STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435122	A. BUILDING _____ B. WING _____	C 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST WILLIAM'S CARE CENTER	103 N VIOLA ST MILBANK, SD 57252

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/30/24 through 10/2/24. St William's Care Center was found not in compliance with the following requirements: F582, F625, F759, and F804. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/30/24 through 10/2/24. Areas surveyed included dietary services related to a choking incident and staff to resident abuse. St William's Care Center was found not in compliance with the following requirement: F600.	F 000		
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and	F 582		

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

Rene' Thrift | Administrator | 10/27/24

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

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F 582	Continued From page 1 periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and interview the provider failed to ensure appropriate and timely Medicare notices had been provided for two of three sampled residents (47 and 250) who discharged from skilled services. Findings include:	F 582	F582 Facility not able to correct prior non-compliance for resident 47 as date of discharge from skilled service was 8/20/24. Facility not able to correct prior non-compliance for resident 250 as date of discharge from skilled services was 8/19/24. NOMNC form updated. An audit will be completed for ABN notices and NOMNC issued since survey to ensure accuracy and updated forms used. ADDENDUM 10/25/24: Training will be provided to the SSD on the proper forms, and proper instructions for completing the forms, and where to locate updates on the forms. The SSD will demonstrate this knowledge by completing cheat sheets for herself to utilize. The Licensed Social Worker will verify that correct forms are used initially and at her quarterly visits. System change: During the weekly Medicare Meeting, the team is notified of discharge dates from skilled services as well as ABN notices to be sent. The Social Service Designee or her designee will maintain a list of the ABNs/NOMNC's issued and verify that they were completed accurately, timely and correct forms used.	10/28/24

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F 582	Continued From page 2 1. Review of resident 47's Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review form provided by social services designee E revealed: *Her Medicare Part A Skilled Episode start date was 7/25/24. *Her last covered day of Part A Service was 8/20/24. *Her signed SNF Advance Beneficiary Notice of Non-coverage (ABN) form had been completed on 8/19/24. *She had not been given notice 48 hours prior to her services ending. *Her Notice of Medicare Non-Coverage (NOMNC) form was outdated and did not have the correct header. 2. Review of resident 250's CMS SNF Beneficiary Protection Notification Review form provided by social services designee E revealed: *He was discharged to his home on 6/4/24. *His Medicare Part A Skilled Episode start date was 5/17/24. *His last covered day of Part A Service was 6/4/24. *His SNF ABN form was completed and signed on 6/4/24. *He had not been given notice 48 hours prior to his services ending. *His NOMNC form was outdated and did not have the correct header. 3. Interview on 10/2/24 at 10:46 a.m. with social services designee E regarding Medicare non-coverage notices revealed: *She had been completing the Medicare beneficiary reviews since 2021.	F 582	The system change will be monitored by the Social Services Designee or her designee and reported to QAPI committee on a monthly basis for 3 months, The QAPI committee will determine if further monitoring is needed. ADDENDUM 10/25/24: The system change will be monitored by the Administrator or her designee and reported to QAPI committee monthly for the next 6 months at which time the committee will determine if further monitoring is required.	10/28/24

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F 582	Continued From page 3 *She was aware that notices were to be given 48 hours prior to services ending. *She was unaware that the forms were old and needed updating.	F 582		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI] report, interview, record review and policy review the provider failed to prevent staff to resident sexual abuse from occurring for one of one resident (29). Findings include: 1. Review of the SD DOH FRI report for resident 29 revealed: *On 9/21/24 at 11:35 p.m. certified nursing assistants [CNAs] reported to licensed practical nurse (LPN) H that resident 29 was complaining of CNA M being rough after she had used the	F 600	Regularly scheduled full time and part time (and PRN if working) staff will be instructed on Abuse, Neglect, and Exploitation through a directed inservice, beginning 10/28/24 - November 1, 2024. Any PRN staff who did not attend will be trained prior to next shift scheduled. ADDENDUM 10/25/24: Dates of the directed in-service are 10/28-30/24. Education/training will include procedure response to influence staff's understanding of what constitutes any abuse, neglect, or exploitation, and factors that will help sustain compliance with our statement that "Residents at St. William's Care Center will be treated with dignity and respect--no resident of this facility will be mistreated, abused or neglected." Education/training includes: F600-definitions of abuse, neglect, sexual abuse, willful, staff to resident abuse, allegation, process of reporting and investigating, why and how abuse may occur, prevention techniques of QTIP and Take a Break concepts. This information will be added to the New Hire Packet given to new hires and new agency staff.	10/30/24

