STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A140	A. BUILDING B. WING	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUSTER CARE AND REHAB CENTER	1065 MONTGOMERY ST , CUSTER, South Dakota, 57730

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 8/21/2025. Custer Care and Rehab Center was found not in compliance with the following requirement(s): E0006.	E0000		
E0006 SS = D	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.	E0006	E0006 Ensured the completion of an all hazard risk assessment	10/10/25

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Samuel Van Voorst	Regional Administrator	9/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A140	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

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E0006 SS = D	Continued from page 1 (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This STANDARD is NOT MET as evidenced by: Based on record review and interview on 8/21/2025, the provider has not developed an all-hazards risk assessment as required by E0006. Findings included:Interview on 8/21/2025 at 2:00 p.m. with the Director of Nursing and Facility Manager, both members of the provider's emergency preparedness board, revealed that the facility's emergency plan did not include an all-hazards risk assessment. Neither the Director of Nursing nor the Facility Manger were able to provide instruction on where or when such a process was performed, documented, or the resulting document developed.There was no evidence identified within the provided emergency preparedness binder indicating that an all-hazards risk assessment had been developed.	E0006		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A140	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

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K0000	INITIAL COMMENTS A recertification survey was conducted on 8/21/2025 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Custer Care and Rehab Center was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K0922 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0919 SS = D Bldg. 01	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider has failed to consider various safety requirements in the location of a new LP-Gas tank serving the facility backup electrical generator. Those requirements include:NFPA 99 (2012) 6.4.1.1.2 requires the provider to consider in the design of the [electrical] distribution systems the "(3) stability and power capability of the prime mover [generator] during and after normal conditions." This is interpreted to include "careful consideration ... given to the location of the spaces housing the components of the essential electrical system to minimize interruptions caused by natural forces common to the area (e.g., storms, floods, or earthquakes; or hazards created by adjoining structures or activities)." NFPA 110 (2010) 7.2.4 requires "minimizing the possibility of damage resulting from interruptions of the emergency source	K0919	K 919 Relocated generator power supply to greater than 10 ft from generator/ source of ignition	10/10/25

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Samuel Van Voorst	Regional Administrator	9/25/25

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K0919 SS = D Bldg. 01	Continued from page 1 shall be a design consideration of the EPSS [emergency power supply system] equipment."NFPA 58 (2011) 6.3.9 requires a minimum distance of 10 feet between "the container filling connection to exterior sources of ignition" (e.g., a generator).NFPA 58 (2011) 6.5.3 requires a minimum horizontal distance between the point of LP-Gas transfer and public ways, including throughfares and sidewalks, to be 10 feet, and driveways to be 5 feet.NFPA 58 (2011) 6.6.1.2 requires "LP-Gas containers or systems of which they are a part shall be protected from damage from vehicles." Findings included: Observation and interview on 8/21/2025 at 11:35 a.m. with the Facility Manager revealed a 500-gallon LP fuel tank located within 10 feet from the facility backup electrical generator.The fuel tank was located within the rear facility driveway/parking lot, violating the 5-foot minimum horizontal distance between a fuel tank and a driveway required by NFPA 58 (2011) 6.5.3. The fuel tank was protected by a makeshift barrier system, which does not satisfy the requirement of NFPA 58 (2011) 6.6.1.2, since it allowed the potential for a vehicle to drive through or over the barrier system while traversing the driveway. The location of the fuel tank also made it susceptible to vandalism as well as fire or explosion while filling the tank due to its proximity (less than 10 feet) to an exterior source of ignition (backup electrical generator), violating NFPA 99 (2012) 6.4.1.1.2, NFPA 110 (2010) 7.2.4, and NFPA 58 (2011) 6.3.9.Interview with the Facility Manager at the time of the above observations confirmed the findings.The deficiency affected 100% of the facility patients, employees, and suppliers who park, walk, get dropped off, or deliver supplies on or near the rear facility driveway/parking lot since the new tank was put into service in 2019.	K0919		

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F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/19/25 through 8/21/25 and from 8/25/25 through 8/26/25. Custer Care and Rehab Center was found not in compliance with the following requirements: F628, F637, F641, F644, F655, F656, F657, F700, F727, F732, F757, F841, F851, F865, F868, F880, and F909. Findings include:	F0000		
F0628 SS = F	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other	F0628	F 628 Unable to correct prior non-compliance DON or designee will provide education provided to all nurses and SSD. Policy and proceedures for bed holds and notification of ombudsman of transfers created by interdisciplinary team. SSD or designee will audit completion of bed holds and notficaiton to ombudsman of transfers weekely for four weeks and monthly for two additional monthsand randomly thereafter until substantial compliance has been received Findings will presented at QAPI meetings for their review and guidance until substantial compliance has been determined by the QAPI committee	10/10/25

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Samuel Van Voorst	Regional Administrator	10/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A140	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

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F0628 SS = F	Continued from page 1 documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.	F0628		

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F0628 SS = F	Continued from page 2 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is	F0628		

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F0628 SS = F	Continued from page 3 the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) 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. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to	F0628		

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F0628 SS = F	Continued from page 4 include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure: *The resident or the resident's representative was given a bed hold notice for five of five sampled residents (6, 7, 8, 26, and 30) who transferred to the hospital. *The ombudsman was notified of resident transfers to the hospital for three of five sampled residents (6, 26, and 30) who transferred to the hospital. Findings include: 1. Review of resident 6's electronic medical record (EMR) revealed: *The resident had a resident representative who acted on her behalf. *She was hospitalized on 7/6/25, and her EMR did not contain any documentation that indicated her resident representative had received a bed hold notification. *No documentation in her EMR indicated that the ombudsman had been notified of her transfer to the hospital. 2. Review of resident 30's EMR revealed: *She was hospitalized on 1/1/25 and 3/22/25, and her EMR did not contain any documentation that indicated she or her resident representative had received a bed hold notification. *No documentation in her EMR indicated that the ombudsman had been notified of her transfer to the hospital. 3. Record review of resident 26's EMR revealed she was	F0628		

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F0628 SS = F	Continued from page 5 hospitalized on 6/20/25. There was no documentation in her EMR that her resident representative had received a bed hold notification or that the ombudsman had received notification of her transfer to the hospital. 4. Review of resident 8's EMR revealed: *She was hospitalized on 3/31/25 and on 5/19/25. *The resident had a resident representative who acted on her behalf. *There was no documentation in her EMR that her representative had received a bed hold notification for those transfers to the hospital. 5. Review of resident 7's EMR revealed she was hospitalized on 5/31/25 and on 7/5/25. *The resident had a resident representative who acted on her behalf. *There was no documentation in her EMR that indicated her representative had received a bed hold notification for those transfers to the hospital. 6. Interview on 8/21/25 at 3:47 p.m. with director of nursing (DON) B, regarding bed hold notices revealed: *The admission agreement included a bed hold notification notice. *Bed hold policies were signed on the resident's initial admission day. -The resident or the representative was not provided a bed hold notice each time the resident was hospitalized. *The resident's bed was always held, unless the resident or the representative said they did not want to hold the bed. *She was not aware that a bed hold notice was required with each transfer to the hospital. 7. Interview on 8/25/25 at 2:12 p.m. with business office manager (BOM) H revealed she was not responsible for reporting the resident transfers or discharges to the Ombudsman, and she was not sure who was.	F0628		

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F0628 SS = F	Continued from page 6 8. Interview on 8/25/25 at 2:19 p.m. with social service director F revealed she was not responsible for reporting resident transfers or discharges to the Ombudsman, and she was not sure who was. 9. Contact on 8/25/25 at 3:55 p.m. with Ombudsman S revealed she had not received notifications from the provider regarding residents who had transferred or discharged to the hospital. 10. Administrator A was out of the facility and not available for an interview throughout the survey. 11. Review of the 12/7/23 provider's admission agreement revealed: *"The Notice of a Bed-Hold Policy is provided to the Resident/financially responsible party upon admission and at the time of transfer." *"For Medicaid (Title XIX) residents, government regulations specify that Medicaid will pay for a maximum of fifteen (15) bed hold days per therapeutic leave and five (5) hospitalization days. For extended hospitalization, a Resident may be charged at a rate of the lowest Medicaid daily RUG rate to maintain their bed at Facility. *"If the source of payment for the residents [resident's] stay is Medicare Part A or Private Pay and the resident/financially responsible party requests to have the bed/room held, the resident is responsible for private payment based on semi or private room rate to maintain their bed/room at [the] facility." 12. Review of the provider's 12/7/23 Bed-Hold Policy revealed: *"It is the policy of [providers' name] to inform you of our bed-hold procedure upon admission to the facility and in the event of a hospitalization or therapeutic home visit." *"If you choose not to sign the bed-hold policy, it may result in discharge." *"In the event of an unplanned leave, the facility may obtain verbal agreement or denial of the bed-hold and the written notice will be faxed to the facility where	F0628		

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F0628 SS = F	Continued from page 7 hospitalized or mailed designated responsible party or POA [power of attorney]. Once notified of the bed-hold policy, the designated responsible party or POA has until [the] end of business hours the day of notice to agree or deny."	F0628		
F0637 SS = E	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure that two of two sampled residents (6 and 7), who experienced two or more areas of decline from their baseline conditions, had a significant change in status assessments completed related to fractures that resulted from their falls. Findings include: 1. Review of resident 6's electronic medical record (EMR) revealed: *She was admitted to the facility on 1/18/24 and readmitted on 8/6/25. *Her diagnoses included dementia (a group of symptoms affecting memory, thinking, and social abilities) with behavioral disturbances (consistent, unhealthy pattern of behaviors that significantly interfere with daily functions), major depressive disorder (a mental health condition with persistent feelings of sadness, hopelessness, and loss of interest in activities), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).	F0637	F 637 MDS coordinator or designee will completedsig changes for residents 6 and 7 by 10/10/25. MDS coordinator or desingeee audited all other residents for sig changes. MDS coordinator and DON will be educated on sig changes by 10/10/25 Policies and proceedures created for sig changes as needed by interdiscplinary team. MDS coordinator or designee will audit residents for sig changes weekly for four weeks and monthly for two additional months and randomly thereafter until substantial compliance has been received MDS coordinator or designee will present findings at QAPI meetings for their review and recommendations until substantial compliance has been reached as determined by the QAPI committee	10/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A140	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

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F0637 SS = E	Continued from page 8 *Her 8/13/25 Brief Interview for Mental Status (BIMS) assessment score was 0, which indicated she had severe cognitive impairment. She did not complete the assessment. -She had severely impaired daily decision-making skills, and she rarely/never understood others, so a staff assessment of her mental status was completed. -She had short-term and long-term memory problems, inattention (being easily distracted), and disorganized thinking (unclear flow of ideas). *She fell in her room on 7/16/25 and was taken to the emergency room by ambulance. *She was hospitalized on 7/16/25 with a diagnosed fracture of her left hip and returned to the facility on 8/6/25. *Her Minimum Data Set (MDS) assessments (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) had been completed quarterly. *Her MDS dated 8/13/25 was not coded for dementia. *A significant change MDS assessment was not completed to reflect her significant status changes related to: -A left hip fracture that required surgical repair. -An increase in mental status changes. -An impairment to her lower extremity (leg). -An increase in pain. --She was started on an opioid (medication to treat moderate to severe pain) medication for additional pain control. -A decline in her activities of daily living (ADLs). --Her oral hygiene assistance changed from having needed setup help to needing partial/moderate staff assistance. --Her toileting hygiene changed from having been independent to requiring substantial or maximum staff assistance. --Her shower/bath assistance needs increased from partial/moderate help to being dependent on staff for	F0637		

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F0637 SS = E	Continued from page 9 bathing. --Her walking with a walker, covering all distances, changed from having been independent to needing partial or moderate staff assistance to walk ten feet. --Her positioning in bed and sitting up changed from having been independent to partial/moderate staff assistance. --Her chair, bed, and toilet transfers changed from having been independent to partial/moderate staff assistance. --Her ability to move around in her wheelchair changed from having been independent to dependence on staff. 2. Interview on 8/21/25 at 2:55 p.m. with Minimum Data Set (MDS) nurse/assistant director of nursing (ADON) E revealed: *She was hired on 12/2/24 as a full time employee. -Her roles and responsibilities included ADON and MDS nurse. *She confirmed that she was responsible for completing the residents' MDS assessments. *She stated she was still learning the process on her own, following the MDS manual instructions, and had a lot to learn. -She stated, "I take responsibility," and she had purchased additional resources to support her learning process. -She needed a minimum of six months of experience with the MDS process before testing. *She stated that she had not completed the course training to become MDS certified, but had recently signed up to get the class completed. *She confirmed that she had not completed significant change assessments with residents who experienced a change in condition. 3. Review of resident 7's EMR revealed: *Her admission date was 5/16/24.	F0637		

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F0637 SS = E	Continued from page 10 *Her diagnoses included: dementia with behaviors, a history of falling, pain in her right hip, anxiety, and diabetes (a condition involving disruptions in how the body regulates blood sugar). *Her 3/2/25 BIMS assessment score was a 1, which indicated she had severe cognitive impairment. *On 5/31/25, she had transferred herself out of her bed, into her wheelchair, and then she fell out of the wheelchair and onto the floor. -She had an "open gash" to her left eyebrow, a skin tear (torn skin) to her left knee, and her left forearm, and she complained of pain in her "left leg". -She was transferred to the emergency department and then admitted to the hospital with a diagnosis of a non-operative "Greater Trochanter" (bony prominence located at the upper end of the thigh bone) fracture. *She was readmitted to the facility on 6/17/25, with a nurse progress note that indicated "Resident readmits with a scab to her left eyebrow. She has bruising on various locations at various healing stages to her left side. She has a large, swollen, deep bruise [bruised] area the side [size] of a tennis ball to her left hip. Resident bruising r/t [related to] fall." *A significant change MDS assessment was not completed after her return from the hospital, to reflect her significant status changes related to: -Prior to falling, she "frequently attempts to ambulate to look for her husband and often forgets to use her walker". She was able to walk with the assistance of a staff member and the use of a walker. Staff provided her with mobility throughout the facility with a wheelchair. -After she fell, and her thigh bone was fractured, she was unable to walk and needed staff assistance to transfer and reposition in and out of her bed. -Her cognition had declined. 4. Interview on 8/25/25 at 12:32 p.m. with MDS nurse/ADON E revealed: *Resident 7 was hospitalized on 5/31/25 with a fractured thigh bone, after she had fallen. She returned to the facility on 6/17/25.	F0637		

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F0637 SS = E	Continued from page 11 *MDS nurse/ADON E confirmed a significant change MDS should have been completed when resident 7 returned from the hospital. -She stated resident 7's ADL needs had changed after her 5/31/25 fall, primarily in the areas of bed mobility and ambulation. She used a walker before the fall, and after she fell, she used a wheelchair. -She indicated she had no training on the completion of a resident's MDS. 5. Review of the Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.19.1 October 2024 revealed: *A "significant change" is a major decline or improvement in a resident's status that: -"1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered "self-limiting";" -2. Impacts more than one area of the resident's health status; and -3. Requires interdisciplinary review and/or revision of the care plan." *Decline in two or more of the following: Resident's decision-making ability has changed; -Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency (PHQ-2 to 9©), e.g., increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (Behavior); -Changes in frequency or severity of behavioral symptoms of dementia that indicate progression of the disease process since the last assessment; -Any decline in an ADL physical functioning area (e.g., self-care or mobility) (at least 1) where a resident is newly coded as partial/moderate assistance, substantial/maximal assistance, dependent, resident refused, or the activity was not attempted since last assessment and does not reflect normal fluctuations in that individual's functioning;	F0637	F 644 PASRR completed for resident 6 All other residents assessed by SSD or designee for need for a PASRR Education on PASRRs provided to SSD by adminis Policies and proceedures on PASRRs created as necessary by interdisciplinary team SSD or designee will audit completion of PASSRs weekly for four weeks and monthly for two additional months and randomly thereafter until substantial compliance has been received SSD or designee will present finding at QAPI meetings for their review and guidance until substantial has been determined by QAPI committee	

