STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435122	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St William's Care Center	**103 N VIOLA ST , MILBANK, South Dakota, 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
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 2/10/26 through 2/12/26, and from 2/18/26 through 2/19/26. St. William's Care Center was found not in compliance with the following requirements: F635, F644, F658, F686, F761, F803, F812, F868, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/10/26 through 2/12/26, and from 2/18/26 through 2/19/26. Areas surveyed included quality of care/life related to resident personal hygiene and resident rights, resident safety related to elopements, and resident abuse/neglect related to mandatory reporting and investigating. St. William's Care Center was found not in compliance with the following requirement: F689.	F0000		
F0635 SS = D	Admission Physician Orders for Immediate Care CFR(s): 483.20(a) §483.20(a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. 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 resident (1) had a physician's order for supplemental oxygen when she was readmitted to the facility, and was provided continuous oxygen using a nasal cannula (flexible tubing with prongs that delivers oxygen through the nose) by the staff. Findings include: Based on observation, interview, record review, and policy review, the provider failed to ensure one of one	F0635		

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
Rene Thrift	Administrator	3/19/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **435122**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **02/19/2026**

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F0635 SS = D	Continued from page 1 resident (1) had a physician's order for supplemental oxygen when she was readmitted to the facility and was provided continuous oxygen using a nasal cannula (flexible tubing with prongs that delivers oxygen through the nose) by the staff. Findings include: 1. Observation and interview on 2/11/26 at 10:41 a.m. with resident 1 in her room revealed there was an oxygen concentrator (a device that filters room air into purified oxygen). Attached to the concentrator was an NC tube and a plastic bottle that contained water (a bubbler), which was used to humidify the oxygen inside it. There was no date on the bubbler or the NC tubing to indicate when they were provided or cleaned. There was no sign outside of the resident's room to indicate that oxygen was in use. Resident 1 indicated she propelled herself to her room after she had breakfast in the dining room, and she did not start the oxygen concentrator or put on the NC tubing when she returned. She stated she knew that she was to receive the oxygen and wear the NC tubing per her doctor's order. Resident 1 attached the NC tubing around her ears, placed the nasal prongs on the tubing in her nose, and turned on the oxygen concentrator. Observation and interview on 2/11/26 at 11:00 a.m. in resident 1's room revealed that resident 1 did not have the NC tubing on, and the oxygen concentrator was not on. Still, shortly after I had entered her room, she stated, "I better put this on like I am supposed to" (NC tubing) and applied the NC tubing. She then turned on the oxygen concentrator, which revealed the settings were set to 1.3 L/min. The resident was short of breath during our interview and stated, "I am short of breath because I just brought myself back to my room from the dining room". Licensed practical nurse (LPN) G entered resident 1's room and checked her oxygen saturation level with a pulse oximeter (a finger-clipped device that measures blood oxygen saturation and pulse). The amount of oxygen resident 1 was to receive using the NC was contingent upon her oxygen saturation level, which was 98 percent, and she did not remove the NC tubing or shut off the concentrator.	F0635	F635 Corrective Action: A policy for Standing Orders and Guidelines for Oxygen Administration was reviewed and a process for standing orders is being developed and reviewed by providers. The resident has been seen by her physician for further evaluation and treatment. Her orders for oxygen has been clarified. Chart audits were performed of 100% of residents to determine verify residents currently having orders for oxygen. Resident care plans and the CNA worksheets are being reviewed to ensure orders are accurate. Direct observation of resident compliance is being completed to verify oxygen is used as ordered. Chart audits were performed of 100% of residents to verify residentscurrently having orders for oxygen. System change: The facility has developed a standing order to be used facility wide for oxygen use. Resident care plans and CNA worksheets are being reviewed to ensure that orders are accurate in all areas.The DON will monitor the system changes. Performance Monitoring: The Director of Nursing will report findings of the system changes to the QAPI committee for 1 month at which time the QAPI committee will determine if further monitoring is needed.	3/19/26