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F 600	Continued From page 4 bathroom and was being cleaned up. *LPN H assessed resident 29 in her room. *Administrator A and director of nursing (DON) B were notified. *Resident 29's power of attorney (POA) was notified. *Resident 29's primary physician was notified. *Administrator A contacted CNA M to suspend her pending investigation results. *Medical director C was contacted and he arranged for her transfer to the local emergency room for further assessment. *CNA M was terminated from the facility on 9/25/24. 2. Interview on 9/30/24 at 4:42 p.m. with resident 29 revealed: *She had a urinary tract infection (UTI) and was on antibiotics. *She stated she would get UTIs from her catheter. -"I am on the strongest antibiotic you can be on for a UTI and I take my last pill tonight." *She stated staff treated her with respect and dignity and she had no problems with any staff. 3. Review of resident 29's electronic medical record revealed: *Her recent Brief Interview for Mental Status (BIMS) score was 15 indicating she was cognitively intact. *An order on 9/26/24 5:41 p.m. for, "LevoFloxacin [antibiotic] 500 mg [milligrams] tablet dose ordered (1/2 tablet /500 mg) by mouth daily x 5 days Supper through: 9/30/24 for: urinary tract infections." *Her care plan dated 8/22/24 indicated she had a indwelling catheter, and history of UTIs.	F 600	F600 cont The Abuse, Neglect, Misappropriation Policy has been updated 10/24/24 as follows: SWCC staff will provide support to each other while working by practicing these 2 concepts: 1. Take a break: if it is noticed that a staff is at risk of saying something or doing something that is not promoted at SWCC, offer them help by giving them the sign to "take a break" (hand on their back followed by the statement "take a break". 2. The concept of QTIP: (Quit Taking It Personal) when dealing with resident behaviors such as repeated questions, vulgar language or non-flattering comments toward staff. It is important to remember that the residents come first! Practicing QTIP can transform emotional well-being and improve performance and relationships with others. By learning to quit taking things personally, resilience is gained, less stress and anxiety is experienced, and it fosters greater self-awareness. System change: The new training/education information will be added to the New Hire Packet given to new hires and new agency staff. An attestation page will be signed and filed in the HR office.	

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F 600	Continued From page 5 4. Interview on 10/01/24 at 3:03 p.m. with resident 29 regarding the incident on 9/19/24 with CNA M revealed: *CNA M had been cleaning her up after she had used the bathroom. -She stated, "I didn't think she should be cleaning me in that area." She clarified she was referring to her vagina. -The way CNA M cleaned her hurt her and she stated, "I'm not sure she realized where she was going and was digging into my vagina from behind after I went to the bathroom and had a bowel movement." *She had no problems with any other staff. *She stated, "I believe she did it intentionally because she told me I was dirty and she wanted to get me clean so I wouldn't get any infections, that was different from when my catheter gets pulled on." *She stated, "She didn't tell me she needed to clean my vagina just that she needed to clean me." *She felt bad for reporting CNA M and stated, "But what if she did that to someone else." *She went to the emergency room and had a video conference evaluation. They gave her a choice of a more thorough exam and she agreed to have the additional exam. -She stated they did not draw blood but did a swab of her vagina and she was told she did not have any open areas. -She did not know if she would get any results back from the exam but had not gotten any as of today (10/1/24). *She stated she thought the staff handled the incident well. *She was not aware of any new or different interventions or cares for her since this incident.	F 600	The HR Director will present to QAPI the number of new hires that received training for the 2 months at which time QAPI committee will determine if further monitoring/reporting is needed. ADDENDUM 10/25/24: The HR Director will report to the QAPI committee monthly, the number of new hires that received training, for the next 2 months, at which time the QAPI committee will determine if further monitoring/reporting is needed. ADDENDUM 10/25/24: A member of Leadership will monitor the number and types of incidents, shift of occurrence, and what educational materials were reviewed for any reported incidents. The Administrator or designee will report this information to QAPI committee on a monthly basis for 6 months at which time it will be determined if further monitoring is required. A request was made by the Medical Director on 10/25/24 for the SANE results, with the following response from medical records at Avera: The SANE nurse documentation is a confidential document that is scanned. Only the SANE nurse has access to it. If an agency needs a copy, a subpoena will need to be submitted to Health Information Management who will request the document from the SANE nurse. The SANE nurse will send it directly to the agency requesting.	10/30/24