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F0637 SS = E	Continued from page 12 -Resident's incontinence pattern changes or there was placement of an indwelling catheter; -Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days); -Emergence of a new pressure ulcer at Stage 2 or higher, a new unstageable pressure ulcer/injury, a new deep tissue injury or worsening in pressure ulcer status; -Resident begins to use a restraint of any type when it was not used before; and/or -Emergence of a condition/disease in which a resident is judged to be unstable".	F0637		
F0641 SS = E	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for	F0641	F 641 Residents 3 and 4 assessed by MDS coordinator or designee for accurate MDS coding of restraints All other residents assessed for accurate coding of restraints Education provied to MDS coordinator and DON on accurate MDS coding of restraints. Policies and proceedures on restraints created as needed by interdisciplinary team MDS coordinator or desingee will audit for accurate coding of restraints weekly for four weeks and monthly for two additional months and randomly thereafter until substantial has been receached MDS coordinator or designee will present finding at QAPI meetings for their review and guidance until substantial compliance has been determined by QAPI committee	10/10/25

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F0641 SS = E	Continued from page 13 each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.19.1 October 2024 review, the provider failed to ensure two of two sampled residents' (3 and 4) Minimum Data Set (MDS) (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) assessments were accurately coded for the area of restraints. Findings include: 1. Observation on 8/19/25 at 11:10 a.m. of resident 4's room revealed her bed had a side rail attached to it, on the left side of the bed, and it was the up position. 2. Observation on 8/25/25 at 12:20 p.m. of resident 4 in her bed, revealed the left side rail was in the up position. 3. Review of resident 4's medical record revealed: *Her admission date was 10/10/24. *Her 7/14/25 Brief Interview of Mental Status assessment (BIMS) score was an 8, which indicated she had moderate cognitive impairment. *Her diagnoses included: adjustment disorder (mental health condition characterized by emotional or behavioral symptoms that develop in response to a stressful life event), anxiety (the apprehensive anticipation of future danger or misfortune, accompanied by feelings of distress, sadness, or symptoms such as restlessness or irritability), depression (depressed mood or loss of interest and pleasure), intellectual disability, hearing loss, insomnia (sleep disorder), osteoarthritis (a common joint disease that causes pain, stiffness, and swelling), and heart failure (condition in which the heart cannot fill with enough blood or pump blood with enough force to meet the body's needs).	F0641		

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F0641 SS = E	Continued from page 14 *Her 7/10/25 Bed Rail Assessment indicated she used the left side rail on her bed to serve as an enabler to promote her independence while in bed. *Her 8/20/25 care plan indicated: -She needed partial assistance of one staff member for transferring from one surface to another. -There was a "transfer loop" (side rail) on her bed to maximize her independence with turning and repositioning when in her bed. *Her 8/16/25 MDS was coded that she used a side rail as a restraint. -There was no other indication in her EMR of a restraint being used. 4. Review of resident 3's medical record revealed: *Her admission date was 6/12/25. *Her 6/12/25 BIMS assessment score was a 15, which indicated her cognition was intact. *Her diagnoses included: depression, pain in her left shoulder and arm, weakness, abnormal gait (walk) and mobility, chronic pain, amnesia, heart failure, and incontinence (involuntary urine or bowel leakage). *Her 6/25/25 Bed Rail Assessment indicated she had requested and used a side rail on the right side of her bed. *Her 8/25/25 care plan did not include that she used a restraint or a side rail. *Her 6/25/25 MDS was coded that she used a side rail as a restraint. -There was no other indication in her EMR of a restraint being used. 5. Interview on 8/21/25 at 2:55 p.m. with MDS Nurse/ADON E regarding coding side rails as restraints on a resident's MDS assessment revealed: *She was responsible for ensuring MDS assessments were completed.	F0641		

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F0641 SS = E	Continued from page 15 *She completed a residents' side rail assessment every quarter, and used that information to complete the resident's MDS assessment. -The side rails were used for the residents' mobility and positioning when in bed. *She confirmed the bed/side rails were not restraints. -She had coded the side rails as restraints on the residents' MDS, as that is how she understood the instructions in the RAI manual. -She confirmed she had not reviewed the entire section of the RAI manual related to restraints and how to code a side rail if it was not a restraint. *She had been the MDS nurse for "about six months" and was just learning the process. -She had not had any formal training in how to complete an MDS. 6. Review of the Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.19.1 October 2024 revealed: "SECTION P: RESTRAINTS AND ALARMS Intent: The intent of this section is to record the frequency that the resident was restrained by any of the listed devices or an alarm was used, at any time during the day or night, during the 7-day look-back period. Assessors will evaluate whether or not a device meets the definition of a physical restraint or an alarm and code only the devices that meet the definitions in the appropriate categories." *Coding Instructions *"Identify all physical restraints that were used at any time (day or night) during the 7-day look-back period. After determining whether or not an item listed in (P0100) is a physical restraint and was used during the 7-day look-back period, code the frequency of use: -Code 0, not used: if the item was not used during the 7-day look-back period or it was used but did not meet the definition." *"Bed rails include any combination of partial or full rails (e.g., one-side half-rail, one-side full rail,	F0641		

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F0641 SS = E	Continued from page 16 two-sided half-rails or quarter-rails, rails along the side of the bed that block three-quarters to the whole length of the mattress from top to bottom, etc.). Include in this category enclosed bed systems. Bed rails used as positioning devices. If the use of bed rails (quarter-, half- or three-quarter, one or both, etc.) meet the definition of a physical restraint even though they may improve the resident's mobility in bed, the nursing home must code their use as a restraint at P0100A." *"Bed rails used with residents who are immobile. If the resident is immobile and cannot voluntarily get out of bed because of a physical limitation or because proper assistive devices were not present, the bed rails do not meet the definition of a physical restraint. For residents who have no voluntary movement, the staff need to determine if there is an appropriate use of bed rails. Bed rails may create a visual barrier and deter physical contact from others. Some residents have no ability to carry out voluntary movements, yet they exhibit involuntary movements. Involuntary movements, resident weight, and gravity's effects may lead to the resident's body shifting toward the edge of the bed. When bed rails are used in these cases, the resident could be at risk for entrapment. For this type of resident, clinical evaluation of alternatives (e.g., a concave mattress to keep the resident from going over the edge of the bed), coupled with frequent monitoring of the resident's position, should be considered. While the bed rails may not constitute a physical restraint, they may affect the resident's quality of life and create an accident hazard." *In classifying any manual method or physical or mechanical device, material or equipment as a physical restraint, the assessor must consider the effect it has on the resident, not the purpose or intent of its use. It is possible that a manual method or physical or mechanical device, material or equipment may improve a resident's mobility but also have the effect of physically restraining them. *Definition Physical Restraints -Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body (State Operations Manual, Appendix PP). -"Remove easily" means that the manual method or	F0641		

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F0641 SS = E	Continued from page 17 physical or mechanical device, material, or equipment can be removed intentionally by the resident in the same manner as it was applied by the staff (e.g., side rails are put down or not climbed over, buckles are intentionally unbuckled, ties or knots are intentionally untied), considering the resident's physical condition and ability to accomplish their objective (e.g., transfer to a chair, get to the bathroom in time).	F0641		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled residents (6) had a Level II Preadmission Screening and Resident Review (PASRR) screening (a federally mandated program that requires all individuals applying for admission to or currently residing in a Medicaid-certified nursing facility to be screened to determine if they have a serious mental illness, intellectual disability, or developmental disability. Level I screening is conducted to identify if individual has a PASRR condition; if positive, a comprehensive Level II evaluation is performed to determine individual needs, appropriate placement, and services.) completed. Findings include:	F0644	F 644 PASRR completed for resident 6 All other residents assessed by SSD or designee for need for a PASRR Education on PASRRs provided to SSD by administrator Policies and proceedures on PASRRs created as necessary by interdisciplinary team SSD or designee will audit completion of PASSRs weekly for four weeks and monthly for two additional months and randomly thereafter until substantial compliance has been received SSD or designee will present finding at QAPI meetings for their review and guidance until substantial has been determined by QAPI committee	10/10/25

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F0644 SS = D	Continued from page 18 1. Record review of resident 6's PASRR dated 12/20/23 revealed: *She did not have an intellectual or developmental disability (IDD). *She did not have a serious mental illness. *She was not required to have a Level II PASRR unless she had a serious mental illness, IDD, or a significant change in her treatment needs. *She was admitted to the facility on 1/18/24. *During her stay at the facility, she was diagnosed with anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities) on 8/15/24. *During her stay at the facility, she was diagnosed with major depressive disorder (a mental health condition with persistent feelings of sadness, hopelessness, and loss of interest in activities) on 4/21/25. -A physician order was received on 8/29/24, and she was started on buspirone (an antianxiety medication used to treat anxiety) 7.5 milligram (mg) tablets three times daily to treat her anxiety. -A physician order was received on 11/21/24, and she was started on quetiapine (an antipsychotic medication used to treat a variety of mental health conditions) 25 mg tablet twice daily to treat her anxiety. -A physician order was received on 2/16/25, and she was started on bupropion (an antidepressant medication used to treat depression) 300 mg tablet daily to treat her anxiety. -A physician order was received on 4/21/25, and she was started on mirtazapine (an antidepressant medication) 15 mg tablet by mouth at bedtime. *She was discharged to a hospital on 7/16/25 and readmitted on 8/6/25. *She was diagnosed with dementia (a group of symptoms affecting memory, thinking, and social abilities) with behavioral disturbances (consistent, unhealthy pattern of behaviors that significantly interfere with daily functions) on 8/19/25.	F0644		

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F0644 SS = D	Continued from page 19 -A physician order was received on 8/26/25, and she was started on an additional dose of quetiapine 12.5 mg twice daily to treat her anxiety. *Her 8/13/25 Brief Interview for Mental Status (BIMS) assessment score was 0, which indicated she had severe cognitive impairment. She did not complete the assessment. -She had severely impaired daily decision-making skills, and she rarely/never understood others, so a staff assessment of her mental status was completed. -She had short-term and long-term memory problems, inattention (being easily distracted), and disorganized thinking (unclear flow of ideas). *During her stay at the facility, she was prescribed and taking an antipsychotic (a drug used to treat conditions like schizophrenia and bipolar disorder) medication and other psychotropic (drugs that affect a person's mental processes and behavior) medications to manage her diagnoses of anxiety, depression, and behaviors. *No documentation in her EMR indicated that a Level II PASRR had been completed with her significant change in treatment needs. 2. Interview on 8/21/25 at 10:05 a.m. with director of nursing (DON) B revealed: *She does not complete PASRR screenings. *She stated that PASRR screenings should be in the resident's EMRs. *She stated that social services designee (SSD) F was responsible for completing the residents' PASRR screenings. 3. Interview on 8/25/25 at 4:33 p.m. with social services director (SSD) F revealed: *She confirmed that she was responsible for completing the residents' PASRR screenings. *She stated that she was unaware that she should have completed PASRR Level II screenings if a resident experienced a significant change in their mental or physical condition.	F0644		

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F0644 SS = D	Continued from page 20 *She agreed residents should be referred to the local contact agency for a resident review upon a significant change in their mental or physical condition. *She confirmed that she had not completed a level II PASRR for resident 6. *She confirmed that resident 6 should have had a level II PASRR completed when she started on an antipsychotic medication. 4. Administrator A was out of the facility and not available for an interview throughout the survey. 5. Review of the facility's December 2023 PASRR policy revealed: *"Purpose:" *"To ensure that Nursing Facility (NF) applicants and residents with Serious Mental Illness (SMI) or Mental Retardation (MR) are:" -"Placed appropriately (least restrictively)." -"Evaluated and admitted or allowed to remain in a NF only if they can be appropriately served in a NF." -"Provided with the MI/MR services they need, including Specialized Services (SS)." *"Procedure:" *"PASRR evaluation and determination documents should be on the chart (current chart, not archived). In SD the following documents need to be available in the active chart:" -"Screening for Admissions to the Nursing Facility for Mental Illness, Mental Retardation, Developmental Disabilities." -"PASRR Level I screening determination." -"PASRR Level II screening determination." *"PASRR findings and recommendations should be reflected in plan of care…" *"PASRR Resident Review requirement:"	F0644		

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F0644 SS = D	Continued from page 21 -"NF must refer a resident to the state mental health or mental retardation authority for RR [resident review] upon significant change in mental or physical condition." *"MDS Significant Change in Status Assessment (SCSA):" -"Evaluation process required upon significant change in physical or mental conditions." -"NF will need to have well developed protocol and definition of significance." -"Establish NF standard operating procedure."	F0644		
F0655 SS = E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-	F0655	F 655 Unable to correct prior non-compliance Educated DON, MDS coordinator, Administrator and nurses on baseline careplans by DON or desingee Policies and proceedures on baseline careplans created by interdiscpliary team DON or Designee will audit completion, signing and reviewe with residents/ resident repreentative of baseline careplans weekly for four weeks and monthly for two additional months and randomly thereafter until substantial compliance has been received DON or designee will present findings at QAPI meetings for review and guidance until substantial compliance has been been determined by QAPI committee	10/10/25

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F0655 SS = E	Continued from page 22 (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure the resident or the resident's representative was involved in the development of a baseline care plan and given a copy of that care plan within 48 hours of admission for four of four sampled residents (1, 7, 21, and 26) reviewed. Findings include: 1.Review of resident 7's electronic medical record (EMR) revealed: *She was admitted on 5/16/24. *The resident had a resident representative who acted on her behalf. *There was no documentation to support her (date) baseline care plan was reviewed and acknowledged [ML1] [DW2] by resident 7 or her representative. *There was no documentation that resident 7 or her representative was involved with the development of the baseline care plan or given a copy of it. 2. Review of resident 21's EMR revealed:	F0655		

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F0655 SS = E	Continued from page 23 *A baseline care plan dated 8/5/25 had areas that were partially filled out. *The areas that were filled out on the form included: -Initial goals, dietary orders, social services, activities of daily living (ADLs), special treatments, bowel and bladder, skin concerns, and physician orders. *The areas that were not filled out on the form included: -Therapy services, alarms and restraints, medications, discharge plans, and resident or caregiver education needs. *The form was signed by director of nursing (DON) B, social services director (SSD) F, and Minimum Data Set (MDS) nurse/assistant director or nursing (ADON) E. *There was a section at the end of the form that indicated "Written Summary of Baseline Care Plan (To be delivered to resident/responsible party no later than [the] completion of [the] comprehensive care plan)." *There was no documentation that the resident or resident representative was involved with the development of the baseline care plan or given a copy of it. 3. Review of resident 1's EMR revealed: *She was admitted to the facility on 8/22/24. *The baseline care plan was completed on 8/27/24 by previous DON R. *There was no documentation that the resident was involved with the development of the baseline care plan or given a copy of it. 4. Review of resident 26's EMR revealed: *She was admitted to the facility on 10/29/24. *The first baseline care plan was developed on 11/18/24. That care plan did not include any documentation of the resident involvement. *There was no documentation that the resident was involved with her care plan until 12/6/24.	F0655		