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F0635 SS = D	Continued from page 2 2. Observation of the certified nurse assistant (CNA) B pocket care plan (a document that identifies residents' care needs and interventions) revealed that resident 1 was to have "Oxygen at all times". 3. Interview on 2/18/26 at 9:34 a.m. with ward secretary (WS) V revealed that resident 1 did not have a physician's order for oxygen using an NC at 1 percent L/min if her oxygen saturation level was less than 90 percent, to change the oxygen tubing, or to have the bubbler cleaned. 4. Interview on 2/18/26 at 9:52 a.m. with LPN D revealed that the CNAs will ask the nurse what the resident's oxygen concentrator should be set to when they turn the concentrator on and apply the NC tubing for residents. 5. Interview and record review on 2/18/26 at 12:25 p.m. with LPN F revealed that resident 1 was admitted to the hospital on 1/3/26, and was discharged from the hospital and readmitted to the facility on 1/8/26. When she was readmitted to the facility, there was no physician's order written for oxygen to be administered using a NC if the resident's oxygen saturation level was less than 90 percent. 6. Interview on 2/18/26 at 9:39 a.m. with CNA GG revealed she was not aware of resident 1's physician's order for oxygen, and it was not on the CNA pocket care plan on how to care for the residents. She indicated that she only knew resident 1 was to have her NC on. 7. Interview on 2/18/26 at 3:09 p.m. with director of nursing (DON)/infection preventionist B revealed that resident 1 should have had a physician order in her electronic medical record (EMR) for oxygen to be applied using a NC at 1 L/min if her oxygen saturation level was less than 90 percent. Resident 1 should have treatments to be completed by the staff listed on her treatment administration record (TAR) for the bubbler to be cleaned weekly, for the NC tubing to be changed twice per month, and for a sign to be placed outside of her room to indicate oxygen was in use. 8. Review of resident 1's EMR revealed her 1/13/26	F0635		

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F0635 SS = D	Continued from page 3 Brief Interview for Mental Status (BIMS) was 15, which indicated she was cognitively intact. She had a diagnosis of heart failure. There was a respiratory treatment order in resident 1's TAR to check her oxygen saturation level three times a day, morning, evening, and at night. The order indicated that if her oxygen saturation level was greater than 90 percent, she did not need supplemental oxygen. There was no physician order for oxygen to be supplied using a NC at one percent L/min if her oxygen level was less than 90 percent. There was no order to change the NC tubing or clean the bubbler. 9. Review of the provider's revised 10/19/26 Oxygen Therapy policy revealed, "Place sign "OXYGEN IN USE" outside the room of the resident." "Cleanse humidifier/bubbler on a weekly basis." "Reservoirs must be kept dry when not in use."	F0635		
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	F0644		