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F 600	Continued From page 6 5. Interview on 10/01/24 at 4:01 p.m. with CNA K regarding providing peri cares for resident 29 revealed: *She would put on a gown and gloves and explain what cares she would be providing to resident 29. *She and another staff would use the mechanical lift to position her to clean the peri area. *She stated one staff would stand in front of resident 29 to keep her steady while the other staff would stand behind her to clean her. -She stated she cleaned her from front to back with wet wipes then with a washcloth and soap and water. She held the catheter to one side and cleaned the opposite side. *She was not aware of any new interventions for resident 29. *She was not aware of any abuse to residents. *She was not aware of any abuse education or training provided in the last month. 6. Interview on 10/01/24 at 4:27 p.m. with CNA N revealed: *He was not aware of any staff being rough with resident cares. *He thought he had abuse and neglect education in August. 7. Interview on 10/2/24 at 8:32 a.m. with certified medication assistant (CMA) J regarding abuse revealed: *She stated there had been staff to resident abuse in July or August a staff member had slapped a resident. -CNA M was no involved in this incident. -She was not aware of any allegations of staff to resident sexual abuse. *She had not had any sexual abuse education in the last couple of weeks.	F 600		

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F 600	Continued From page 7 8. Interview on 10/2/24 at 8:39 a.m. with social service designee E regarding the above incident involving resident 29 and CNA M revealed: *She stated she didn't know much but she knew that resident 29 had been in the mechanical lift. -Resident 29 had said 'ouch" to the CNA when a nurse was putting in a catheter. -She stated she thought resident 29 had said "ouch" to the catheter being put in. *She said CNA M no longer worked there. *She was in the room when administrator A confronted CNA M about the incident. *She was not aware of any type of abuse education that had been provided since this incident. *She did not completed interviews or take part in the investigation regarding the incident, but administrator A did. *She did not put a social services note in resident 29's record regarding the incident on 9/19/24. 9. Interview and on 10/02/24 at 8:51 a.m. with DON B regarding resident 29's hospital report dated 9/22/24 revealed: *She agreed the provided hospital report did not have the sexual assault nurse examiner (SANE) dictation or results. -She called the medical director C while this surveyor was in the room. -She placed the phone on speaker mode and informed him this surveyor was in the room and asked about resident 29's SANE report results that had been done via telehealth conference. -The medical director stated he would have to talk to the nurses and call back. *DON B said medical director was called during resident 29's emergency room visit. -Medical director C did not call back regarding resident 29's SANE report or results before the	F 600		

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F 600	Continued From page 8	F 600		

end of the survey.
*She stated she would get this surveyor CNA M's employee file to review.
-CNA M's file was not provided before the end of the survey.

10. Interview on 10/2/24 at 10:19 a.m. with CMA I regarding abuse revealed:
*She was aware of a staff to resident physical abuse that involved a staff member who slapped a resident, but she was not aware of any sexual abuse allegations.
*She had attended abuse education in August or September, and everyone in the building had to attend and sign in for the training.
-She was not aware of any other training or education regarding sexual abuse.