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F0655 SS = E	Continued from page 24 5. Interview on 8/21/25 at 2:46 p.m. with certified nurse aide (CNA) M revealed: *She was a contracted CNA and had started at the facility three days ago. *She was given pocket care plans (a document that identifies residents' care needs and interventions) along with task lists to be completed at the beginning of her shifts. *She had not been there long enough to see the process for developing a care plan for a newly admitted resident. 6. Interview on 8/21/25 at 2:51 p.m. with unlicensed medication aide (UMA) K revealed she thought that when a resident weas admitted to the facility, SSD F would complete the resident assessment and provided the CNAs with a paper outlining how to care for the basic needs of the new resident. 7. Interview on 8/21/25 at 2:55 p.m. with MDS nurse/ADON E revealed: *DON B completes the resident baseline care plan upon admission. *She confirmed that care plans are not being updated from the baseline care plan as the residents' care needs change. 8. Review of the provider's 12/2023 Care Plan Policy and Procedure revealed: *"Basic Responsibility: MDS Coordinator or designee" *"Care plan will be developed by an interdisciplinary team with participation of the resident, family, and/or representative (when available). Care plans include active and historical diagnoses, goals and/or expected outcomes, specific nursing interventions so that any nursing staff member is able to quickly identify a resident's individual needs and to decrease the risk of incomplete, incorrect, or inaccurate care, and to enhance continuity of nursing care." *"Upon admission, resident will be assessed by the Charge Nurse and a baseline care plan will be developed with information gathered from the resident and	F0655	F 656 Unable to correct prior non-compliance All residents including rncluding ssessed for completed comprehensive careplans All necessary staff educated on completion of comprehensive careplans Policies and proceedures reviewed, revised and created as necessary for comprehensive careplans MDS Coordiantor or designee will audit comprehensive careplans for completion within 14 days of admission weekly for four weeks and monthly for two additional months MDS Coordinator or designee will present findings at QAPI meetings	

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F0655 SS = E	Continued from page 25 resident's family within 48 hours of their admission."	F0655		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F0656	F 656 Unable to correct prior non-compliance All residents including residents 1, 7, 21, and 26 assessed for completed comprehensive careplans by MDS coordinator or designee DON, MDS coordinator and nurses educated on completion of comprehensive careplans by DON or designee Policies and proceedures created for comprehensive careplans by interdisciplinary team MDS Coordiantor or designee will audit comprehensive careplans for completion within 14 days of admission weekly for four weeks and monthly for two additional months and randomly thereafter until substantial compliance has been received MDS Coordinator or designee will present findings at QAPI meetings for their review and guidance until substantial compliance has been reached as determinded by the QAPI committee	10/10/25

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F0656 SS = D	Continued from page 26 must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure that a comprehensive care plan was developed within 14 days of their admission for four of four sampled residents (1, 7, 21, and 26) reviewed. Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed she was admitted to the facility on 8/22/24. The first care plan was documented 19 days later on 9/10/24. 2. Review of resident 21's EMR revealed: She was admitted to the facility on 8/5/25. *A baseline care plan dated 8/5/25 had areas that were partially filled out. *The areas that were filled out on the form included: -Initial goals, dietary orders, social services, activities of daily living (ADLs), special treatments, bowel and bladder, skin concerns, and physician orders. *The areas that were not filled out on the form included: -Therapy services, alarms and restraints, medications, discharge plans, and resident or caregiver education needs. *There was no documentation of the development of a comprehensive care plan after that baseline care plan. 3. Review of resident 12's EMR revealed the resident was admitted to the facility on 4/15/25. The resident's comprehensive care plan was created 93 days later on 7/17/25. There have been no documented revisions to the comprehensive care plan since it was created on 7/17/25. 4. Review of resident 3's EMR revealed:	F0656		

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F0656 SS = D	Continued from page 27 *Her admission date was 6/12/25. *Her baseline care plan was completed on 6/13/25. *Her comprehensive care plan was developed on 7/18/25, 36 days from the date of her admission. 5. Interview on 8/21/25 at 2:55 p.m. with Minimum Data Set (MDS) nurse/assistant director of nursing (ADON) E revealed: *She was responsible for completing the resident's comprehensive care plans. -She stated, "I take responsibility," and agreed that the above residents' comprehensive care plans were not created within 14 days of their admission. -She had purchased additional resources to support her learning process, including a care plan manual. 6. Interview on 8/25/25 at 12:42 p.m. with director of nursing (DON) B regarding the development of resident 3's comprehensive care plan revealed: *She confirmed resident 3's comprehensive care plan had not been completed within 14 days of her admission to the facility. *She would have expected all residents' comprehensive care plans to be completed within 14 days of their admission. 7. Review of the provider's 12/2023 Care Plan Policy and Procedure revealed: *"Basic Responsibility: MDS Coordinator or designee" *"Care plan will be developed by an interdisciplinary team with participation of the resident, family, and/or representative (when available). Care plans include active and historical diagnoses, goals and/or expected outcomes, specific nursing interventions so that any nursing staff member is able to quickly identify a resident's individual needs and to decrease the risk of incomplete, incorrect, or inaccurate care, and to enhance continuity of nursing care." *"MDS Coordinator or designee will be in charge of notifying the following departments for completion of	F0656		

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F0656 SS = D	Continued from page 28 the care plan by day 14 of admission. Each discipline will update the care plan as changes occur between assessments and scheduled care conferences. -Social Services -Dietary -MDS Coordinator -Activities" *"Each discipline will update the care plan as changes occur between assessments and scheduled care conferences." *"Care Plans will be reviewed quarterly, annually, and with any significant change in resident condition." *"Care plans are written by exception from Resident Centered Care Plan Facility Standards and Short Term Care Plans. They include measurable outcomes and identify interventions that are specific to the individual resident with defined time frames and parameters. Target dates are through next review period unless otherwise specified."	F0656		
F0657 SS = E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their	F0657	F 657 Care plans updated to reflect current needs for residents 5, 6, 12, 21 and 26. All other residents assessed for care plans that reflect current needs. MDS coordinator,DON and nurses educated on careplans reflecting currents needs by administrator. Policies and proceedures on care plans reviewed, revised and created as needed by interdisciplinary teams. MDS coordinator or designee will audit care plans for reflecting current needs weekly for four weeks and monthly for two additional months and rnadomly thereafter until substantial compliance has been received MDS coordinator or designee will reports findings at QAPI meetings for their review and guidance until substantial compliance is determined by the QAPI comittee	10/10/25

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F0657 SS = E	Continued from page 29 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 record review, interview, and policy review, the provider failed to ensure the resident's care plan was reviewed and revised to reflect the current necessary care needs for six of six sampled residents (5, 6, 12, 21, and 26). Findings include: 1. Review of resident 6's electronic medical record (EMR)revealed: *She was admitted to the facility on 1/18/24 and readmitted on 8/6/25. *Her diagnoses included dementia (a group of symptoms affecting memory, thinking, and social abilities) with behavioral disturbances (consistent, unhealthy pattern of behaviors that significantly interfere with daily functions), major depressive disorder (a mental health condition with persistent feelings of sadness, hopelessness, and loss of interest in activities), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). *Her 8/13/25 Brief Interview for Mental Status (BIMS) assessment score was 0, which indicated she had severe cognitive impairment. She did not complete the assessment. -She had severely impaired daily decision-making skills, and she rarely/never understood others, so a staff assessment of her mental status was completed. -She had short-term and long-term memory problems, inattention (being easily distracted), and disorganized thinking (unclear flow of ideas). *She fell in her room on 7/16/25 and was hospitalized	F0657		

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F0657 SS = E	Continued from page 30 for a left hip fracture. *She returned to the facility on 8/6/25. *Her 2/7/24 care plan was not revised to reflect her changed condition upon her re-admission on 8/6/25 after she fell and sustained a left hip fracture regarding: -Her left hip fracture, sustained from falling that was surgically repaired. -Her impairment of her left lower extremity (leg). -Her weight-bearing status. -Her need for physical therapy services. -Her increased pain and the start of the opioid pain medication, tramadol, on 7/25/25. -Her change in mental status. --Disorganized thinking and altered level of consciousness. -Her dementia with behaviors. -Her decline in her ADLs. --Her oral hygiene assistance changed from setup help to partial/moderate staff assistance. --Her toileting hygiene changed from independence to requiring substantial or maximum staff assistance. --Her shower/bath assistance decreased from partial/moderate help to staff-dependent. --Her walking with a walker, covering all distances, changed from independent to needing partial or moderate staff assistance to walk ten feet. --Her positioning in bed and sitting up changed from independent to partial/moderate staff assistance. --Her chair, bed, and toilet transfers changed from independent to partial/moderate staff assistance. --Her ability to move around in her wheelchair changed from independent to staff dependence. -Her use of an anticoagulant (a medication that helps prevent blood clots from forming by slowing down the body's clotting mechanisms).	F0657		

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F0657 SS = E	Continued from page 31 --She had an order for one Eliquis 2.5 mg tablet two times daily. *Her psychotropic medications, monitoring for their side effects, gradual dose reductions, and monthly pharmacy and physician reviews were not included in the care plan. 2. Interview on 8/21/25 at 2:55 p.m. with MDS nurse/ADON E revealed: *She was hired on 12/2/24 as a full-time employee. -Her roles and responsibilities included ADON and MDS nurse. *She confirmed that she was responsible for completing and revising the residents' comprehensive care plans. *She confirmed that the revisions had not been completed with new orders or as areas were resolved or changed. *She stated that DON B completed the baseline care plans. *She stated she was still learning the process on her own, following the MDS manual instructions, and had a lot to learn. -She stated, "I take responsibility," and she had purchased additional resources to support her learning process, including a care plan manual. -She needed a minimum of six months of experience with the MDS process before testing. *She stated that she had not completed the course training to become MDS certified, but had recently signed up to get the class completed. 3. Interview on 8/25/25 at 12:05 p.m. with DON B revealed: *Care plans were located at the nurses' station for staff to utilize. *Nursing staff also used walking care plans (a personalized document that assesses the residents' specific actions and treatments that need to be implemented during their daily care) when working on	F0657		

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F0657 SS = E	Continued from page 32 the floor. *She stated that baseline and comprehensive care plans were available in the residents' EMRs. 4. Review of resident 1's EMR revealed: *She was admitted to the facility on 8/22/24. The first care plan was documented 19 days later on 9/10/24. *Her care plan included 25 areas of focus with listed interventions. -21 of the 25 areas in her care plan had no documented updates to the interventions since 9/12/24. 5. Review of resident 21's EMR revealed: *She was admitted to the facility on 8/5/25. *There was no documentation of the development of a comprehensive care plan after the baseline care plan was completed with missing interventions. 6. Review of resident 26's EMR revealed: *She was admitted to the facility on 10/29/24. The first care plan was created on 11/11/24. *Her care plan included ten areas of focus with listed interventions. -Six of the ten areas had no documented revision after 11/18/24. 7. Review of resident 12's EMR revealed: *The resident was admitted to the facility on 4/15/25. The comprehensive care plan was created 93 days later on 7/17/25. There have been no documented revisions to the comprehensive care plan since it was created on 7/17/25. 8. Interview on 8/20/25 at 2:48 p.m. with resident 5 revealed: *She was aware the facility was a non-smoking facility, as there were "signs everywhere".	F0657		

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F0657 SS = E	Continued from page 33 *She had smoked a couple of times outside, was "caught", and told she could not smoke there. Because of this, she gave the cigarette and lighter to staff "sometimes" when she went outside. Review of resident 5's medical record revealed: *She was admitted on 7/1/25. *Her diagnoses included: nicotine dependence with cigarettes. *She had a 7/25/25 physician's order for nicotine gum once every one to two hours as needed. *Her 8/25/25 care plan included: -An 8/8/25 focus area that indicated she had a diagnosis of osteoporosis (a medical condition in which the bones become brittle and fragile from loss of tissue) related to inadequate calcium intake, and the interventions included "Do not smoke". -There were no other interventions, including that she was non-compliant with the rules of a non-smoking facility or that she used nicotine gum. Observation and interview on 8/20/25 at 2:48 p.m. with resident 5 revealed: *Her bed had one-quarter side rails attached to the sides of her bed, and they were in the up position. *She stated she had asked for side rails to be installed on her bed so she could use them to get in and out of bed. Her care plan did not include that she used a side rail on her bed. Review of the provider's 2023 Smoke Free Facility policy revealed: *"Residents with a history of smoking will be further assessed to determine whether or not interventions are needed to help them cope with the "Smoke Free" policy. Examples include pharmacological and/or behavioral interventions to curb urges to smoke." *"If a resident does not abide by the smoking policy,	F0657		

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F0657 SS = E	Continued from page 34 care plan revisions shall be documented and implemented to promote safety." Review of the provider's 12/2023 Proper Use of Bed Rails policy revealed: *"The facility will continue to provide necessary treatment and care to the resident who has bed rails in accordance with professional standards of practice and the resident's choices. This should be evidenced in the resident's records, including their care plan, including, but not limited to, the following information:" -a. The type of specific direct monitoring and supervision provided during the use of the bed rails, including documentation of the monitoring; -b. The identification of how needs will be met during use of the bed rails, such as for re-positioning, hydration, meals, use of the bathroom and hygiene". -"e. The identification of who may determine when the bed rail will be discontinued; and -f. The identification and interventions to address any residual effects of the bed rail (e.g., generalized weakness, skin breakdown)". *"The interdisciplinary team will make decisions regarding when the bed rail will be used or discontinued, or when to revise the care plan to address any residual effects of the bed rail." Interview on 8/21/25 at 2:55 p.m. with MDS nurse/ADON E regarding care plans revealed: *She was responsible for revising the residents' care plans when there were changes in their care needs or condition, to keep the care plans updated to reflect their current needs. -She stated she had not been updating the residents' care plans. Review of the provider's 12/2023 Care Plan Policy and Procedure revealed: *"Each discipline will update the care plan as changes occur between assessments and scheduled care conferences."	F0657		

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F0657 SS = E	Continued from page 35 *"Care Plans will be reviewed quarterly, annually, and with any significant change in resident condition." *"Care plans are written by exception from Resident Centered Care Plan Facility Standards and Short Term Care Plans. They include measurable outcomes and identify interventions that are specific to the individual resident with defined time frames and parameters. Target dates are through next review period unless otherwise specified."	F0657		
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure that three of three sampled residents (3, 5, and 8) who used bed rails/bars attached to the bed had other attempted interventions documented. Findings include:	F0700	F 700 Residents 3, 5 and 8 assessed by MDS coordinator or designee for proper interventions tried prior to use of side rail All other residents assessed by MDS coordinator or deignee for proper interventions tried prior to use of side rail. MDS coordinator and nurses educated on the proper use of side rails by DON or designee. Policies and proceedures for side rails reviewed, revised, and created as necessary by interdisciplinary team. MDS coordinator or desingee will audit for proper interventions tried prior to installation of side rails weekly for four weeks and monthly for two additional months and random thereafter until substantial compliance has been received MDS coordinator or deisgnee will present fingings at QAPI meetings for their review and guidance until substantial compliance has been determined by QAPI committee	10/10/25