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F0644 SS = D	Continued from page 4 significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to incorporate one of one sampled resident's (9) Level II (2) Preadmission Screening and Resident Review (PASRR) into the 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) assessment. Findings Include: 1. Review of resident 9's electronic medical record (EMR) revealed she had a diagnosis of post-traumatic stress disorder (PTSD) and she was admitted to the facility on 11/3/25. Her 11/11/25 MDS comprehensive assessment and 1/28/26 MDS quarterly assessment indicated that a PASRR Level II was not completed. 2. Interview on 2/18/26 at 2:30 p.m. with social worker (SW) J revealed that the facility did not have a process to update the staff on if a PASRR Level II was completed for a resident. She completed the PASRR forms and kept them in her office. She did not share the completed PASRR documentation with the interdisciplinary team or registered nurse (RN)/MDS coordinator C. SW J stated, "It would never occur to me that I would have to tell [RN/MDS coordinator C] if the resident was a PASRR Level I or II. I would let the nursing team know what the recommendations were, if any, from the PASRR. I don't have permissions other than Section S [state defined items] on the MDS to update anything." 3. Review of resident 9's PASRR Level II obtained from SW J revealed she was reviewed by the South Dakota's contracted PASRR service on 10/27/25 and was approved for a 180 day stay at the facility with an end date of 4/25/26. 4. Interview on 2/18/26 at 3:25 p.m. with RN/MDS coordinator C revealed there was no process to determine whether a PASRR Level II was completed for a resident and that Section S of the MDS assessment does not trigger Section A (the section for the resident's identifying information). RN/MDS coordinator C was not aware that SW J completed a PASRR Level II for the residents. 5. Review of the provider's July 2025 Admission Process – Criteria policy revealed "The resident must meet the following medical/psychosocial and financial criteria	F0644	F644 Corrective Action: Correction made to resident (9)'s MDS at the time of the survey. SSD completed an audit of other Level II PASARR's, (4 other residents); this information was provided to the MDS Coordinator who updated MDS assessments as necessary. System Changes: A PASRR policy was written by the Social Service Designee, approved by the Social Service Consultant, and nurses were inserviced by the Social Service Designee. The New Admission Information Sheet now contains the PASRR level for disciplines access. Updates or changes to current PASRR'S will be noted via email to the MDS Coordinator so she is aware of the change. Performance Monitoring: The SSD will monitor the system changes and report findings to the QAPI committee for 2 months at which time the committee will determine if further monitoring is needed.	3/19/26

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F0644 SS = D	Continued from page 5 to be eligible for admission: Must have PASRR pre-admission screening and approval for appropriate level of care prior to admission."	F0644	F658 ADDENDUM: Clarification to the notation regareding the PCP statement regarding the insulin order is clarified as reading Order are now to check blood glucose BID two times per week and call MD if values >300 or <60 consistently	
F0658 SS = E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: A. Based on observation and interview the provider failed to ensure one of one sampled resident (32) had anything to eat or drink or had blood glucose monitoring within thirty minutes of receiving Novolog (a fast-acting insulin used to lower blood sugar) administered by licensed practical nurse (LPN) D. Findings include: 1. Observation and interview on 2/12/26 at 7:51 a.m. of LPN D revealed: *She woke up resident 32 to administer her insulin. The resident had not eaten breakfast yet but was going to get a room tray. *Resident 32's blood sugar was 264 (normal blood sugars are 70-130), and LPN D administered 5 units of Novolog and 42 units of Toujeo SoloStar (a long-acting insulin). 2. Observation on 2/12/26 at 8:53 a.m. revealed resident 32 was sleeping, her room tray was delivered and left on her bedside table by CNA GG. 3. Interview on 2/12/26 at 9:17 a.m. with resident 32 revealed that the staff did not wake her up when they delivered her room tray, and she did not eat anything yet that day. 4. Observation on 2/12/26 at 9:22 a.m. revealed resident 32 was sleeping, and her breakfast tray sat on her bedside table untouched.	F0658	F658 A. Resident 32's PCP was contacted and asked to review orders based upon the frequency with which she has been requiring sliding scale insulin and asked about changing the time of administration to be breakfast rather than 7am. The PCP determined to increase the dose of this resident's long acting insulin while discontinuing her sliding scale insulin Orders are not to check blood glucose BID two times per weeks and call MD if values > 300 or < 60 consistently. B. Resident 42 was asked about the compression stockings she was choosing to wear. This resident said she "really does not like to wear them". After being told that doctor discontinued the stockings and noted that there was insistence upon wearing them, the resident said, "then I guess I will stop wearing them". This resident's PCP was notified of the decision to comply with previous orders to discontinue the stockings and they were removed from her room. A. Chart audits were performed 100% residents and it was noted that only 1 other resident had orders for sliding scale insulin orders.This resident's prescribed medication times correspond with the meal/snack times (this resident does not sleep in or skip breakfast. B. Chart audits were performed 100% residents to verify orders for supportive or compression stockings. Resident care plans and CNA worksheets are being reviewed to ensure accuracy. Direct observation of resident compliance is being completed to verify prescribed stockings are being used. System Changes: A. 1. A policy addressing insulin administration was developed to include the following: "Sliding scale insulin should be administered according to the established parameters ordered by the physician. Blood sugar results will be recorded in the MAR and administration will be approximately 20-30 minutes before a meal or oral intake. A diabetic resident has a yellow tray card (also noting CCHO = constant carbohydrate diet). If the resident is not in the dining room for a meal and an aide is delivering the room tray, the CNA must notify the nurse that the tray is ready to ensure the resident can begin eating (if glucose has not been checked and insulin given, this need to be done before the resident begins to eat). If there is a delay in receiving a meal tray, the resident should be offered some type of oral intake(juice, milk, or food) and/or the blood sugar may be re-checked after 20-30 minutes.If a resident declines to accept a meal after insulin is administered, some type of oral intake should continue to be encouraged and blood sugars monitored accordingly to avoid a hypoglycemic episode". 2. Nursing staff, Trained Medication Aides (TMAs), and CNA are being educated about the newly developed "Insulin Administration Policy" and a monitoring tool has been put into place to document when sliding scale insulin is administered. This log will be completed by the nurse noting the time of sliding scale insulin administration and then the time at which oral intake is given (or there is a recheck of the glucose level). This log will be reviewed at least 4 times weekly by the Director of Nursing (DON)to ensure that times in between insulin and oral intake does not exceed 30 minutes	

