued From page 22 *There was no documentation supporting a fluid restriction in any notes from his admission on 2/14/24 through 5/9/24. *On 5/12/24 Nurse notes stated, "Resident in hospital". *On 5/22/24 Nurse notes stated, "Currently admitted Gregory Nursing Home". *On 5/27/24 Nurse notes stated, "Passed away". Interview on 8/22/24 at 7:44 a.m. with RN B revealed: *She was new to the facility in April 2024. *Resident 4 had been admitted prior to her hire. *She was not aware the resident was on a fluid restriction. *There should have been a plan of care developed at admission regarding the fluid restriction. *2000 ml of fluid should have been divided between nursing and dietary and input and output should have been tracked and documented. Interview on 8/22/24 at 8:15 a.m. with RN C revealed: *She was hired after the resident had discharged. *There should have been a plan of care developed at admission regarding the fluid restriction. *2000 ml of fluid should have been divided between nursing and dietary and input and output should have been tracked and documented. Interview on 8/22/24 at 10:16 a.m. with cook D revealed: *She was not aware resident 4 had been on a 2000 ml fluid restriction. *Had she known about the fluid restriction they would have developed a plan to split the 2000 ml between dietary and nursing. *The nurse or the administrator would be the	S 405	Nursing staff will review this communication book upon starting their shift at least 1 x weekly. The manager will also review this book at least 2x weekly. Nursing checks will be performed indefinitely.	

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S 405	Continued From page 23 person who notified dietary of the fluid restriction. Interview on 8/22/24 at 2:45 p.m. with administrator A revealed: *She was not aware resident 4 was on a 2000 ml fluid restriction. *She had placed the orders and all the paperwork into the resident's chart. *She did not notice he was on a fluid restriction. *There should have been a plan of care developed at admission regarding the fluid restriction. *2000 ml of fluid should have been divided between nursing and dietary and input and output should have been tracked and documented on the medication administration record. *There was no policy for the implementation of a fluid restriction. 2. Review of resident 1's care record revealed: *She was admitted to the facility on 10/12/21. *Diagnoses include type II diabetes mellitus, diabetic retinopathy, diabetic neuropathy, history of stroke, and end stage renal disease and on dialysis. *The weekly nursing assessments indicated that she had dialysis every Monday, Wednesday, and Friday in a neighboring town. Review of resident 1's undated care plan revealed no information related to her being on dialysis. 3. Review of resident 9's physician orders and medication administration record revealed: *Oxygen was to be used at two liters by nasal cannula during the night. *Oxygen was to be used at two liters by nasal cannula as needed for shortness of breath.	S 405		

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S 405	Continued From page 24	S 405		

Review of resident 9's care record revealed:
*He was admitted to the facility on 10/5/23.
*Has diagnoses of chronic obstructive pulmonary disease, anxiety, congestive heart failure, and osteoporosis.
*The resident's oxygen saturation during weekly nursing assessment ranged from 85 -96% on room air.
-He would be encouraged by the nurse to wear his oxygen as needed when he was short of breath.

Observation on 8/20/24 at 11:25 a.m. of resident 9's room:
*There was oxygen use signage present near the door to his room.
*Oxygen was present in resident 9's room.
*The resident was not in his room or wearing the oxygen at the time this observation occurred.

Review of resident 9's undated care plan revealed the section for oxygen was not addressed had been left blank.

4. Interview on 8/22/24 at 2:00 p.m. with registered nurse (RN) B and RN C regarding resident 9 and resident 1 revealed:
*For resident 1:
-They acknowledged that the dialysis component was not on her care plan.
*For resident 9:
-They acknowledged the oxygen component was not on his care plan.
*The existing care plans had been developed by the nurse that was no longer employed at the facility.
-No care plan updates had occurred in the last several months.
*They did not receive training or direction regarding who was responsible for developing