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F0700 SS = D	Continued from page 36 1. Observation and interview on 8/20/25 at 2:48 p.m. with resident 5 revealed: *Her bed had quarter bed rails attached to the sides of her bed, and they were in the up position. *She stated she had asked for bed rails to be installed on her bed so she could use them to get in and out of bed. *She did not remember signing a consent form, or having other alternatives attempted before the bed rails were installed on her bed. Review of the resident 5's signed 7/1/25 Bed Rails Informed Consent for Use revealed the area to document "Alternatives considered but not attempted because they were considered inappropriate" included a handwritten note of "Resident Requested". 2. Observation and interview on 8/21/25 at 10:45 a.m. with resident 8 revealed: *Her bed had a bed rail on the right side of her bed, in the up position. *She stated she had asked for the bed rail to help her get in and out of bed. *She thought she had signed a consent form but was not certain. Review of resident 8's electronic medical record (EMR) revealed: *Her 8/21/25 care plan included that she used a "transfer loop [bed] to maximize her independence" with turning and repositioning in bed. *Her 4/25/25 Bed Rail Assessment included: she was non-ambulatory, she had a history of falling, she displayed poor bed mobility or difficulty moving to a sitting position on the side of the bed, she had difficulty with balance or poor trunk control, she had expressed a desire to have "Side Rails/Assist Bar" (bed rail) for safety and comfort. -The area that documented "Side Rail Placement" included bilateral (both sides) bed rails to serve as an enabler to promote independence, and she "expressed a desire to have Side Rails/Assist Bar".	F0700		

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F0700 SS = D	Continued from page 37 *Her 7/25/25 Bed Rail Assessment had been started but was not completed. Resident 8's 7/8/25 Bed Rails Informed Consent for Use, signed by her representative, revealed: *She used an upper, left side, one-quarter bed rail. *The area to document "Alternatives considered but not attempted because they were considered inappropriate" included a handwritten note of "N/A [not applicable] This is per resident request". 3. Observation on 8/25/25 at 10:20 a.m. with resident 3 revealed: *The right side of her bed had a bed rail attached to it, and it was in the up position. *She stated she used the bed rail to help her to sit up when she was in her bed. Review of resident 3's EMR revealed: *Her admission date was 6/12/25. *Her 6/12/25 baseline care plan indicated she used a one-quarter right bed rail on her bed. *Her 6/12/25 Bed Rail Assessment included: she had a history of falling, she displayed poor bed mobility or difficulty moving to a sitting position on the side of the bed, she had postural hypertension, she had "not expressed a desire to have Side Rails/Assist Bar for safety and/or comfort", and she was visually challenged. -The area that documented "Side Rail Placement" included a side rail on the right side and that she "expressed a desire to have Side Rails/Assist Bar". -There were no documented attempts for alternatives to bed rails. *Her EMR did not include any documented attempts at alternatives to bed rails. Resident 3's signed 7/21/25 Bed Rails Informed Consent for Use revealed:	F0700		

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F0700 SS = D	Continued from page 38 *She used an upper, left-sided, one-quarter bed rail. *The area to document "Alternatives considered but not attempted because they were considered inappropriate" included a handwritten note of "N/A – Resident Requested". 4. Interview on 8/21/25 at 2:55 p.m. with Minimum Data Set nurse (MDS)/assistant director of nursing (ADON) E regarding resident use of side rails on their beds revealed: *Every three months, a side/bed rail assessment was to be completed for each resident. *Side/bed rails are used for mobility and positioning and are coded as a restraint on those residents' MDS assessments. Interview on 8/25/25 at 12:40 p.m. with director of nursing (DON) B regarding residents' use of side/bed rails revealed: *When a resident was admitted, and they requested a side rail, one was attached to their bed. -There were no alternatives to the side rails attempted before they were provided to the resident. *She was not aware that alternatives needed to be attempted before providing the resident with a side rail. 5. Review of the provider's 12/2023 Proper Use of Bed Rails policy revealed: *"Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used, the facility ensures correct installation, use, and maintenance of the rails." *"The resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the resident's assessed needs." *"The facility will attempt to use appropriate alternatives prior to installing or using bed rails. Alternatives include, but are not limited to:	F0700		

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F0700 SS = D	Continued from page 39 -a. Roll guards -b. Foam bumpers -c. Lowering the bed -d. Concave mattresses" *"If no appropriate alternatives are identified, the medical record should include evidence of the following: -a. Purpose for which the bed rail was intended and evidence that alternatives were tried and were not successful".	F0700		
F0727 SS = F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 1919(b)(4)(C);1919(b)(4)(C)(i);1819(b)(4)(C);1819(Social Security Act §1919 [42 U.S.C. 1396r] §1919(b)(4)(C) Required nursing care; facility waivers.- §1919(b)(4)(C)(i) General requirements.-With respect to nursing facility services provided on or after October 1, 1990, a nursing facility- (II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week. Social Security Act §1819 [42 U.S.C. 1395i-3] §1819(b)(4)(C) REQUIRED NURSING CARE.- §1819(b)(4)(C)(i) IN GENERAL.-Except as provided in clause (ii), a skilled nursing facility … must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week. §483.35(c)(3) Except when waived under paragraph (f) or (g) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(c)(4) The director of nursing may serve as a	F0727	F 727 Nurse waiver being filed by Administrator or designee. Will ensure proper RN coverage until waiver is approved. DON educated on requirements of RN coverage BOM or deisgnee will audit proper RN coverage weekly for four weeks and monthly for two additional months and randomly thereafter until substantial compliance has been recieved BOM or designee will present findings QAPi meetings for their review and guidance until substantial compliance has been determined by the QAPI committee	10/10/25

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F0727 SS = F	Continued from page 40 charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is NOT MET as evidenced by: Based on Payroll Based Journal (PBJ) CASPER (Certification and Survey Provider Enhanced Reporting) reports, interview, and record review, the provider failed to ensure the PBJ data was submitted accurately to the Centers for Medicaid and Medicare Services (CMS) for Federal Fiscal Quarter 2 (Q2) (January, February, and March 2025). Findings include: 1.Review of the provider's Q2 2025 PBJ submission report to CMS revealed there was no registered nurse (RN) coverage (worked for eight consecutive hours each day) on 1/26/25, 2/2/25, 3/1/25, 3/8/25, 3/15/25, and 3/22/25. Interview with 08/21/2025 at 12:30 p.m. with director of nursing (DON B) revealed: *She confirmed there was not always a registered nurse for eight consecutive hours each day at the facility. *She confirmed there was no registered nurse (RN) coverage on the days indicated for Q2 2025. *She was not aware that RN coverage was needed seven days per week. *She confirmed the provider had no nurse waiver. Interview on 8/21/25 at 12:45 p.m. with business office manager (BOM) H regarding PBJ submission and RN coverage revealed: *She started her employment as the BOM at the facility in January of 2025. *Administrator A had assisted her in the submission of the Q2 2025 PBJ data to CMS. *She completed the nurse scheduling and was aware that a skilled nursing facility needed RN coverage seven days a week, but was not aware that this was required for a nursing facility that was not skilled.	F0727		

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F0727 SS = F	Continued from page 41 Interview and review of the provider's licensed nurse schedule from 8/1/25 through 8/24/25 8/26/25 at 3:05 p.m. with BOM H revealed there was no RN coverage, 8/9/25, 8/17/25, and 8/24/25. Interview and review of the provider's licensed nurse schedule from 8/1/25 through 8/24/25 on 8/26/25 at 3:15 p.m. with DON B confirmed there were three days with no RN coverage, which included 8/9/25, 8/17/25, and 8/24/25. Review of the provider's 6/2025 Facility Assessment revealed there was no indication that an RN was required to work for eight consecutive hours a day, seven days a week. The provider had no staffing policy.	F0727		
F0732 SS = D	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a	F0732	F 732 Unable to correct prior non-compliance All nurses and BOM educated on posting of nurse staffing information by adminsitrator or designee DON or Designee revised form to inclide all required info BOM or deignee will audit daily posting or nurse staffing weekly for four weeks and monthly for two additional months and randomly thereafter until substantial compliance has been received BOM or designee will report findings at QAPI meetings for their review and guidance until substantial compliance has been reached as determined by the QAPI committee	10/10/25

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F0732 SS = D	Continued from page 42 daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the provider failed to ensure the required daily nurse staffing information, including the total number and actual hours worked by licensed and unlicensed nursing staff, and the resident census was current and posted daily. Findings include: 1. Observation on 8/25/25 at 3:15 p.m. of the posted nurse staffing information revealed: *The form was posted on a board outside the activities room. *Staff scheduled to work that day were listed by shift: "AM [day] SHIFT (6A-6P)" and "NOC [night] SHIFT (6P-6A)." *Below each shift, a list of pod one, pod two, and pod three, with the name of a staff member next to it, was on that form. -There were three hallways in the facility with resident rooms, which the staff called "pods." *No categories to indicate whether each nursing staff member listed was a registered nurse (RN), licensed practical nurse (LPN), or certified nursing assistant (CNA) were included on that form.	F0732		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A140	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUSTER CARE AND REHAB CENTER	1065 MONTGOMERY ST , CUSTER, South Dakota, 57730

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F0732 SS = D	Continued from page 43 *The total number of RN, LPN, and CNA staff members who were scheduled to work was not listed on that form. *The staff members' hours worked were combined and listed for each shift in the "Total Hours" area on that form. *A separate piece of paper was posted above the nurse staffing information form that listed room numbers and the names of the residents who resided in those rooms. It did not specify the total number of residents in the facility (resident census). -The date on that resident listing indicated it had last been updated on 8/12/25. 2. Interview on 8/26/25 at 10:01 a.m. with director of nursing (DON) B revealed: *Business office manager (BOM) H was responsible for posting the daily nurse staffing information form. *She thought that BOM H had been updating that form if there was a staffing change. *DON B was unaware that the total number and actual hours worked by each nursing staff's discipline, and the current resident census, should have been listed on the posted staffing information form. 3. Interview on 8/26/25 at 10:47 a.m. with BOM H revealed: *She was not aware that the total number and actual hours worked by each nursing staff's discipline, and the current resident census, should have been listed on the posted staffing information form. *She updated the staffing information form when there was a staffing change, but those updates usually happened a week later and were used for their internal record-keeping. *She was not aware that the posted staffing information needed to be updated daily to reflect the current staffing of the facility for the residents and visitors to review. 4. A policy regarding posting nursing staffing information was requested for review on 8/26/25. DON B stated the provider did not have a specific policy	F0732		

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F0732 SS = D	Continued from page 44 related to posting nursing staffing information.	F0732		
F0757 SS = E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure: *Psychotropic medications (drugs that affect brain activities associated with mental processes and behavior) ordered to be given as needed were not discontinued after 14 days, and did not have a rationale documented for continued use for four of nine sampled residents (7, 13, 21, and 30) reviewed with physician's orders for psychotropic medications. *Abnormal Involuntary Movement Scale (AIMS) (an assessment to identify the severity of involuntary movements in residents taking neuroleptic medications) assessments were routinely completed to evaluate for signs of adverse effects for eight of nine sampled residents (1, 6, 7, 13, 18, 21, 23, and 30) reviewed	F0757	F 757 Cannot corret prior non-compliance for PRN anti-psycs being not being stopped after 14 days Ensured all current PRN anti-psycs have a stop order and documented rational Cannot Correct prior noncompliance for AIMS assessments being completed Ensured all curent residents taking neuroleptic medications are having rountinely completed AIMS assessments Education on anti-psycs provided to all nurses by DON or designee Cannot correct prior noncompliance on anti-psyc consent forms Policies and proceedures on anti-psyc medications reviewed, revised or created as necessary by interdisciplinary team DON or designee will audit PRN anti-psycs being stopped after 14 days and documented rational being completed for hose medciations weekly for four weeks and monthly for two additional months and randomly thereafter until substantial compliance has been received DON or designee will audit completion of AIMS assessments weekly for four weeks and monthly for two additonal months and randomly thereafter until substantial compliance has been received DON or designee will audit completion of anti-psyc consent forms weekly for four weeks and monthly for two additonal months and randomly thereafter until substantial compliance has been received Don or designee will report findings at QAPI meetings for their review and guidance until substantial compliance has been reached as determined by the QAPI committee	10/10/25

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F0757 SS = E	Continued from page 45 with physician's orders for psychotropic medications. *Consent forms for the use of psychotropic medications were obtained for nine of nine sampled residents (1, 6, 7, 13, 18, 21, 23, 26, and 30) reviewed with physician's orders for psychotropic medications. Findings included: 1. Review of resident 21's electronic medical record (EMR) revealed: *Four orders for Lorazepam (a psychotropic antianxiety medication) for the diagnosis of "unspecified dementia, unspecified severity, with anxiety." *An 8/5/25 physician's order for "Lorazepam [a psychotropic antianxiety medication] 0.5 milligrams (mg). Give 0.5 tablet orally [by mouth] every two hours as needed." *An 8/5/25 physician's order for "Lorazepam [a psychotropic antianxiety medication] 1 mg. Give 0.5 tablet orally every two hours as needed." *An 8/5/25 physician's order for "Lorazepam [a psychotropic antianxiety medication] 1.5 mg. Give 0.5 tablet orally every two hours as needed." *An 8/5/25 physician's order for "Lorazepam [a psychotropic antianxiety medication] 2 mg. Give 0.5 tablet orally every two hours as needed." -There was no stop date for the medication or a rationale to continue the as needed doses beyond 14 days documented in the above Lorazepam orders. *She was prescribed Seroquel (an antipsychotic medication) on 8/5/25 for the diagnosis of "unspecified dementia, unspecified severity, with anxiety." -There was no documented psychotropic consent for the resident's use of Lorazepam or Seroquel. -The resident was not assessed for tardive dyskinesia (TD) using an Abnormal Involuntary Movement Scale (AIMS). TD was a possible side effect of Seroquel. 2. Review of resident 26's EMR revealed: *She was prescribed Memantine (a psychotropic medication used to treat moderate to severe Alzheimer's	F0757		

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F0757 SS = E	Continued from page 46 disease) with the directions to "give one cap [capsule] by mouth every morning" on 11/1/24 for her diagnosis of dementia. -There was no documented consent for the resident's use of the Memantine medication in the resident's EMR. 3. Review of resident 1's EMR revealed: *The resident had a 8/19/25 prescription for Citalopram (a psychotropic antidepressant medication) with the instructions to "give 1 tab [tablet] by mouth once daily" for her diagnosis of anxiety. *The resident had a 3/20/25 prescription for Buspar (a psychotropic antianxiety medication) with the instructions to "give 1 tab by mouth three times daily" for her diagnosis of anxiety. -There was a psychotropic medication consent signed for Buspar. There was no consent signed for Citalopram. -Both Citalopram and Buspar can cause TD. There were no AIMS performed to assess the resident for potential side effects of the medications, including TD. 4. Review of resident 6's EMR revealed: *An 8/29/24 physician's order for buspirone (a psychotropic antianxiety medication) 7.5 mg to be given three times daily for her diagnosis of anxiety disorder. *An 11/21/24 physician's order for quetiapine (an antipsychotic medication) 25 mg to be given twice daily, with the indication for use being her anxiety. *An 8/26/25 physician's order for quetiapine 12.5 mg to be given twice daily was not documented with a diagnosis or an indication for its use. *A 2/16/25 physician's order for bupropion (a psychotropic antidepressant medication) 300 mg to be given daily for her diagnosis of anxiety disorder. *A 4/21/25 physician's order for mirtazapine (a psychotropic antidepressant medication) 15 mg to be given at bedtime, with the indication for use being her depression. -A signed psychotropic consent form dated 4/21/25 for her use of mirtazapine was retained in her EMR.	F0757		