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F0658 SS = E	Continued from page 6 5. Interview on 2/12/26 at 9:24 a.m. with LPN D revealed: *After Novolog was administered, the resident should have something to eat or drink within 20 to 30 minutes because it was a fast-acting insulin. *The staff were to wake resident 32 up to eat and set up her room tray. *She went into resident 32's room, woke her up, set her tray up, and encouraged her to eat her food. 6. Interview on 2/12/26 at 9:35 a.m. with certified nursing assistant (CNA) GG revealed: *She had delivered the room tray to resident 32. *She was to wake the residents up when she dropped their room trays off, set the room tray up if they needed her to, and feed the residents if they could not feed themselves. *Resident 32 was able to feed herself but needed her room tray set up. 7. Interview on 2/12/26 at 10:07 a.m. with pharmacist Q revealed that after administering Novolog to a resident, the resident should have something to eat or have blood glucose monitoring completed within 30 minutes. 8. Interview on 2/19/26 at 12:55 p.m. with director of nursing (DON) B revealed that after Novolog was administered to a resident, the resident should eat within 20 to 30 minutes. The provider did not have an insulin administration policy. B. Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (42) had a physician's order for compression stockings in her electronic medical record (EMR) and on her treatment administration record (TAR). 1. Observation and interview on 2/10/26 at 4:23 p.m. with resident 42 in her room revealed she had bilateral compression stockings on each of her lower legs. She	F0658	B. 1. Nursing staff, Trained Medication Aides (TMAs), CNAs and the ward cerk are being re-educated about the need for each resident's record to accurately reflect (in both digital and written formats) the current recommended treatment modalities determined by the physician orders. Monitoring will consist of 2 separate logs-a log maintained by the ward clerk for each order received for supportive stockings/other modality for compression to ensure that it is entered into the resident's electronic physician orders with subsequent updating of the resident care plan and CNA worksheet and a separate log maintained by CNA's to note if/when there are any discrepancies noted on the CNA worksheet, a specific resident request or declination of the use of supportive stockings/other modality for compression. Direct observation of resident compliance is being completed to verify prescribed stockings are being used. The DON and/or designee have reviewed and revised care plans. The ward clerk updates the CNA worksheets. Direct observation audits were completed by the DON as to compliance with prescribed modalities. 100% of resident having orders for compression stockings wear them on a daily basis. The log sheets put in place will continue as a system's change tool to communicate when there is a need to clarify an order/resident choice. ADDENDUM: Staff education will include: the importance of complying with physician orders and/or communicating a r esident 's choice to refuse treatment has been discussed with the staff and will be re-emphasized at the next nurse/CNA meeting. 2. After each admission/readmission and/or upon a physician visit a nurse will review all orders to verify completeness. If any orders require clarification, there is an additional resident request and/or non-adherence with an order given for supportive stockings/other modality for compression, this will be documented and the Primary Care Provider (PCP) or physician extender will be contacted. Written copies of any clarified orders will be co-signed and after the hard copy (or fax is received), the orders will be processed either directly by a nurse or the ward clerk. If the ward clerk enters orders into the residen's electronic chart, a nurse must co-sign orders. The ward clerk will update CNA worksheets and the nurses will update care plans. Performnce Monitoring: A.The DON will monitor system changes and resport findings to the QAPI committee for one month at which time the committee will determine if further monitoring is needed. B.The DON will monitor each log at least 4X weekly for the first month and report the findings to the QAPI committee who will then determine if further monitoring is needed. ADDENDUM TO B: addendum: The Performance Monitoring section states the DON will monitor each log 4 times weekly for the first month at which time the QAPI committee will determine if further monitoring is needed.	3/19/26