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S 405	Continued From page 25 and updating the resident care plans. A policy related to care plans was requested from administrator A on 8/22/24 at 9:15 a.m. but was not provided prior to the end of the survey.	S 405	Each patient will have indicated within their Chart and care plan their specific diet needs. The staff will follow the menus and extension for each prescribed diet. Careplans will be accessible to caregiving staff/med aids within the Nursing Communication Book. A diet list will also be given to our Kitchen staff/cooks that indicate any specific diet needs/restrictions that the resident has. A diet reference will also be available to medication aids and caregivers in the Nursing communication Book ,which will list suggestions to each modified diet. Any specific supplementations/shake orders by a provider will be listed within the MAR for the medication aid to chart that the resident has received them that shift. Nurse will check MAR's weekly and document any deficiencies. This information will be shared with management and at monthly OAPI meetings. Nursing checks of MAR will be performed weekly, indefinitely.	10/4/24
S 477	44:70:06:09 Written Menus Any regular or therapeutic menu, including therapeutic diet menu extensions for all diets served in the facility, must be written, prepared, and served as prescribed by each resident's physician, physician assistant, nurse practitioner, or dietician. Each menu must be written at least one week in advance. This Administrative Rule of South Dakota is not met as evidenced by: Based on resident review, license review, review of menus, and interview, the provider failed to serve a renal diet prescribed by a physician for one of one resident (1) on a renal diet. Findings include: 1. Review of resident 1's care record revealed she had been prescribed a renal diet by her physician. She went to dialysis three times a week. Review of the provider's current 7/1/24 license revealed they were approved for providing the additional service of therapeutic diets. Review of the menus used in the kitchen on 8/20/24 at the noon meal service revealed there was no extension for a renal diet. Interview with cook D on 8/20/24 at 11:45 a.m. revealed:	S 477		

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S 477	Continued From page 26 *The dietician had come in and wrote an extension for the renal diet. *The dietician had handwritten the extension on the side of the menu, but she was not aware where her copy of that menu was. Interview with caregiver/cook E on 8/21/24 at 1:30 p.m. revealed: *She started as a caregiver in March of 2024 and started cooking in May. *She was not aware of a renal diet extension. *She had not been trained where to find or how to follow a renal diet extension. Interview with cook D on 8/22/24 at 10:16 a.m. revealed: *She confirmed she did not know where the renal diet extension was. *They had not followed the renal extension and served resident 1 the same meal as everyone else. On 8/22/24 at 1:30 p.m. administrator A provided the renal diet extension. Interview on 8/22/24 at 2:45 with administrator A revealed: *She was not aware the cooks did not have a copy of the renal diet extension in the kitchen. *She agreed the cooks should have known where the renal diet extension was and how to follow the extension.	S 477	Our diatician attended the nursing meeting on 9/26/24 to educate staff on how to follow the diet extensions.	
S 685	44:70:07:09 Self-Administration of Medications A resident with the cognitive ability to safely perform self-administration, may self-administer medications. At least every three months, a registered nurse, or the resident's physician,	S 685		

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S 685	Continued From page 27 physician assistant, or nurse practitioner shall determine and record the continued appropriateness of the resident's ability to self-administer medications. The determination must state whether the resident or healthcare personnel is responsible for storage of the medication and include documentation of its administration in accordance with this chapter. Any resident who stores a medication in the resident's room or self-administers a medication, must have an order from a physician, physician assistant, or nurse practitioner allowing self-administration. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, observation, and policy review, the provider failed to ensure: *Three of five sampled residents (1, 6, and 9) who self-administered their medications had been screened quarterly regarding their ability to self-administer medications. *One sampled resident (7) who had cognitive impairment had a physician order and a screening for a medication to be self-administered. *One sampled resident (8) had a physician order and up-to-date screening for medications he self-administered. Findings include: 1. Review of the 11/2/23 nurse practitioner's order for resident 1 revealed she was able to continue to self-administer several medications. These medications included: *Nasal spray (for congestion). *Insulin (lower blood glucose).	S 685	A "self administration of medication" book will indicate which residents are performing self administration of medications. Within this book, it will include the nurses/doctors evaluation of the patient's ability to continue to perform self-administration and a doctors' order to do so. This evaluation of "readiness" will be updated every three months. This list will also be updated by nursing staff to ensure that each medication has an order to be "self-administered". This book will also indicate if the patient is storing their own medication within their room. In the MAR, it will indicate to the staff if a patient is self-administering medications. The medication aid will document administration within the MAR	10/4/24