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F0757 SS = E	Continued from page 47 *No documentation in her EMR indicated that psychotropic medication consent forms had been completed and signed for the resident's use of buspirone, quetiapine, and bupropion. *No documentation in her EMR indicated that an AIMS assessment had been completed to assess for potential side effects of the medications. 5. Review of resident 7's EMR revealed: *A 1/17/25 physician's order for lorazepam 1 mg to be given once daily as needed for panic attacks. *No 14-day discontinuation date or reassessment with rationale for continued use of the 'as needed' lorazepam by the physician had been documented in her EMR. *No documentation in her EMR indicated that a psychotropic medication consent form had been completed and signed for the resident's use of the lorazepam. *No documentation in her EMR indicated that an AIMS assessment had been completed to assess for potential side effects of the medication. 6. Review of resident 13's EMR revealed: *A 10/21/24 physician's order for sertraline (a psychotropic antidepressant medication) 50 mg to be given at bedtime, with the indication for use being behaviors. *A 7/10/25 physician's order for lorazepam 0.5 mg to 2 mg (one to four tablets) to be given every two hours as needed, with the indications for use being anxiety, pain, restlessness, or dyspnea (shortness of breath). *A 7/11/25 physician's order for morphine sulfate (a medication with risk for abuse and addiction used to treat moderate to severe pain) solution 100 mg per 5 milliliters (mL) to be given 0.25 mg to 0.75 mg (5 mL to 15 mL) every three hours as needed, with indications for use being pain or air hunger (a severe sensation of not being able to get enough air). *No 14-day discontinuation dates or reassessment for the rationale for continued use of the 'as needed' medications by the physician had been documented in his EMR.	F0757		

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F0757 SS = E	Continued from page 48 *No documentation in his EMR indicated that a psychotropic medication consent form had been completed or signed for the resident's use of the above medications. *No documentation in his EMR indicated that an AIMS assessment had been completed to assess for potential side effects of the medications. 7. Record review of resident 18's EMR revealed: *A 10/21/24 physician's order for sertraline 100 mg to be given every morning, with the indication for use being behaviors. *A 11/27/24 physician's order for quetiapine 50 mg to be given three times daily, with the indication for use being behaviors. *A 6/2/25 physician's order for buspirone 10 mg to be given twice daily, with the indication for use being behaviors. *No documentation in her EMR indicated that a psychotropic medication consent form had been completed or signed for the resident's use of the above medications. *No documentation in her EMR indicated that an AIMS assessment had been completed to assess for potential side effects of the medications. 8. Review of resident 23's EMR revealed: *A 9/22/24 physician's order for escitalopram (a psychotropic antidepressant medication) 20 mg to be given at bedtime, with the indications for use being depression and anxiety breakthrough. *An 8/23/25 physician's order for lorazepam 0.5 mg to 1 mg (1 to 2 tablets) every two hours as needed, with the indication for use being anxiety. *An 8/23/25 physician's order for morphine sulfate solution 100 mg per 5 mL to be given 0.25 mg to 0.75 mg (5 mL to 15 mL) every three hours as needed, with the indication for use being pain or air hunger. *A physician assessed and renewed her lorazepam and morphine use orders on 8/23/25.	F0757		

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F0757 SS = E	Continued from page 49 *No documentation in her EMR indicated that a psychotropic medication consent form had been completed or signed for the resident's use of the above medications. *No documentation in her EMR indicated that an AIMS assessment had been completed to assess for potential side effects of the medications. 9. Review of resident 30's EMR revealed: *A 10/14/24 physician's order for fluoxetine (a selective serotonin reuptake inhibitor (SSRI) medication, a drug used to treat various mental health conditions) 40 mg to be given daily, with the indication for use being depression. *A 10/14/24 physician's order for trazodone (a psychotropic antidepressant medication)100 mg to be given at bedtime, with the indication for use being sleep. *A 3/25/24 physician's order for one bupropion 150 mg and one 10 mg tablet to be given twice daily, for her diagnoses of anxiety and depression. *A 3/25/24 physician's order for lamotrigine (a medication for bipolar disorder)100 mg to be given at bedtime, for her diagnosis of bipolar disorder. *A 3/25/24 physician's order for risperidone (an antipsychotic medication used to treat several mental health conditions) 1 mg to be given twice daily, for her diagnosis of bipolar disorder. *An 8/8/25 physician's order for oxycodone (a potent opioid analgesic used to treat moderate to severe pain) 5 mg to be given every twelve hours, with the indication for use being pain management. She could also take one 5 mg tablet once daily as needed. *No 14-day discontinuation date or reassessment with rationale for continued use of the 'as needed' medications by the physician had been documented in her EMR. *No documentation in her EMR indicated that a psychotropic medication consent form had been completed or signed for the resident's use of the above medications. *Her last AIMS assessment was completed on 6/26/24.	F0757		

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F0757 SS = E	Continued from page 50 10. Interview on 8/21/2025 at 9:58 a.m. with registered nurse (RN) N revealed: *She stated that as needed controlled medications (medications classified at risk for abuse and addiction) that require a maintained count can only be administered by nurses. -There were as-needed controlled medications that required 14-day renewals or were discontinued and were locked in the medication cart. *The pharmacist reviewed the resident's charts every month. *She stated that the as needed medications should be reviewed every 14 days and would either be discontinued or have their orders renewed. 11. Interview on 8/21/25 at 10:05 a.m. and again on 8/25/25 at 2:44 p.m. with director of nursing (DON) B revealed: *She stated that residents receiving as-needed psychotropic medications ordered by physicians must have a visit by the physician and be reassessed for the as needed medication order renewals every 14 days. *The pharmacy would send a message to the physician on HUCU (a confidential communication platform) regarding new prescription orders, including any as needed psychotropic medications that may be required. *She stated that no progress note would be completed at that time for the resident. *The physician's office staff would add the resident to the next scheduled rounds for the physician to assess the resident and complete the progress note. *She stated that the best process would be for them to wait until the visit occurred, but some medications would be ordered and filled before the physician's visit. *DON B would receive an email report from consultant pharmacist D with nursing and physician recommendations. *DON B would place a copy in the "physician folder" at the nurse's station for the physician to review during rounds with residents.	F0757		

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F0757 SS = E	Continued from page 51 *MD C was scheduled twice weekly for resident visits at the facility and would address the recommendations then. *She stated that after she completed August's pharmacy recommendation review, she noted that July's physician recommendations were still in the "provider folder" at the nurses' station, unaddressed. -She was unable to recall the date. *She stated that consultant pharmacist D should have been monitoring resident medications due for renewal every 14 days during her monthly visit. *She stated the "pharmacy was not tracking the 14-day renewals consistently." *She stated, "consultant pharmacist D was only reviewing them when in the facility to complete resident chart reviews." *DON B stated that the 14-day stop dates for as-needed psychotropic medications had been identified by her as a problem over the past few months. *DON B had no process in place before July 2025 to monitor medications that required 14-day renewals. *She stated she was now using a desk calendar to track the medications, but "the process was not the best." -She expected herself to audit the medications that required 14-day renewals every two weeks. *She confirmed that some psychotropic as needed medication stop dates were entered as "indefinite" and that no 14-day stop dates were entered when the orders were entered into the EMR system. *She confirmed that some residents' medications with a 14-day stop date requirement had continued to be given beyond 14 days. *A psychotropic risk assessment tool was not utilized routinely for residents on psychotropic medications to monitor for adverse side effects. *She stated, "the order to monitor for side effects in place on the resident's treatment administration record (TAR) was not an assessment." *DON B stated she would only complete an AIMS	F0757		

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F0757 SS = E	Continued from page 52 assessment when recommended by consultant pharmacist D. *DON B confirmed that the AIMS assessments were not performed routinely, such as upon admission, quarterly, or after significant changes in the resident's condition. *DON B confirmed that psychotropic medication consent forms were not completed or updated as they should be for residents (1, 6, 7, 13, 18, 21, 23, 26, and 30) on psychotropic medications. *She stated that the facility currently had no "psychotropic medication" policy and was unable to provide a related policy for review. *DON B provided a toolkit packet from the American Health Care Association (AHCA) and the National Center for Assisted Living (NCAL) titled "Clinical Considerations of Antipsychotic Medication Management". -She used the toolkit as a guide. *She stated that the process for psychotropic medications needed improvement. *She confirmed that the 14-day stop dates for as-needed psychotropic medications and the process for monitoring adverse effects using an AIMS assessment were neither reported nor tracked in the facility's QAA/QAPI program. 12. Interview on 8/21/25 at 11:00 a.m. with Minimum Data Set (MDS) nurse/assistant director of nursing (ADON) E revealed: *She did not complete an AIMS assessment for residents during their MDS assessment time frames. *She agreed and confirmed that AIMS assessments should be completed with residents on psychotropic medications to monitor for adverse side effects. 13. Telephone interview on 8/26/2025 at 11:06 a.m. with consultant pharmacist D revealed: *She completed monthly resident chart reviews. *She made nursing and physician recommendations for dose reductions, discontinuations, renewals, labs, and reviewed departmental progress notes.	F0757		

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F0757 SS = E	Continued from page 53 *She stated, "I take responsibility for monitoring the 14-day renewals and stop dates for the as-needed psychotropic medications when I am at the facility." *Her process was to email DON B her recommendation report monthly with her findings, which would have included medications that needed to be addressed. -The report could include psychotropic medications that would need a 14-day renewal or discontinuation. *She stated that it would take 30 days or longer for MD C to respond to her recommendations. 14. Telephone interview on 8/26/25 at 11:34 a.m. with medical director C revealed: *Monthly medication reviews were conducted each month. *He was unable to provide any guidance regarding the 14-day stop dates for as-needed psychotropic medications. *He stated that he would like "the rules sent to him that showed an assessment was needed to be re-done with renewing medications." *He stated, "I think nursing will put in their own reasons or diagnosis," "they do whatever is easiest for them." *He confirmed that he does not assign a diagnosis to his medication orders. *He stated, "It should be inferred from my progress notes." 15. Administrator A was out of the facility and not available for an interview throughout the survey. 16. Review of the provider's 2023 Director of Nursing job description revealed: *"Planning, organizing, developing and directing the overall operations of the Nursing Service Department in accordance with local, state and federal standards and regulations, established facility policies and procedures and as may be directed by the Administrator and the Medical Director, to provide appropriate care and services to the residents."	F0757		

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CUSTER CARE AND REHAB CENTER	1065 MONTGOMERY ST , CUSTER, South Dakota, 57730

(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
F0757 SS = E	Continued from page 54 17. Review of the provider's December 2023 Medical Director Physician Agreement revealed: *"EXIBIT A," *"DUTIES AND RESPONSIBILITIES," *"A. ...Physician's duties and responsibilities shall include, but are not limited to:" -"1. Monitoring medical care in the Facility to assist Facility in providing adequate and appropriate medical services to the patients in the Facility..." --"(c) evaluating reports of inadequate medical care, including drug irregularities, and advising on appropriate corrective steps to correct any identified concerns;" -"5. Consulting with the Administrator and the director of nursing services in monitoring the adequacy of both the nursing staff and the Facility to meet the psychosocial as well as the medical and physical needs of patients." *"B. Physician agrees to abide by all Facility policies and procedures in performing Physician's duties hereunder..." 18. Review of the provider's December 2023 Medication Monitoring policy revealed: *"Policy:" *"This facility takes a collaborative, systematic approach to medication management, including the monitoring of medications for efficacy and adverse consequences." *"Definitions:" *"Adverse consequences is a broad term referring to unwanted, uncomfortable, or dangerous effects that a drug may have, such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status." *"Indications for use:" *"Refers to the identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition and	F0757		

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F0757 SS = E	Continued from page 55 therapeutic goals and is consistent with manufacturer's recommendations and/or clinical practice guidelines." *"Policy Explanation and Compliance Guidelines:" *"5. Licensed nurses, with periodic oversight by nurse managers, shall:" -"b. Adhere to facility policies and current standards of practice for administration and monitoring of medications." *"6. Interventions shall be identified on the resident's comprehensive plan of care for the systematic monitoring of high-risk medications to facilitate early identification of adverse consequences." *"7. Target symptoms and goals for use of medications shall be indicated on the resident's plan of care. The interdisciplinary team shall evaluate progress toward meeting the goals in accordance with timeframes indicated on the plan of care, but no less than quarterly or when significant changes in status occur." *"8. Each resident's medication regimen is reviewed by a licensed pharmacist at designated intervals, and whenever changes in condition that could be related to medications are noted. Irregularities are reported and addressed in accordance with facility policy for medication regimen reviews and addressing irregularities."	F0757		
F0841 SS = E	Responsibilities of Medical Director CFR(s): 483.70(g)(1)(2) §483.70(g) Medical director. §483.70(g)(1) The facility must designate a physician to serve as medical director. §483.70(g)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure:	F0841	F 841 Medical director C will attend and participate in the QAA process and meetings quarterly going forward. Medical Director educated on his responsbilities to the QAA process by adminstrator or designee Adminstrator or designee will audit medical director participation in QAA quraterly for three quarters and randomly thereafter until substantial compliance has been received Administrator or designee will report findings at QAPI meetingsfor their review and guidance until substantial compliance has been reached as determined by the QAPI comitttee	10/10/25

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F0841 SS = E	Continued from page 56 *MD C fulfilled his role and responsibilities to assist according to the provider's medical director physician agreement to provide guidance in developing and implementing patient care policies and the duties as a member of the QAA/AQPI committee, including evaluating and guiding other committee members on corrective plans for high-risk or problem-prone areas identified. Findings include: 1. Interview on 8/21/25 at 10:05 a.m. and again on 8/25/25 at 2:44 p.m. with director of nursing (DON) B revealed: *She stated that residents receiving as-needed psychotropic medications ordered by physicians must have a visit by the physician and be reassessed for the as needed medication order renewals every 14 days. *The pharmacy would send a message to the physician on HUCU (a confidential communication platform) regarding new prescription orders, including any as needed psychotropic medications that may be required. *She stated that no progress note would be completed at that time for the resident. *The physician's office staff would add the resident to the next scheduled rounds for the physician to assess the resident and complete the progress note. *She stated that the best process would be for them to wait until the visit occurred, but some medications would be ordered and filled before the physician's visit. *DON B would receive an email report from consultant pharmacist D with nursing and physician recommendations. *DON B would place a copy in the "physician folder" at the nurse's station for the physician to review during rounds with residents. *MD C was scheduled twice weekly for resident visits at the facility and would address the recommendations then. *She stated that after she completed August's pharmacy recommendation review, she noted that July's physician recommendations were still in the "provider folder" at the nurses' station, unaddressed.	F0841		

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F0841 SS = E	Continued from page 57 -She was unable to recall the date. *She confirmed that some residents' medications with a 14-day stop date requirement had continued to be given beyond 14 days. *She stated that the facility currently had no "psychotropic medication" policy and was unable to provide a related policy for review. *DON B provided a toolkit packet from the American Health Care Association (AHCA) and the National Center for Assisted Living (NCAL) titled "Clinical Considerations of Antipsychotic Medication Management". -She used the toolkit as a guide. *She stated that the process for psychotropic medications needed improvement. *She confirmed that the 14-day stop dates for as-needed psychotropic medications and the process for monitoring adverse effects using an AIMS assessment were neither reported nor tracked in the facility's QAA/QAPI program. 2. Interview on 8/21/25 at 4:31 p.m. with DON B revealed: *The facility's policies and procedures were reviewed annually or whenever a policy was revised. *She stated that she and Administrator A reviewed the policies and procedures in January 2025. *She stated that MD C had not reviewed the policy and procedures to date. *She stated that there was currently no designated board member reviewing the facility policies and procedures. 3. Observation and interview on 8/25/25 at 12:05 p.m. with DON B regarding the facility's policy and procedure binder and current process revealed: *The policy and procedure binder contained a tracking form that tracked the following: -"Policy name", "date implemented", "implemented by", "date reviewed", and "reviewed by".	F0841		

