

South Dakota Department of Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>67414</b>            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/28/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALCESTER CARE AND REHAB CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>101 CHURCH ST<br/>ALCESTER, SD 57001</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X5)<br>COMPLETE<br>DATE                               |
| S 000                                                                     | Compliance Statement<br><br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 8/26/25 through 8/28/25. Alcester Care and Rehab Center was found not in compliance with the following requirement: S331.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | S 000                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                        |
| S 331                                                                     | 44:70:04:10(1) Tuberculin Screening...<br>Requirements<br><br>Tuberculin screening requirements for healthcare personnel and residents are as follows:<br><br>(1) Each healthcare personnel or resident shall receive an initial individual TB risk assessment that is documented and the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within twenty-one days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a twelve-month period prior to the date of admission or employment are considered two-step. A TB blood assay test completed within a twelve-month period prior to the date of admission or employment is an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new healthcare personnel or resident transfers from one licensed healthcare facility to another licensed healthcare facility within this state if the facility received documentation from the transferring healthcare facility, healthcare personnel, or resident, of the last skin or blood assay TB testing having been completed within the prior twelve months. Skin testing or TB blood assay tests are not necessary if documentation is provided by the transferring healthcare facility, healthcare personnel, or resident, of a previous positive reaction to either | S 331                                                                                | Unable to correct past noncompliance for resident 1 due to time requirement of completion within twenty-one days of admission. All other residents have the potential to be affected by this deficient practice.<br><br>Administrator, or designee, and interdisciplinary team will review and revise as necessary the policy and procedure for tuberculin screening for new residents on 9/15/2025.<br><br>DON, or designee, will provide education to all staff responsible for ensuring TB tests are completed in the required timeframe on 9/26/2025 and 10/03/2025.<br><br>DON, or designee, will perform audits on all new admissions to the facility to ensure there is a TB test completed timely once a week for four weeks and once per month for two more months.<br><br>DON or designee will present findings from these audits monthly for three months at the QAPI meetings for review until the QAPI committee advises to discontinue monitoring. | 10/10/2025                                             |

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

*Tiffany Miller*

TITLE

Administrator

(X6) DATE

9/15/2025

South Dakota Department of Health

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALCESTER CARE AND REHAB CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>101 CHURCH ST<br/>ALCESTER, SD 57001</b> |                                                                                                                          |                                                        |
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| S 331                                                                     | <p>Continued From page 1</p> <p>test. Any healthcare personnel or resident who has a newly recognized positive reaction to the skin or TB blood assay test must have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;</p> <p>This Administrative Rule of South Dakota is not met as evidenced by:<br/>Based on record review, interview, and policy review the provider failed to ensure one of one sampled resident (1) had a two-step Mantoux tuberculin (TB) skin test (a test used to detect latent TB infections) completed within 14 days of the resident's admission to the facility, according to the provider's policy.<br/>Findings include:</p> <p>1. Review of resident 1's electronic medical record (EMR) revealed:<br/>*He admitted to the facility on 3/11/24.<br/>*Immunization documentation listed that he had one TB skin test completed on 3/22/24 that was negative.<br/>*There was no other documentation of another TB skin test being completed.</p> <p>2. Interview on 8/27/25 at 9:08 a.m. with director of nursing (DON) A she confirmed that resident 1 only received a 1 TB skin test.</p> <p>3. Review of the provider's revised 5/18/25 Tuberculosis Policy revealed:<br/>*"To provide testing, surveillance, containment, and education on tuberculosis."<br/>*"b. Surveillance:<br/>-Each new healthcare worker or resident should receive a two-step, TST (Tuberculin Skin Test) within 14 days of employment or admission to the</p> | S 331                                                                                |                                                                                                                          |                                                        |

South Dakota Department of Health

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| S 331                                                                     | Continued From page 2<br><br>facility. If a new employee or resident can provide documentation results of a negative TST (or other diagnostic TB test) conducted within the previous 12 months, a single-step TST may be administered and be considered the second step of the two-step method. There must be documentation in the resident chart or employee file of a previous skin test if applicable." | S 331                                                                                |                                                                                                                          |                          |                                                        |