11. Interview on 10/02/24 at 11:06 a.m. with LPN G regarding resident 29 revealed:
*She had been informed by DON B about resident 29's sexual abuse allegation Monday because it was reported over the weekend.
*She stated, "It was kept hush hush, but staff were whispering about it."
*The incident happened Thursday evening 9/19/24.
-Resident 29 did not report what happened until Saturday 9/21/24 and she reported to the nurse aides who then reported to LPN H.
-LPN G stated LPN H had contacted administrator A and DON B about resident 29's allegation.
-LPN H had been told to file an incident report by DON B.
-Resident 29 was sent to the ER for a rape kit to be done on Sunday 9/22/24 for vaginal swabbing.
-Staff were told to monitor resident 29 for vaginal bleeding which there was none reported.

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F 600	Continued From page 9 *They had a safety meeting on Monday 9/23/24 with administrator A, DON B and human resource manager (HRM) F. -LPN G stated she had walked in during the discussion about resident 29 because she was late. -She stated she had asked DON B why there were no nurse's notes made regarding the incident and DON B told her LPN H would be coming back to make a nurse's notes. -LPN G stated DON B reassured her LPN H would make a late entry because she was a new nurse and was unsure how to chart the incident. *LPN G showed this surveyor the abuse audits she had done which were given at a nurses meeting on 9/19/24. -She stated abuse had been talked about along with incident reporting to the state, and both nurses and aides were in the meeting. -Nurse managers were to complete the abuse audits weekly and the audits would be given to administrator A. -She stated the audit was from the plan of correction from the previous abuse where staff slapped a resident. *LPN G stated CNA M had been terminated on 9/24/24 at 10:30 p.m. *LPN G said she had worked there for seven years and worked with resident 29 "a lot." She stated, "She has a BIMS of 15 and knows what is going on." -She did not think that resident 29's current UTI was from the alleged sexual abuse incident. -Resident 29 had a history of UTIs and had refused peri cares and did not want to be cleaned up because the nurse would ask her about moving her skin folds when she was being cleaned, and she would not let them. -Resident 29 had requested often that her	F 600		

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F 600	Continued From page 10 catheter be advanced. 12. Interview on 10/2/24 at 11:50 a.m. with administrator A about abuse education and investigation revealed: -She had provided staff abuse education and was completing audits for abuse from the previous physical abuse incident. -She agreed she was using the same audits for the facility-reported incident regarding the alleged sexual abuse. -There was no education regarding sexual abuse provided after the incident with resident 29 and CNA M. -She stated, "Abuse is abuse." *They terminated CNA M and had reported the incident to her employment agency which she thought would go on her record. -She stated she would print off CNA M's personnel information for this surveyor to review. -CNA M's information was not provided by the end of the survey. 13. Review of the provider's 8/19/24 abuse, neglect and misappropriation of resident property policy revealed, "Residents will be treated with dignity and respect. There is a zero tolerance for abuse. each staff member is a mandatory reporter for the state of SD."	F 600		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to	F 625		

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F 625	Continued From page 11 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. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to provide a bed-hold notice to the resident or their representative when transferred to the hospital for one of one sampled resident (26). Findings include: 1. Inteview on 9/30/24 at 2:00 p.m. with resident 26 revealed she had thought she went to the hospital recently but forgot what for. 2. Review of resident 26's electronic medical record (EMR) revealed: *She was transferred to the hospital on 8/13/24. -Her power of attorney (POA) was notified of her transfer.	F 625 F625	The facility is not able to correct prior non-compliance for providing a bed hold policy for resident 26. The Bed Hold Policy was updated 10/24/24 with the addition of the statement of where the bed hold form is located and when it is to be used. ADDENDUM 10/25/24: The bed hold policy was updated to reflect current information on Medicaid, Medicare, and Private Pay sources. The Admission Agreement reflects the same information. During the weekly Medicare Meeting, the team is notified of any hospitalizations during the week. ADDENDUM 10/25/24: The SSD will meet with the DON or designee on a daily basis (M-F) to determine if any hospitalizations occurred, and if a bed hold was signed. System Change: The Social Service Designee or her designee will maintain a list of who was hospitalized, bed hold forms sent and signed by either the resident or the representative to verify completion timely and accurately. If the resident is not able to complete the form, the SSD or designee will review information with POA via phone contact and obtain verbal consent for the bed hold the next day.	10/2724