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F0841 SS = E	Continued from page 58 *The most recent policy and procedure review was documented 1/2025 and initialed by Administrator A and DON B. *No documentation had been identified or documented that MD C had acknowledged that he had reviewed the facility's policies and procedures. *No documentation had been identified or documented that a board member had acknowledged that they had reviewed the facility's policies and procedures. *Don B confirmed that neither MD C nor a board member discussed, reviewed, or signed to acknowledge the facility's policies and procedures during the 2025 scheduled board or QAA/QAPI meetings. 4. Telephone interview on 8/26/2025 at 11:06 a.m. with consultant pharmacist D revealed: *She completed monthly resident chart reviews. *She made nursing and physician recommendations for dose reductions, discontinuations, renewals, labs, and reviewed departmental progress notes. *Her process was to email DON B her recommendation report monthly with her findings, which would have included medications that needed to be addressed. *She stated that it would take 30 days or longer for MD C to respond to her recommendations. 5. Telephone interview on 8/26/25 at 11:34 a.m. with MD C revealed: *Monthly medication reviews were conducted each month. *He was unable to provide any guidance regarding the 14-day stop dates for as-needed psychotropic medications. *He stated that he would like "the rules sent to him that showed an assessment was needed to be re-done with renewing medications." *He did not know if he had attended the last six months of the QAA/QAPI meetings, and stated, "he would have to check his calendar." *MD C provided no other information regarding his active involvement in the facility's QAA/QAPI process.	F0841		

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F0841 SS = E	Continued from page 59 *He stated, "I think nursing will put in their own reasons or diagnosis," "they do whatever is easiest for them." *He confirmed that he does not assign a diagnosis to his medication orders. -The diagnoses are recorded in his progress notes. *He stated, "It should be inferred from my progress note." *He thought he had reviewed the policies with DON B, and stated, "he would have to check his calendar." *MD C provided no other information regarding his active involvement in the facility's policy and procedure process. 6. Administrator A was out of the facility and not available for an interview throughout the survey. 7. Review of the provider's December 2023 Medical Director Physician Agreement revealed: *"AGREEMENT," *"EXIBIT A," *"DUTIES AND RESPONSIBILITIES," *"A. …Physician's duties and responsibilities shall include, but are not limited to:" -"1. Monitoring medical care in the Facility to assist Facility in providing adequate and appropriate medical services to the patients in the Facility…" -"2. Assisting in the development of and ensuring the implementation of patient care policies, which policies shall include, without limitations:" --"(a) admission, transfer and discharge policies," --"(b) infection control policies;" --"(c) policies on use of restraints;" --"(d) policies on physician privilege and practices;" --"(e) policies on responsibilities of non-physician	F0841		

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F0841 SS = E	Continued from page 60 healthcare workers…" --"(f) policies related to accidents and incidents;" --"(g) policies regarding ancillary services, such as laboratory, radiology, and pharmacy:" --"(h) policies regarding use of medications:" --"(i) policies regarding use and release of clinical information; and" --"(j) policies regarding overall quality of care." -"5. Consulting with the Administrator and the director of nursing services in monitoring the adequacy of both the nursing staff and the Facility to meet the psychosocial as well as the medical and physical needs of patients." -"7. Consulting with the Administrator on matters of employee health policies." -"10. Providing advice regarding policies and programs of public health agencies…" *"B. Physician agrees to abide by all Facility policies and procedures in performing Physician's duties hereunder…"	F0841		
F0851 SS = F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the	F0851	F 851 Unable to correct prior noncompliance BOM educated on the requirements of PBJ submissions and how to complete by administrator or designee BOM or designee will complete quarterly PBJ submissions BOM or designee will audit completionof PBJ submissions quarterly for three quarters and randomly thereafter until substantial compliance has been received BOM or designee will report finding at QAPI meetings for review and guidance until substantial compliance has been reached as determined by the QAPI committee	10/10/25

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F0851 SS = F	Continued from page 61 long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: Based on Payroll Based Journal (PBJ) CASPER (Certification and Survey Provider Enhanced Reporting) reports, interview, and record review, the provider failed to ensure the PBJ data was submitted accurately to the Centers for Medicaid and Medicare Services (CMS) for Federal Fiscal Quarter 2 (Q2) (January, February, and March 2025).	F0851		

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F0851 SS = F	Continued from page 62 Findings include: 1. Review of the provider's Q2 2025 PBJ submission report to CMS revealed: *There was no recorded 24-hour licensed nurse coverage on 1/2/25, 2/19/25, 3/15/25, and 3/22/25. *There was no registered nurse (RN) coverage for consecutive eight hours daily on 1/26/25, 2/2/25, 3/1/25, 3/8/25, 3/15/25, and 3/22/25. Interview with 08/21/2025 at 12:30 p.m. with director of nursing (DON B) regarding submission of PBJ data revealed: *She confirmed there was no registered nurse (RN) coverage on the days indicated for Q2 2025. *She was not aware that RN coverage was needed seven days per week. *She was able to provide documentation that there was 24-hour licensed nurse coverage for the days indicated for Q2 2025, but not for the consecutive eight hours of RN coverage. Interview on 8/21/25 at 12:45 p.m. with business office manager (BOM) H regarding PBJ submission and RN coverage. *She started in January. *Administrator A had assisted her in the submission of the Q2 2025 PBJ data to CMS. *She does the scheduling and was aware that a skilled nursing facility needed RN coverage 7 days a week, but was not aware that a nursing facility that was not skilled did also. Review of licensed nurse schedule from 8/1/25 through 8/24/25 and interview on 8/26/25 at 3:05 p.m. with BOM H revealed there were three days with no RN coverage, 8/9/25, 8/17/25, and 8/24/25. Review of licensed nurse schedule from 8/1/25 through 8/24/25 and interview on 8/26/25 at 3:15 p.m. with DON	F0851		

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F0851 SS = F	Continued from page 63 B confirmed there were three days with no RN coverage, 8/9/25, 8/17/25, and 8/24/25.	F0851		
F0865 SS = F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices;	F0865	F 865 Performance Improvement Plan "PIP" put in place for 14 days PRN anti-psycs and the team will deteemine if any other PIPs need to be put in place based on other citations DON or deisgnee will be incharge of the PIP DON educated on the PIP process and how to complete by Administrator or designee Caring professionals operates as the liason for the board of directors as the governing borad for the facility Administrator or designee will audit PIP in place weekly for fours weeks and monthly for two additional months and randomly thereafter until substantial compliance has been recieved Administrator or designee will report findings at QAPI meetings for their review and guidance until substantial compliance has been reached as determined by the QAPI committee	10/10/25

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F0865 SS = F	Continued from page 64 §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect.	F0865		

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F0865 SS = F	Continued from page 65 §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to maintain an effective, ongoing quality assurance and performance improvement (QAPI) program regarding quality of care and outcomes to ensure: *A performance improvement plan (PIP) was implemented, actions were taken, and improvements were evaluated for the high-risk and problem-prone areas identified. This included the 14-day as needed psychotropic medication stop dates, missing consent forms, and the assessment tools used to monitor adverse side effects in residents taking psychotropic medications. *Governing board member oversight of the facility's QAPI program. Findings include: 1. Interview on 8/21/25 at 10:05 a.m. and again on 8/25/25 at 2:44 p.m. with director of nursing (DON) B revealed: *She stated that residents receiving as needed psychotropic medications ordered by physicians must have a visit by the physician and be reassessed for the as needed medication order renewals every 14 days. *The pharmacy would send a message to the physician on HUCU (a confidential communication platform) regarding new prescription orders, including any as needed psychotropic medications that may be required. *She stated that no progress note would be completed at that time for the resident.	F0865		

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F0865 SS = F	Continued from page 66 *The physician's office staff would add the resident to the next scheduled rounds for the physician to assess the resident and complete the progress note. *She stated the "pharmacy was not tracking the 14-day renewals consistently." *She stated, "consultant pharmacist D was only reviewing them when in the facility to complete resident chart reviews." *DON B stated that the 14-day stop dates for as needed psychotropic medications had been identified by her as a problem over the past few months. *DON B had no process in place before July 2025 to monitor medications that required 14-day renewals. *She stated she was now using a desk calendar to track the medications, but "the process was not the best." -She expected herself to audit the medications that required 14-day renewals every two weeks. *She confirmed that some psychotropic as needed medication stop dates were entered as "indefinite" and that no 14-day stop dates were entered when the orders were entered into the EMR system. *She confirmed that some residents' medications with a 14-day stop date requirement had continued to be given beyond 14 days. *A psychotropic risk assessment tool was not utilized routinely for residents on psychotropic medications to monitor for adverse side effects. *She stated, "the order to monitor for side effects in place on the resident's treatment administration record (TAR) was not an assessment." *DON B stated she would only complete an AIMS assessment when recommended by consultant pharmacist D. *DON B confirmed that psychotropic medication consent forms were not completed or updated as they should be for residents (1, 6, 7, 13, 18, 21, 23, 26, and 30) on psychotropic medications. *She stated that the facility currently had no "psychotropic medication" policy and was unable to provide a related policy for review. *DON B provided a toolkit packet from the American	F0865		

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F0865 SS = F	Continued from page 67 Health Care Association (AHCA) and the National Center for Assisted Living (NCAL) titled "Clinical Considerations of Antipsychotic Medication Management". -She used the toolkit as a guide. *She stated that the process for psychotropic medications needed improvement. *She confirmed that the 14-day stop dates for as needed psychotropic medications and the process for monitoring adverse effects using an AIMS assessment were neither reported nor tracked in the facility's QAPI program. 2. Interview and observation on 8/25/25 at 12:05 p.m. with DON B regarding the provider's QAPI binders and process revealed: *The facility conducted monthly QAPI meetings with committee members. *Each department member on the committee was expected to attend the monthly meetings. *Each committee member was expected to bring a report of the information they monitored. *She stated that an acting board oversaw the facility, but no board member was assigned to review and acknowledge the facility policies and procedures or to oversee the QAPI program. *She stated that the QAPI committee had not yet implemented a PIP into the QAPI process that had been identified. *Review of Administrator A's QAPI binder confirmed that there was no clear PIP plan, including the process, procedure, and expected improvement outcomes, recorded or maintained for the high-risk and problem-prone areas that were identified with the 14-day as needed psychotropic medication stop dates, consents, and the assessment tools. -It was verified that no reports by MD C were maintained in Administrator A's binder. -It was verified that committee members' reports were missing from Administrator A's binder in various months. *She stated she was auditing nurse documentation as part of a PIP, but she did not record the necessary	F0865		

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F0865 SS = F	Continued from page 68 information to identify the results. *She did not report her information at the scheduled QAPI monthly meetings. *Review of DON B's PIP binder confirmed there was no clear process to measure improvement outcomes. -Clear and consistent data was not recorded or maintained in DON B's QAPI binder 3. Interview on 8/21/25 at 11:00 a.m. with Minimum Data Set (MDS) nurse/assistant director of nursing (ADON) E revealed: *She did not complete an AIMS assessment for residents during their MDS assessment time frames. *She agreed and confirmed that AIMS assessments should be completed with residents on psychotropic medications to monitor for adverse side effects. 4. Telephone interview on 8/26/2025 at 11:06 a.m. with consultant pharmacist D revealed: *She completed monthly resident chart reviews. *She made nursing and physician recommendations for dose reductions, discontinuations, renewals, labs, and reviewed departmental progress notes. *She stated, "I take responsibility for monitoring the 14-day renewals and stop dates for the as-needed psychotropic medications when I am at the facility." *Her process was to email DON B her recommendation report monthly with her findings, which would have included medications that needed to be addressed. -The report could include psychotropic medications that would need a 14-day renewal or discontinuation. *She stated that it would take 30 days or longer for MD C to respond to her recommendations. 5. Telephone interview on 8/26/25 at 11:34 a.m. with MD C revealed: *Monthly medication reviews were conducted each month. *He was unable to provide any guidance regarding the	F0865		

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F0865 SS = F	Continued from page 69 14-day stop dates for as needed psychotropic medications. *He stated that he would like "the rules sent to him that showed an assessment was needed to be re-done with renewing medications." *MD C provided no other information regarding his active involvement in the facility's QAPI process. 6. Administrator A was out of the facility and not available for an interview throughout the survey. 7. Review of the provider's 2023 Director of Nursing job description revealed: *"Planning, organizing, developing and directing the overall operations of the Nursing Service Department in accordance with local, state and federal standards and regulations, established facility policies and procedures and as may be directed by the Administrator and the Medical Director, to provide appropriate care and services to the residents." *"Plans, develops, organizes, implements, evaluates and directs the overall operations of the Nursing Services department, as well as its programs and activities, in accordance with current state and federal laws and regulations." *Acts in an administrative capacity in the absence of the Administrator." 8. Review of the provider's 2023 Administrator job description revealed: *"Leads, guides and directs the operations of the healthcare facility in accordance with local, state and federal regulations, standards and established facility policies and procedures to provide appropriate care and services to residents." *"Plans, develops, organizes, implements, evaluates and directs the overall operation of the facility as well as its programs and activities, in accordance with current state and federal laws and regulations." 9. Review of the provider's 2023 Business Office Manager job description revealed:	F0865		

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F0865 SS = F	Continued from page 70 *Participates in QAPI or facility assessment activities as needed, such as carrying out duties assigned as part of the performance improvement committee. 10. Review of the provider's December 2023 Medical Director Physician Agreement revealed: *"AGREEMENT," *"1. Obligations of Physician." *"1.1 Services." -"...Physician agrees to perform the duties and responsibilities set forth in Exhibit A..." -"Physician agrees to serve on the QA [Quality Assurance] Committee of the Facility..." -"Physician shall participate in QA Committee services and functions in accordance with all applicable requirements of federal, state, local and/or Facility laws..." -"...Physician shall report to the administrator of the Facility..." *"1.3 Records and Reports." -"(a) Physician acknowledges and agrees....Physician participating in any QA Committee scheduled..." –"...Record of participation in QA Committee meetings shall be kept as required..." -"(b) Physician shall prepare reports and other records related to Physician's activities..." *"EXIBIT A," *"DUTIES AND RESPONSIBILITIES," *"A. ...Physician's duties and responsibilities shall include, but are not limited to:" -"1. Monitoring medical care in the Facility to assist Facility in providing adequate and appropriate medical services to the patients in the Facility..." --"(a) providing consultation to the QA Committee in matters relating to patient care services;" --"(c) evaluating reports of inadequate medical care, including drug irregularities, and advising on	F0865		

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F0865 SS = F	Continued from page 71 appropriate corrective steps to correct any identified concerns;" -"2. Assisting in the development of and ensuring the implementation of patient care policies, which policies shall include, without limitations:" --"(c) policies on use of restraints;" --"(g) policies regarding ancillary services, such as laboratory, radiology, and pharmacy:" --"(h) policies regarding use of medications:" --"(j) policies regarding overall quality of care." -"3. Participating in Facility's development of a system to assure that a medical care plan is prepared for each patient which covers medications, nursing care, restorative services, client and other services, and, if appropriate, a plan for discharge." -"4. Assisting Facility in the development and implementation of effective patient care utilization review..." -"5. Consulting with the Administrator and the director of nursing services in monitoring the adequacy of both the nursing staff and the Facility to meet the psychosocial as well as the medical and physical needs of patients." -"...9. Consulting with the Administrator as to recommendations, proposed plans for implementation, and continuing assessments of, the clinical care of patients, through the QA Committee process..." *"B. Physician agrees to abide by all Facility policies and procedures in performing Physician's duties hereunder..." 11. Review of the provider's December 2023 Quality Assessment and Assurance (QAA) Committee policy revealed: *"Policy:" *"[The facility] will employ a Quality Assessment and Assurance (QAA) Committee that will act as the responsible Interdisciplinary Team for all facility practice, function, and review." *"Policy Explanation and Compliance Guidelines:"	F0865		