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S 685	Continued From page 28 *Nystatin powder (anti-fungal). Review of the self-administration quarterly evaluation for resident 1 revealed: *It had been completed on 3/6/24 by the nurse that was no longer employed with the facility. *The following medications had been on the evaluation form: -Humalog (fast-acting) insulin pen. -Levemir (long-acting) insulin pen. -Artificial tears (for dry eyes). -Nasal spray. -Albuterol inhaler (bronchodilator to open airways). *There was no documentation related to follow up with the medical provider regarding an order to self-administer the artificial tears and inhaler. *There was no documentation related to the Nystatin powder not being included in the evaluation. *No evaluation had been completed for the second quarter of 2024. 2. Review of the 11/15/23 nurse practitioner's order for resident 6 revealed he was able to continue to self-administer several medications. These medications included: *Calcium antacid (for indigestion/heartburn). *Hemorrhoid ointment (reduce discomfort associated with hemorrhoids). *Muscle rub (muscle aches and pains). *Vicks (cough drops). Review of the self-administration quarterly evaluation for resident 6 revealed: *It had been completed on 3/6/24 by the nurse that was no longer employed with the facility. *The following medications had been evaluated on the form: -Tums (calcium antacid)	S 685	All medication aids will be educated upon hire, yearly with competency, and PRN, on how to approprately chart self administered medications. Nursing staff review MARS weekly. Results will be shared between nurse and manager and with QAPI at the monthly meetings. Nursing staff will check MARS weekly, indefinitely.	

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S 685	Continued From page 29 -Muscle rub -Vicks -Hemorrhoid cream *No self-administration evaluation was completed for the second quarter of 2024. 3. Review of the physician's orders for resident 9 revealed: *A 10/10/23 order that he was able to self-adminster Duoneb a bronchodilator (opens airways) medication via a nebulizer in his room. *A 10/11/23 order that he was able to self-administer Xopenex a second bronchodilator medication via an inhaler in his room. Review of the self administration quarterly evaluation for resident 9 revealed: *It had been completed on 12/6/23 by the nurse that was no longer employed with the facility. *The medication on the evaluation form for self administration was Xopenex inhaler. *There was no documentation to support that he was evaluated for use of Duoneb via the nebulizer. *No evaluations were completed for the first and second quarter of 2024. 4. Review of the August 2024 MAR for resident 7 revealed: *A medication (Duoneb) could be administered up to four times a day as needed. -He was able to keep the medication at bedside and self-administer it. Review of the physician orders for resident 7 revealed no order to self-administer medications. Review of resident 7's care record revealed a 4/12/24 mini-mental status evaluation score of sixteen out of thirty indicating he had moderate	S 685		

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S 685	Continued From page 30 cognitive impairment. Review of the self-administration quarterly evaluation forms revealed it had not been completed for resident 7. 5. Observation on 8/21/24 at 7:40 a.m. with resident 8 and medication aide (MA) H revealed: *Resident 8 was handed an alcohol swab and cleaned a small area on his left upper arm. *MA H primed the insulin pen and dialed up 50 units of Tresiba (a long-acting insulin). *MA H handed the pen to resident 8 who injected the medication into his left upper arm. Review of the 4/14/24 physician order form for resident 8 revealed the section related to self-administration of medications was not addressed. Review of the self-administration quarterly evaluation for resident 8 revealed: *It had been completed on 3/6/2 [missing a digit on the year] by the nurse that was no longer employed with the facility. *The following medications had been evaluated on the form: -Nystatin (antifungal powder). -Tresiba insulin pen. *There was no documentation located to indicate there was follow up with the physician regarding an order to self-administer medications. *No self-administration evaluation was completed for the second quarter of 2024. 6. Interview on 8/22/24 at 2:00 p.m. with registered nurse (RN) B and RN C regarding residents that self-administered medications revealed: *There were several residents that completed	S 685		

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S 685	Continued From page 31 self-administration of medications. *They were aware an order was needed from the medical provider for residents to self-administer medications. *RN B verbalized that she was not aware an evaluation needed to be completed quarterly and she had not been completing that evaluation. *RN C had not completed any self-administration evaluations since she began her employment in May 2024. 7. Interview on 8/22/24 at 3:00 p.m. with administrator A revealed: *There was a binder in the nurse's office containing the self-administration evaluations. *The evaluations had not been completed since the former nurse left her employment on 4/4/24. *She stated, "I have not shown that to [RN B name] yet." Observation on 8/24/24 at 4:00 p.m. with administrator A revealed she went to the back portion of the nurse office and pulled a black colored binder out of a box and handed it to the surveyor. The binder contained the self-administer evaluations with the last one completed in March 2024. Review of the undated Self-Administration of Patient Medication policy revealed: *"...Any self-administered medication have to be approved by the nurse & physician every 3 months that the patient is still capable of self-administration."	S 685		