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435122	A. BUILDING _____ B. WING _____	C 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 625	Continued From page 12 -There was no documentation the bed hold information was given to the resident or her POA. *On 8/19/24 she returned to the facility from the hospital. 3. Interview on 10/2/24 at 8:18 a.m. with social sevices designee E regarding resident 26's bed hold notice revealed: *She had never received the bed hold notice from the nurses. *She knew for certain it had not gotten done. *She had stated it was the nurse's responsibility to complete the bed hold notices when a hospital transfer occurred. 4. Interview on 10/2/24 at 10:02 a.m. with director of nursing B revealed: *There was no bed hold notice for resident 26's hospital transfer on 8/13/24. *The social services designee was ultimately responsible for ensuring bed hold notices were completed. 5. Review of the provider's undated Bed Hold Policy revealed: *"As per the admission agreement, the facility must transfer or discharge a resident when the facility determines that such action is appropriate in order to meet the resident's needs for healthcare services." *"Private Pay Residents: provider will hold the bed for an agreed upon length of time." *"Medicaid Residents: provider will hold the bed for up to five (5) consecutive days for each separate and distinct medically necessary hospital stay." *There was no documentation for Medicare residents.	F 625	ADDENDUM 10/25/24 to System Change: The SSD will maintain a list of hospitalization dates, and when the bed hold form was sent, signed and returned for each resident. If the resident is not able to complete the form, the SSD or designee will review information with POA via phone contact and obtain verbal consent for the bed hold the next day. Monitoring of the system change will be completed by the Social Services Designee or designee, and will be presented to QAPI monthly for 3 months at which time the committee will determine if further monitoring is required. ADDENDUM 10/25/24: Monitoring of the system change will be accomplished at the weekly Medicare meeting where the SSD will review her list of hospitalizations, bed holds, and POA phone calls. The SSD will report findings on a monthly basis to the QAPI committee for 3 months at which time the committee will determine if further reporting is required.	10/27/24

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F 625	Continued From page 13 6. Review of the provider's Admission Agreement revealed it did not include information about bed hold policies. 7. Review of the provider's Admission Handbook revealed: *"Bed Hold Policy: If desired accommodations at facility may be reserved for a resident during times they are on a leave from the facility, either for a leave of absence or a hospital leave. A bed hold policy will be given prior to a leave."	F 625		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review the provider failed to follow physician orders for two of six residents (36 and 32) during medication administration that resulted in a medication error rate of 5.13%. Findings include: 1. Observation, record review, and interview on 10/1/24 at 5:53 p.m. with licensed practical nurse (LPN) O during resident 36's medication administration revealed: *She withdrew naproxen sodium (pain and fever medication) 220 milligram (mg) tablet from the medication cart. *The physician's order on the resident's medication administration record (MAR) was for naproxen sodium 250mg tablet.	F 759		
		F759	For resident 36, the order for naproxen sodium was clarified on 10/2/24. The order for Naproxen 250mg(1) BID was discontinued and new order for Naproxen 220mg (1) BID morning and supper was received. In reviewing the resident's admission paperwork (MAR) from the transferring facility, it was noted that Naproxen was also listed as 250mg	10/27/24