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F0865 SS = F	Continued from page 72 -"1. Quality Assessment and Assurance committee members will meet monthly to review all aspects of business within each department." -"2. Quality Assessment and Assurance Chair will review old business and any other outstanding projects or QAPI plans." -"3. Committee members will provide written review of each item of business and provide minutes/reports to Committee chair."	F0865		
F0868 SS = E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee.	F0868	F 868 MD will participate in QAA meetings at least quarterly MD will participate in review and make recommendations for and approve policies and proceedures MD was educated on the responsibilties of medical director respondsibilities by adminstrator or designee Administrator or designee will audit MD attenance in QAA quarterly for three quarters and randomly thereafter until substantial compliance has been received Administrator or designee will present findings at QAPI meetings for their review and guidance until substantial compliance has been reached as determined by QAPI committee	10/10/25

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F0868 SS = E	Continued from page 73 The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to maintain an effective quality assessment and assurance (QAA) committee that ensured: *Medical director (MD) C, regional director (RD) T, business office manager (BOM) H, consultant pharmacist D, dietary manager (DM) U, and maintenance manager (MM) G attended the QAA/QAPI meetings at least quarterly as members of the QAA committee. *There was evidence that MD C had assisted with the development, coordination, review, and acknowledgement of the facility's QAA/QAPI policies and procedures and program overview. Findings include: 1. Interview and observation on 8/25/25 at 12:05 p.m. with DON B regarding the QAPI binders and process revealed: *The facility conducted monthly QAA/QAPI meetings with committee members. *Each department member on the committee was expected to attend the monthly meetings. -Committee member attendance was tracked for each meeting. *Each committee member was expected to bring a report of the information they monitored. *She stated that attendance by committee members needed improvement. *She stated that MD C had not attended the meetings regularly and was not highly involved in the process. *She stated that an acting board oversaw the facility, but no board member was assigned to review and acknowledge the facility policies and procedures or oversee the QAA/QAPI program.	F0868		

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F0868 SS = E	Continued from page 74 *It was verified that no reports by MD C were maintained in Administrator A's binder. *It was verified that committee members' reports were missing from Administrator A's binder in various months. 2. Review of the provider's QAA/QAPI meetings attendance records from February 2025 through July 2025 revealed: *Attendance was marked with a check next to each committee member's name if they attended the meeting. *There was no documentation on the attendance record that indicated MD C attended any meetings during the six-month period reviewed. *There was no documentation on the attendance record that indicated dietary manager (DM) U attended any meetings during the six-month period reviewed. *It was documented that RD T attended one meeting in March 2025 during the six-month period reviewed. *It was documented that MM G attended one meeting in March 2025 during the six-month period reviewed. *It was documented that BOM H attended one meeting in July 2025 during the six-month period reviewed. *It was documented that consultant pharmacist D attended one meeting in July 2025 during the six-month period reviewed. * The other committee members regularly attended meetings. *DON B confirmed that neither MD C nor a board member discussed, reviewed, or signed the facility's policies and procedures to acknowledge approval during scheduled board or QAA/QAPI meetings. 3. Telephone interview on 8/26/25 at 11:34 a.m. with MD C revealed: *He did not know if he had attended the last six months of the QAA/QAPI meetings, and stated, "he would have to check his calendar." *MD C provided no other information regarding his	F0868		

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F0868 SS = E	Continued from page 75 active involvement in the facility's QAA/QAPI process. 4. Administrator A was out of the facility and not available for an interview throughout the survey. 5. Review of the provider's 2023 Director of Nursing job description revealed: *"Planning, organizing, developing and directing the overall operations of the Nursing Service Department in accordance with local, state and federal standards and regulations, established facility policies and procedures and as may be directed by the Administrator and the Medical Director, to provide appropriate care and services to the residents." *"Plans, develops, organizes, implements, evaluates and directs the overall operations of the Nursing Services department, as well as its programs and activities, in accordance with current state and federal laws and regulations." 6. Review of the provider's 2023 Administrator job description revealed: *"Leads, guides and directs the operations of the healthcare facility in accordance with local, state and federal regulations, standards and established facility policies and procedures to provide appropriate care and services to residents." *"Plans, develops, organizes, implements, evaluates, and directs the overall operation of the facility as well as its programs and activities, in accordance with current state and federal laws and regulations." 7. Review of the provider's 2023 Business Office Manager job description revealed: *Participates in QAPI or facility assessment activities as needed, such as carrying out duties assigned as part of the performance improvement committee. 8. Review of the provider's December 2023 Medical Director Physician Agreement revealed: *"AGREEMENT," *"1.1 Services."	F0868		

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F0868 SS = E	Continued from page 76 -"…Physician agrees to perform the duties and responsibilities set forth in Exhibit A…" -"Physician agrees to serve on the QA [Quality Assurance] Committee of the Facility…" -"Physician shall participate in QA Committee services and functions in accordance with all applicable requirements of federal, state, local and/or Facility laws…" *"1.3 Records and Reports." -"(a) Physician acknowledges and agrees….Physician participating in any QA Committee scheduled…" –"…Record of participation in QA Committee meetings shall be kept as required…" -"(b) Physician shall prepare reports and other records related to Physician's activities…" *"DUTIES AND RESPONSIBILITIES," *"A. …Physician's duties and responsibilities shall include, but are not limited to:" --"(a) providing consultation to the QA Committee in matters relating to patient care services;" --"(c) evaluating reports of inadequate medical care, including drug irregularities, and advising on appropriate corrective steps to correct any identified concerns;" -"2. Assisting in the development of and ensuring the implementation of patient care policies, which policies shall include..." -"…9. Consulting with the Administrator as to recommendations, proposed plans for implementation, and continuing assessments of, the clinical care of patients, through the QA Committee process…" 9. Review of the provider's December 2023 Quality Assessment and Assurance (QAA) Committee policy revealed: *"Policy:" *"[The facility] will employ a Quality Assessment and Assurance (QAA) Committee that will act as the responsible Interdisciplinary Team for all facility	F0868		

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F0868 SS = E	Continued from page 77 practice, function, and review." *"Policy Explanation and Compliance Guidelines:" -"1. Quality Assessment and Assurance committee members will meet monthly to review all aspects of business within each department." -"2. Quality Assessment and Assurance Chair will review old business and any other outstanding projects or QAPI plans." -"3. Committee members will provide written review of each item of business and provide minutes/reports to Committee chair." -"4. Committee members will participate in Quarterly QA meetings which will include all ancillary staff, RD, and Medical Director." *"Committee Members (Interdisciplinary Team is subject to change with notification to Committee Chair)." -"Committee Chair/President-Administrator A." -"Committee Vice-DON B." -"Business Office-BOM H." -"Social Services/Activities-SSD F." -"Maintenance/Environmental Services-MM G." *"Ancillary Staff:" -"Medical Director C." -"Caring Professionals Regional Director T." -"Pharmacy consultant H." -"Registered Dietician V." -"Dietary Manager U."	F0868		
F0880 SS = F	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	F0880		

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F0880 SS = F	Continued from page 78 prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F0880	F 880 Legionella plan put in place All staff educated on legionella polciy Policy and proceedure on legionella reviewed, revised or created by interdisciplinary team Maintenance director or designee will audit completion of legionella plan weeky for four weeks and monthly for two additional months and randomly thereafter until substantial compliance has been received Maintenance director or designne will report findings at QAPI meetings for their review and guidance until substantial has been has been determined by the QAPI committee	10/10/25

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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
F0880 SS = F	Continued from page 79 §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 interview, record review, and policy review, the provider failed to ensure infection control practices and facility policies were followed regarding the assessment for the risk of Legionella (bacteria that can grow in water and cause serious illness), the implementation of measures to prevent the growth of Legionella, and the establishment of testing protocols for Legionella. Findings include: 1. Interview on 8/26/25 at 10:01 a.m. with director of nursing (DON) B revealed: *There was a hallway in the facility that was not currently occupied by residents. *That hallway had eight rooms in it. *Two of those rooms were currently being used by contracted travel staff, and the remaining rooms were vacant. *She did not know if the water in the vacant rooms was being flushed to avoid stagnant water in the pipes. *She did not know if there was a water flow map for the facility to identify areas where Legionella could grow and spread. *Maintenance manager (MM) G would be responsible for the provider's water management program. *There had been no cases of Legionella infections	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A140	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

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F0880 SS = F	Continued from page 80 identified at the facility. 2. Interview on 8/26/25 at 10:38 a.m. with MM G about the provider's water management program to prevent waterborne pathogens revealed: *The water systems had not been assessed to determine where Legionella or other opportunistic pathogens could grow. *No measures had been implemented to prevent the growth of Legionella in the facility. *Testing protocols to monitor for the presence of Legionella in the facility's water system had not been followed as indicated in their policy. *He was not aware of the need to routinely flush water in vacant rooms to avoid stagnant water and potential growth of waterborne pathogens such as Legionella in the pipes. 3. Review of the facility's 2023 Legionella Surveillance policy revealed: *"Policy -It is the policy of this facility to establish primary and secondary strategies for the prevention and control of Legionella infections." *"Definitions: -Primary prevention strategy refers to the approaches to prevention and control of Legionella infections in health care facilities with no identified cases." *"Policy Explanation and Compliance Guidelines -Legionella surveillance is one component of the facility's water management plans for reducing the risk of Legionella and other opportunistic pathogens in the facility's water systems. -In the absence of Legionella infections for a period of at least one year, the facility shall implement primary prevention strategies." *"Principles of Legionella transmission:" -"Legionella grows best in water temperatures of 77 degrees Fahrenheit to 108 degrees Fahrenheit,	F0880		

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F0880 SS = F	Continued from page 81 particularly in water that is not moving or that does not have enough disinfectant (i.e. pH 6.5-8.5) to kill germs." *"Primary prevention strategies: -Diagnostic testing: --The facility will test the water supply inside the facility annually." -"Temperature controls: --Cold water shall be stored and distributed below 68 degrees Fahrenheit. --Hot water shall be stored above 140 degrees Fahrenheit and circulated at a minimum return temperature of 124 degrees Fahrenheit."	F0880		
F0909 SS = D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the provider failed to ensure the bed/side rails for three of three sampled residents (3, 5, and 8) who had side rails on their beds were inspected for safety, including entrapment (being caught between bed system parts) risk, before being placed on the residents' beds and were monitored after installation to ensure they were maintained in safe conditions for use and free of entrapment risks. Findings include: 1. Observation on 8/20/25 at 2:48 p.m. with resident 5 revealed her bed had one-fourth-size side rails attached to the sides of her bed, and they were in the up position. 2. Observation and interview on 8/21/25 at 10:45 a.m. with resident 8 revealed her bed had a side rail on the right side of her bed, in the up position.	F0909	F 909 Residents 3,5 and 8 bed rails assessed for safety All other residents bed rails assessed for safety Maintenance director educated on bed rails safety Polcies and proceedures for bed rails reviewed, revised or created as necessary by interdisciplinary team Bed rail checks including entrapment risk and other possible dangers to a resident added to maintenance director PM schedule Maintenance director or designee will audit bed rails inculding risk of entrapment and other dangers for residents weekly for weeks and monthly for two additional months and randomly thereafter until substantial compliance has been received Maintenance director or designee will report findings at QAPI meetings for their review and guidance until substantial compliance has been reached as determined by the QAPI committee	10/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A140	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

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F0909 SS = D	Continued from page 82 3. Observation on 8/25/25 at 10:20 a.m. with resident 3 revealed the right side of her bed had a side rail attached to it, and it was in the up position. 4. Interview on 8/25/25 at 12:35 p.m. with maintenance manager G revealed: *When the nursing department notified him that a resident wanted side rails attached to their bed, he would install side rails to that resident's bed. *He had not performed routine maintenance or checked to ensure the safety of the side rails on resident beds, including entrapment. Administrator A was not in the facility and not available for an interview throughout the survey. 5. Review of the provider's 12/2023 Proper Use of Bed Rails policy revealed: *"If bed rails are used, the facility ensures correct installation, use, and maintenance of the rails." -"Assessment of the resident, the bed, the mattress, and rail for entrapment risk (which would include ensuring bed dimensions are appropriate for resident size/weight". *"The facility will assure the correct installation and maintenance of bed rails, prior to use. This includes: -a. Checking with the manufacturer(s) to make sure the bed rails, mattress, and bed frames are compatible. -b. Ensuring that the bed's dimensions are appropriate for the resident by:" -"Inspecting and regularly checking the mattress and bed rails for areas of possible entrapment".	F0909		

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E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 8/21/2025. Custer Care and Rehab Center was found not in compliance with the following requirement(s): E0006.	E0000		
E0006 SS = D	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.	E0006	E0006 Ensured the completion of an all hazard risk assessment	10/10/25

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Samuel Van Voorst	Regional Administrator	9/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A140	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

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E0006 SS = D	Continued from page 1 (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This STANDARD is NOT MET as evidenced by: Based on record review and interview on 8/21/2025, the provider has not developed an all-hazards risk assessment as required by E0006. Findings included:Interview on 8/21/2025 at 2:00 p.m. with the Director of Nursing and Facility Manager, both members of the provider's emergency preparedness board, revealed that the facility's emergency plan did not include an all-hazards risk assessment. Neither the Director of Nursing nor the Facility Manger were able to provide instruction on where or when such a process was performed, documented, or the resulting document developed.There was no evidence identified within the provided emergency preparedness binder indicating that an all-hazards risk assessment had been developed.	E0006		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A140	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

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K0000	INITIAL COMMENTS A recertification survey was conducted on 8/21/2025 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Custer Care and Rehab Center was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K0922 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0919 SS = D Bldg. 01	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider has failed to consider various safety requirements in the location of a new LP-Gas tank serving the facility backup electrical generator. Those requirements include:NFPA 99 (2012) 6.4.1.1.2 requires the provider to consider in the design of the [electrical] distribution systems the "(3) stability and power capability of the prime mover [generator] during and after normal conditions." This is interpreted to include "careful consideration ... given to the location of the spaces housing the components of the essential electrical system to minimize interruptions caused by natural forces common to the area (e.g., storms, floods, or earthquakes; or hazards created by adjoining structures or activities)." NFPA 110 (2010) 7.2.4 requires "minimizing the possibility of damage resulting from interruptions of the emergency source	K0919	K 919 Relocated generator power supply to greater than 10 ft from generator/ source of ignition	10/10/25

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Samuel Van Voorst	Regional Administrator	9/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A140	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

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K0919 SS = D Bldg. 01	Continued from page 1 shall be a design consideration of the EPSS [emergency power supply system] equipment."NFPA 58 (2011) 6.3.9 requires a minimum distance of 10 feet between "the container filling connection to exterior sources of ignition" (e.g., a generator).NFPA 58 (2011) 6.5.3 requires a minimum horizontal distance between the point of LP-Gas transfer and public ways, including throughfares and sidewalks, to be 10 feet, and driveways to be 5 feet.NFPA 58 (2011) 6.6.1.2 requires "LP-Gas containers or systems of which they are a part shall be protected from damage from vehicles." Findings included: Observation and interview on 8/21/2025 at 11:35 a.m. with the Facility Manager revealed a 500-gallon LP fuel tank located within 10 feet from the facility backup electrical generator.The fuel tank was located within the rear facility driveway/parking lot, violating the 5-foot minimum horizontal distance between a fuel tank and a driveway required by NFPA 58 (2011) 6.5.3. The fuel tank was protected by a makeshift barrier system, which does not satisfy the requirement of NFPA 58 (2011) 6.6.1.2, since it allowed the potential for a vehicle to drive through or over the barrier system while traversing the driveway. The location of the fuel tank also made it susceptible to vandalism as well as fire or explosion while filling the tank due to its proximity (less than 10 feet) to an exterior source of ignition (backup electrical generator), violating NFPA 99 (2012) 6.4.1.1.2, NFPA 110 (2010) 7.2.4, and NFPA 58 (2011) 6.3.9.Interview with the Facility Manager at the time of the above observations confirmed the findings.The deficiency affected 100% of the facility patients, employees, and suppliers who park, walk, get dropped off, or deliver supplies on or near the rear facility driveway/parking lot since the new tank was put into service in 2019.	K0919		

South Dakota Department of Health

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	80076	A. BUILDING: _____ B. WING _____	08/26/2025

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 8/19/25 through 8/21/25 and from 8/25/25 through 8/26/25. Custer Care and Rehab Center was found in compliance.	S 000		
S 000	Compliance/noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/19/25 through 8/21/25 and from 8/25/25 through 8/26/25. Custer Care and Rehab Center was found not in compliance with the following requirements: S206, S210, S235, S236, S239, and S240.	S 000		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. All healthcare personnel must complete the orientation program within thirty days of hire and the ongoing education program annually thereafter. The orientation program and ongoing education program must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory	S 206	S 206 Ensure that employees B, K, O, and P get orientation training completed by BOM Ensured all other employees had orientation training completed Ensured employee Q will have annual training completed Ensured all other employees had annual training completed Administrator or designee reviewed orientation process with BOM Policy and proceedures for employee training reviewed, revised or created by interdiscplinary team BOM or designee will audit new staff training recieved within 30 days weekly for four weeks and monthly for two additional months and randomly thereafter until substantial compliance has been received BOM or designee will audit annual staff training completion weekly for four weeks and monthly for two additional months and randomly thereafter until substantial compliance has been received BOM or designee will report findings as QAPI meetings for their review and guidance until substantial compliance has been reached as determined by the QAPI committee	10/10/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Samuel Van Voorst — TITLE: Regional Administrator — (X6) DATE: 10/8/25

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	80076	A. BUILDING: _____ B. WING _____	08/26/2025

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S 206	Continued From page 1 reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; (11) Abuse and neglect; and (12) Advanced directives. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section. The facility shall provide additional personnel education based on the facility's identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee record review and interview, the provider failed to ensure: *Four of four sampled employees (B, K, O, and P) had completed the required orientation training topics within 30 days of hire. *One of one sampled employee (Q) had completed the required annual training topics: Findings include: 1. Review of activity assistant O's employee file revealed she: *Was hired on 4/18/25. *Had not completed the following required orientation training topics within 30 days of hire: -Fire prevention and response. -Emergency preparedness procedures. -Accident prevention and safety procedures. -Infection prevention and control. -Proper restraint use. -Resident rights. -Confidentiality of resident information.	S 206		

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	80076	A. BUILDING: _____ B. WING _____	08/26/2025

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S 206	Continued From page 2 -Mandatory reporting for incidents and diseases. -Care of residents with unique needs. -Dining assistance, nutritional risks, and hydration. -Abuse, neglect, misappropriation of property, and mistreatment. -Advanced directives. 2. Review of unlicensed medication aide (UMA) K's employee file revealed she: *Was hired on 4/21/25. *Had not completed the following required orientation training topics within 30 days of hire: -Fire prevention and response. -Emergency preparedness procedures. -Accident prevention and safety procedures. -Proper restraint use. -Resident rights. -Confidentiality of resident information. -Mandatory reporting for incidents and diseases. -Care of residents with unique needs. -Dining assistance, nutritional risks, and hydration. -Abuse, neglect, misappropriation of property, and mistreatment. -Advanced directives. -Abuse, neglect, misappropriation of property, and mistreatment. -Advanced directives. 3. Review of registered nurse (RN) P's employee file revealed she: *Was hired on 5/1/24. *Had not completed the following required orientation training topics within 30 days of hire: -Mandatory reporting for incidents and diseases. -Abuse, neglect, misappropriation of property, and mistreatment. 4. Review of director of nursing (DON) B's	S 206		

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	80076	A. BUILDING: _____ B. WING _____	08/26/2025

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S 206	Continued From page 3	S 206		

employee file revealed she:
*Was hired on 5/1/24.
*Had not completed the following required orientation training topics within 30 days of hire:
-Mandatory reporting for incidents and diseases.
-Abuse, neglect, misappropriation of property, and mistreatment.

5. Review of certified nurse aide (CNA) Q's employee file revealed she:
*Was hired on 12/7/23.
*Had not completed the following required ongoing training topics within the last twelve months (annually):
-Fire prevention and response.
-Emergency preparedness procedures.
-Accident prevention and safety procedures.
-Proper restraint use.
-Resident rights.
-Mandatory reporting for incidents and diseases.
-Abuse, neglect, misappropriation of property, and mistreatment.
-Advanced directives.
-Abuse, neglect, misappropriation of property, and mistreatment.
-Advanced directives.

6. Interview on 8/21/25 at 1:45 p.m. with business office manager (BOM) H regarding employee required training revealed:
*She was uncertain who was responsible for ensuring that orientation training and ongoing annual training was completed.
*She maintained the employee personnel files in her office.
*She was aware DON B had monthly staff meetings for the nursing department and thought some of the trainings might be covered during those meetings.
-She indicated DON B maintained the records of

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S 206	Continued From page 4	S 206		

those meetings in her office.
*Activity assistant O had not completed any of the required training, as her position did not receive any of the required training.
-BOM H stated that administrator A would know why no training was provided to activity assistants.
*They had not utilized a standardized annual education service to educate all their employees on the required topics annually.
*She could not provide documentation that employees B, K, O, and P, had received the required education within 30 days of hire.
*She could not provide documentation that employee Q had received the required education annually.

7. Interview and record review on 8/26/25 at 11:00 a.m. with DON B regarding required employee education revealed:
*She was not aware of a formal training program for employees.
*She had developed a monthly schedule of required training topics for the nursing department.
*Advanced directives and end-of-life care were presented at the 8/2025 nursing department staff meeting.
-There was no documentation of the day of the month the meeting occurred on the employee signature form.
-Seven of nineteen nursing employees attended that meeting.
*No other required training had occurred at the monthly nursing department meetings.
*She could not provide documentation that nursing department employees B, K, and P, had received the required education within 30 days of hire.
*She could not provide documentation that RN

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S 206	Continued From page 5 employee Q had received the required education annually. 8. Administrator A was out of the facility and not available for an interview throughout the survey.	S 206		
S 210	44:73:04:06 Personnel Health Program The facility shall have a personnel health program for the protection of the residents. Before assignment to duties or within fourteen days after employment, a licensed health professional must evaluate all personnel to ensure no personnel is infected with any reportable communicable disease that poses a threat to others. The evaluation must include an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease that may endanger the health of residents, and fellow personnel may not return to duty until the personnel is determined by a physician, physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee record review and interview, the provider failed to ensure the completion of a health evaluation within fourteen days of employment for five of five sampled employees (B, H, K, O, and P). Findings include:	S 210	S 210 Ensured health evaluations will be completed for employees B, H, K, O, and P Ensured health evaluations will be completed for all other staff BOM will be educated on new hire process and requirements by administrator Policies and proceedures for new employee hires reviewed, revised and created as necessary by interdisciplinary team BOM or designee will audit new staff members having health evaluation completed within 14 days of hire weekly for four weeks and monthly for two additional months and randomly thereafter until substantial compliance has been received BOM or designee will report findings at QAPI meetings for their review and guidance until substantial compliance has been reached as determined by the QAPI committee	10/10/25

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S 210	Continued From page 6 1. Review of director of nursing (DON) B's employee file revealed she was hired on 5/1/24. 2. Review of registered nurse (RN) P's employee file revealed she was hired on 5/1/24. 3. Review of activity assistant O's employee file revealed she was hired on 4/18/25. 4. Review of unlicensed medication aide (UMA) K's employee file revealed she was hired on 4/21/25. 5. Review of business office manager (BOM) H's employee file revealed she was hired on 10/16/24. 6. Interview on 8/21/25 at 1:45 p.m. with BOM H regarding employee health evaluations revealed she: *Was hired on 10/16/24 and did not have a health evaluation completed upon hire, and thought that was unusual. -She had not asked anyone about that. *Stated that none of the employees had a health evaluation completed upon their hire. *Maintained the employee personnel files in her office. 7. Interview and record review on 8/26/25 at 11:03 a.m. with DON B regarding employee health evaluations revealed: *No employee health evaluations were completed. *She was not aware they needed to be completed. *She was unable to locate a policy regarding the completion of employee health evaluations.	S 210		

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S 210	Continued From page 7 8. Administrator A was out of the facility and not available for an interview throughout the survey.	S 210		
S 235	44:73:04:12 Tuberculin Screening Requirements Each facility shall develop criteria to screen healthcare personnel and residents for Mycobacterium tuberculosis (TB) based on the Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019. Each facility shall establish policies and procedures for conducting TB risk assessments that include responsibility, surveillance, and containment. The frequency of repeat screenings depend upon annual risk assessments conducted by the facility. Any resident identified as asymptomatic upon admission with an anticipated stay of thirty days or less is not required to have a tuberculin skin test or a TB blood assay test. This Administrative Rule of South Dakota is not met as evidenced by: Based on the interview, the provider failed to ensure a policy was developed for conducting tuberculin (TB) risk assessments that included responsibility, surveillance, and containment. Findings include: 1. Interview with director of nursing (DON) B regarding the provider's TB policy revealed she was unable to locate a TB policy. 2. Administrator A was out of the facility and not available for an interview during the survey.	S 235	S 235 Policy created for conducting TB risk assessments by interdisciplinary team BOM and DON will be educated on Tb risk asssments by administrator or designee TB risk assessment completed Adminstrator or designee will audit for completed TB risk assessments monthly for three months and randomly there after until substantial compliance has been received Administrator or designee will report findings a QAPI meetins for their review and guidance until substantial compliance has been reached a determined by the QAPI committee	10/10/25

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S 236	Continued From page 8	S 236		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare personnel or residents are as follows: (1) Each new healthcare personnel or resident shall receive an initial individual TB risk assessment and the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within twenty-one days of employment or admission to a facility. The qualified personnel must record the assessment and the test in the employee's record or the resident's medical record. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of admission or employment is considered a two-step test. A TB blood assay test completed within a twelve-month period prior to the date of admission or employment is an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare personnel or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin testing having been completed within the prior twelve months. Skin testing or a TB blood assay test is not necessary if documentation is provided by the transferring healthcare facility, healthcare personnel, or resident, of a previous positive reaction to either test. Any new healthcare personnel or resident who has a newly recognized positive reaction to the skin test or TB blood assay test must have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;	S 236	S 236 Ensured employee O had two-step TB screening completed Endsured all other employees had a two-step TB Screening completed Ensured resident 8 had two-step TB screening completed Ensured all other residents had two-step screening completed Educated BOM and DON on completion of TB screenings by Administrator or designee Policies and proceedures reviewed, revised or created on new hire requirements by interdisciplinary team Policies and proceedures reviewed, revised or created on new admission requirements by interdisciplinary team BOM or designee will audit completion of new hire TB screens within 21 days of hire weekly for four weeks and monthly for two additional months and randomly therafter until substantial compliance has been received BOM or designee will audit completion of new admission TB screens within 21 days of admission weekly for four weeks nad monthly for two additional months and randomly thereafter until substantial compliance has been received BOM or designee will report findings at QAPI meetings for their review and guidance until substantial compliance has been reached as determined by the QAPI committee	10/10/25

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S 236	Continued From page 9 This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure one of five sampled employees (O) had a two-step tuberculin (TB) screening skin test completed within 21 days after her hire, and one of five sampled residents (8) had received a two-step TB screening skin test within 21 days of her admission, to determine if they had a positive reaction to TB test to determine the possible presence of the TB disease. Findings include: 1. Review of activity assistant O's employee record revealed: *She was hired on 4/18/25. *The documentation in her record revealed she had received the first dose of her TB screening skin test on 7/29/25, and the test result was not read. -Her second dose was administered on 8/11/25 and was read on 8/14/25. -This was outside of the 21-day requirement. 2. Review of resident 8's medical record revealed: *She was admitted on 10/25/24. *The documentation in her record revealed she had not received a two-step TB screening skin test within 21 days of her admission. *There was no documentation to support her representative was contacted to request consent for the TB skin test. 3. Interview on 8/26/25 at 11:08 a.m. with director of nursing (DON) B revealed: *The completion of the residents' and employees' TB screening test was assigned to the charge	S 236		

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S 236	Continued From page 10 nurse on duty and was to be documented. *She was not aware that employee O's first dose of her TB screening skin test had not been read. *She was unsure of why employee O's TB screening skin test was completed outside of the 21-day requirement. *She was aware resident 8's TB screening skin test had not been completed. -She stated attempts had been made to contact resident 8's representative to obtain consent for the TB skin test, but the representative had not responded. Those attempts had not been documented in resident 8's medical record. *She was unable to locate a TB screening skin test policy and was not aware of one 4. Administrator A was out of the facility and not available for an interview throughout the survey.	S 236		
S 239	44:73:04:12(4) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare personnel or residents are as follows: (4) Each healthcare personnel or resident identified at increased risk for TB because of an occupational risk or current or planned immunosuppression shall receive an annual TB risk screening. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, the provider failed to ensure that healthcare personnel and residents received an annual tuberculin (TB) risk screening. Findings include: 1. Interview on 8/26/25 at 11:08 a.m. with director	S 239	S 239 Annual TB risk assessment will be completed for facility the administrator or designee BOM and DON educated on TB risk assessment by administrator or designee TB risk assessment added to QAPI agenda for review and ensuring done annually	

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S 239	Continued From page 11 of nursing (DON) B regarding annual TB risk screening for employees and residents revealed, she was: *Not aware of that requirement and no annual TB risk screening for employees and residents had been completed. *Unable to locate a TB policy, and was not aware of one. 2. Administrator A was out of the facility and not available for an interview throughout the survey.	S 239		
S 240	44:73:04:12:01 Tuberculosis Education-Healthcare Personnel A facility shall provide yearly education to all healthcare personnel on TB risk factors, the signs and symptoms of TB, and the TB infection control policies and procedures of the facility. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, the provider failed to ensure that employees received annual education on tuberculin (TB) risk factors, signs and symptoms of TB, and TB policies and procedures. Findings include: 1. Interview on 8/26/25 at 11:08 a.m. with director of nursing (DON) B regarding annual TB education for employees revealed: *She was not aware of that requirement. *Annual education on TB risk factors, signs and symptoms, and policies and procedures had not been completed for any employees. *She was unable to locate a TB policy, and was not aware of one.	S 240	S 240 Ensured all staff recieved training TB risk factors, the signs and symptoms and TB policies and proceedures by DON or designee TB polcies and proceedures reviewed, revised or created as necessary by interdisciplianry team BOM or designee will audit staff being educated on TB weekly for four weeks and monthly for two additional months and randomly thereafter until substantial compliance has been received BOM or designee will report findings at QAPI meetings for their review and guidance until substantial compliance has been reached as determined by the QAPI committee	

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S 240	Continued From page 12 2. Administrator A was out of the facility and not available for an interview throughout the survey.	S 240		