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F 759	Continued From page 14 *She stated she would give the resident the medication because it was a lower dose. *She stated she would call the physician later to verify the correct dose. 2. Observation, record review, and interview on 10/2/24 at 7:25 a.m. with LPN O during resident 32's medication administration revealed: *She withdrew brimonidine tartrate 0.2% solution eye drops from the medication cart. *Prescription on the bottle said to instill one drop into each eye twice a day. *The physician's order on the resident's MAR directed to instill two drops into each eye twice a day. *She stated she would call the doctor to verify the correct dosing. *She instilled one drop in each of the resident's eyes. 3. Interview on 10/2/24 at 9:53 a.m. with director of nursing (DON) B revealed: *Nurses were to verify orders from the physicians with orders in residents' MARs. *She expected staff to verify the prescription on the medications with the physicians' orders before administering medications to residents. *If there was an error, she expected the staff to call the physician and pharmacy before administering medications to residents. 4. Review of provider's reviewed 7/19/24 Administration/Self-Administration of Medication policy revealed: *"The correct medication(s) will be given to the correct resident, at the appropriate time, in the dose ordered by the physician or physician extender by the correct route and for a specific diagnosis."	F 759	For resident 32, the medication order was for Brimonidine tartrate 0.2% solution (1) drop o.u. was clarified with the ophthalmologist. The MAR was corrected and a new label was requested from the pharmacy and was placed on the bottle. System change: There have been 8 new admissions since survey. The physician order list in ECS was printed for each new resident. (This is how medication appears on the MAR). This list was then compared to the admission orders from the hospital. There were no discrepancies noted. This process will be monitored by the DON or her designee for all new admissions and will be reported to the QAPI committee for the next 6 months at which time the committee will determine if further monitoring/reporting is required. ADDENDUM 10/25/24: The system change will be monitored by DON or designee for all new admissions on the day of admission and will be reported to QAPI committee monthly for the next 6 months at which time the committee will determine if further reporting is required.	

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F 759	Continued From page 15 *There was no mention of what should be done when incorrect dosing/orders were found.	F 759		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review the provider failed to ensure room trays were served at a satisfactory temperature for three of thirteen sampled residents (30, 47, and 150) who chose to eat meals in their rooms due to the long wait time for meals to be served in the dining room. Findings include: 1. Interview on 9/30/24 at 1:54 p.m. with resident 30 revealed: *She had been living at the facility for almost two years. *She chose to eat her meals in her room as she felt it took too long to be served in the dining room. *She stated the food on her room tray was often cold when it should have been hot. -She had asked staff to reheat a food item once. -By the time her warmed up food item was returned to her, she was done eating the rest of her meal.	F 804	F804 The facility is not able to correct prior non-compliance of ensuring room tray was served at a satisfactory temperature for resident 30 and 47, as date of meal service was 9/30/24. The facility is not able to correct prior non-compliance of ensuring room tray was served at a satisfactory temperature for resident 150 as date of meal service was 10/1/24. The facility has ordered plastic bases and induction charger for serving plates which will maintain food temperatures up to 60 minutes after charging	10/27/24

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F 804	Continued From page 16 *She felt she was the last resident to get her room tray delivered. 2. Interview on 9/30/24 at 4:10 p.m. with resident 47 revealed: *She was recently admitted on 7/25/24 and ate a regular diet. *After her admission she went to the dining room for meals but decided to eat meals in her room as she felt it took too long to get served in the dining room. *Regarding her room trays, she stated her food was often cold by the time she got her room tray delivered. -She stated her food was "not warm at all and actually cold." -She had not mentioned it to any of the staff as she was new and had not wanted to "make waves [cause trouble]." 3. Interview on 10/1/24 at 8:06 a.m. with resident 150 revealed he: *Was recently admitted on 9/23/24. *Stated he had to wait a long time to be served in the dining room, so he decided to eat his meals in his room. *Had complaints regarding the food on his room tray being cold when it should have been hot. 4. Interview on 9/30/24 at 10:40 a.m. with director of nursing (DON) B regarding their dining room meal times revealed: *Breakfast was served at 7:30 a.m. *Lunch was served at 11:30 a.m. *Supper was served at 5:30 p.m. 5. Observation on 9/30/24 of the noon meal revealed: *At 11:38 a.m. cook P wheeled the cart containing	F 804	System Change: Staff will document what time room trays are assembled, what time sent for delivery, when trays are delivered to residents and what time finished delivering. This will be done for each meal for 30 days followed by weekly audits at all 3 meals for the next 2 months. ADDENDUM 10/25/24: System Change: Dietary staff will document what time room trays are assembled, what time sent for delivery. Nursing staff will document when trays are delivered to residents (start time) and what time finished delivering. This will be done for each meal for the next 2 months. This information will be monitored by the CDM and reported to the QAPI committee for the next 3 months at which time the committee will determine if further monitoring/reporting is required. ADDENDUM 10/25/24: This system change will be monitored by the CDM or DON or designees on a weekly basis and reported to the QAPI committee monthly for the next 2 months at which time the committee will determine if further reporting is required.	10/25/24

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F 804	Continued From page 17	F 804		

the food items into the dining room and loaded the residents' food items into the steam table.
*Ten minutes later, at 11:48 a.m., the first room tray was plated and loaded into the insulated food cart.
*At 11:57 a.m., cook P announced over the walkie-talkie that the room trays were ready and prepared the first plate for the dining room.
*At 12:23 p.m. the meal service was completed for the dining room.
-The first resident to be served in the dining room waited 27 minutes after the stated meal service time.
-The last resident served in the dining room waited 53 minutes from the stated meal service time.

6. Review of the 9/10/24 resident council meeting minutes revealed:
*Eleven residents and one family member attended.
*Resident 17 expressed a suggestion "because there have been residents complaining that meal times are taking too long."
*Social service designee E "told her that she can talk to administration and the kitchen to see what their thoughts are but just not sure ..."
*Resident 4 stated she "likes her food hot and it is not always that way."

7. On 10/1/24 at 6:07 p.m. the requested supper test tray was delivered to the survey team in the conference room and revealed the following food temperatures:
*Three mini corn dogs:
-One was at 99.1 degrees Fahrenheit (F).
-One was at 100.6 degrees F.
-One was at 103.6 degrees F.
*Baked beans that had a good flavor and was at

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F 804	Continued From page 18 128 degrees F. *Cheesy Cauliflower Soup that tasted lukewarm and was at 132.0 degrees F. 8. On 10/2/24 at 9:10 a.m. the requested breakfast test tray was delivered to the survey team in the conference room with a note "10/2/24 test tray served at 8:50 a.m." revealed the following food temperatures: *Coffee in an insulated mug was at 141.8 degrees F. *Cream of Rice in an insulated bowl was at 138.7 degrees F. *Scrambled eggs were at 115.1 degrees F. *The sausage link was at 104.6 degrees F. *The waffle was at 93.4 degrees F. *The syrup was at 88.1 degrees F. Interview on 10/2/24 at 10:50 a.m. with dietary manager D revealed: *She was not aware of any food complaints from September's resident council meeting. *She stated it had been "quite awhile" since she had received any concern forms and stated either residents would bring her a concern form or social service designee E would forward her a concern form. Continued interview with dietary manager D regarding concerns with cold food on the room trays served revealed: *She was aware of complaints regarding food being cold on room trays served to the residents in their rooms. *She agreed that the Cheesy Cauliflower Soup served on the 10/1/24 supper test tray had not looked appetizing to her. *She stated the insulated carts work best if the room trays are served within 10 to 15 minutes.	F 804		

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F 804	Continued From page 19 Interview on 10/2/24 at 11:45 a.m. with social service designee E revealed: *She was the complaint coordinator for the facility. *Resident concern forms were located inside the black box by the facility's bulletin board in the hallway as she was told to put the forms inside the box. *In the past, she had mentioned food complaints to dietary manager D but did not keep a record of those conversations or the complaints. *For concerns voiced at the monthly resident council meeting she would verbally inform the respective department manager of the concern. *She did not fill out a concern form for the concerns raised at resident council. *She had only two concern forms in the past six months. Continued interview with social service designee regarding food complaints at the 9/10/24 resident council meeting revealed: *She had talked to administrator A about resident 17's suggestion and was told the resident's suggestion would not work. *She had not discussed the food complaints with dietary manager D. Interview on 10/2/24 at 12:06 p.m. with administrator A revealed: *She was aware of concerns with cold food on the meal trays delivered to residents' rooms. *She and DON B attended the individual resident care conferences and she stated they would note the concerns expressed but do not use the concern forms. Interview on 10/2/24 at 12:30 p.m. with DON B revealed: *She was aware of cold food complaints	F 804		

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F 804	Continued From page 20 regarding resident room trays. *A dietary aide delivers the insulated food cart to the nursing unit hallway and certified nursing assistants (CNAs) deliver the food trays to the resident rooms. *She would have expected room trays to be delivered to resident rooms within 15 minutes. *She was not sure if this was happening. *The policy on resident room trays was requested. Interview on 10/2/24 at 12:55 p.m. with CNA L revealed: *There were ten room trays for breakfast. *There were six room trays for lunch. *She was not sure how many supper room trays there were as she did not work the evening shift. *It usually took her about 10 minutes to pass the meal trays to the residents' rooms. Review of the provider's Resident Grievance Form revealed: *A space at the top of the form for the resident's name and room number. *The first section indicated to "Describe the concern in detail:" *The second section indicated "What was done resolve [sic] issue and department that resolved issue." *The third section indicated "Are you happy with the way the issue was handled and resolved?" *A space at the bottom of the form for: -The resident's signature and date. -The department staff's signature and date. The policy on resident room trays was not received by the end of the survey.	F 804		

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	435122	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/02/2024**

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K 000	INITIAL COMMENTS A recertification survey was conducted on 10/2/24 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. St William's Care Center was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K325 and K353 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 325 SS=C	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)	K 325		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rene' Thrift	Administrator	10/27/2024

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

OCT 27 2024
SD DOH-OLC

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K 325	Continued From page 1 * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to properly store alcohol-based hand rub (ABHR) in one room (basement Storage 2). Findings include: 1. Observation on 10/2/24 at 10:30 a.m. revealed the basement storage room marked Storage 2 had 7.5 gallons of ABHR stored in the room. Interview with the maintenance technician at the time of the observation confirmed that finding. The deficiency affected one of numerous requirements for ABHR use.	K 325	The hand sanitizer in excess of 5 gallons has been removed from storage room 2 for compliance with NFPA 30 -- In each smoke compartment, do not store outside of dispensers more than 5 gallons (18.9 liters). Hand sanitizer policy written outlining requirements of ABHR use. System change: The Housekeeping Supervisor will complete inventory of ABHR on a quarterly basis for the next 3 quarters reporting findings to the QAPI committee. Report will include how much hand sanitizer on hand, how much ordered if applicable. This will be reported to the QAPI committee quarterly for 3 quarters at which time the QAPI committee will determine if further monitoring/reporting is required.	10/24/24
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435122	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/02/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST WILLIAM'S CARE CENTER	**103 N VIOLA ST** **MILBANK, SD 57252**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 2 any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition (performing the required internal pipe inspection every five years). Findings include: 1. Observation on 10/2/24 at 11:00 a.m. revealed a pipe marking indicating the internal pipe inspection had been done on 10/17/17. No tags for the inspection were present. 2. Document review on 10/2/24 at 1:00 p.m. revealed the required five-year inspection/testing of the internal surface of the piping had not been performed in 2022 or in 2023. The maintenance technician was present when the deficiency was identified. Failure to continuously maintain the automatic sprinkler system as required increases the risk of death or injury due to fire. The deficiency affected one of numerous required tests for the automatic sprinkler system.	K 353	The sprinkler system inspection has been scheduled for November 4, 2024 with Building Sprinkler, Inc. The Maintenance Director will report to QAPI committee when the inspection report is available with any followup to be completed. The QAPI committee will develop new monitoring/reporting at that time.	12/1/24

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435122	A. BUILDING _____ B. WING _____	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST WILLIAM'S CARE CENTER	103 N VIOLA ST MILBANK, SD 57252

(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
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness requirements for Long Term Care Facilities, was conducted on 10/2/24. St Williams Care Center was found in compliance.	E 000		

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

Rene Thrift, Administrator | 10/22/24

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

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10649	A. BUILDING: _____ B. WING _____	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST WILLIAM'S CARE CENTER	103 N VIOLA ST MILBANK, SD 57252

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 9/30/24 through 10/2/24. St William's Care Center was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 9/30/24 through 10/2/24. St William's Care Center was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rene Thrift, Administrator — TITLE — (X6) DATE: 10/22/24

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