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F0658 SS = E	Continued from page 7 indicated the staff would put them on her every morning when they put her clothes on. She stated the stockings helped with the swelling in her lower legs, but was unsure what caused it. Interview on 2/12/26 at 11:07 a.m. with CNA H revealed that resident 42 was to wear her bilateral compression stockings when out of bed to assist with the edema in both lower legs. Interview on 2/18/26 at 1:30 p.m. with resident 42 revealed she did not have bilateral compression stockings on her lower legs. She indicated that the compression stockings were in the bathroom, and the staff did not put them on her when they dressed her that morning. Interview on 2/18/26 at 12:25 p.m. with LPN F verified that resident 42 did not have an active physician's order for the bilateral compression stockings, and she should have. Interview on 2/19/26 at 3:09 p.m. with the director of nursing, A revealed that resident 42 should have had a physician's order for the compression stockings in EMR. She should have had a treatment listed on her TAR for the compression stockings to be applied by the staff in the a.m. and taken off in the p.m. Observation of the "Team 1 CNA B pocket care plan revealed that resident 42 was to have "Ace wraps on/am and off/HS (bedtime)". 2. Review of resident 42's electronic medical record (EMR) revealed her 2/11/25 Brief Interview for Mental Status (BIMS) was 15, which indicated she was cognitively intact. She had a diagnosis of atherosclerotic heart disease of native coronary artery (plaque buildup in the heart's natural arteries), and a cerebral infarction due to an embolism of the left anterior cerebral artery (uncommon ischemic stroke). She had a 11/22/21 physician's order to apply TED (Thrombo-Embolism-Deterrent hose that prevents blood clots) hose (knee high) to both lower extremities in the a.m. and off in the p.m. She had a 6/7/22, physician's order for an Ace elastic bandage to both lower extremities daily, on in the a.m. and off in the p.m. On 8/22/23, the Ace elastic bandages were discontinued.	F0658		

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F0658 SS = E	Continued from page 8 She had a 10/21/25 physician's order to hold the compression stockings and measure both ankles daily in the a.m. starting on 10/22/25 through 10/25/25. She had a 10/27/25 physician's order to discontinue the compression stockings due to no changes in the ankle measurements. Her primary care provider assessed her on 12/15/25, and the progress note indicated "Her weight remained unchanged. She lasted one day right after my last visit without her compression stockings on her lower extremities". There was no physician order initiated on 12/15/25 that indicated resident 42 is to wear bilateral compression stockings. The facility did not have a policy regarding physician orders being transcribed and communicated to the designated staff to be implemented for the residents.	F0658		
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to implement pressure ulcer (skin and/or underlying tissue injury from prolonged pressure) prevention interventions for	F0686	F686 Corrective action: It has now been determined that "open to air"applies strictly to whether a dressing is being applied over the woundbecause until 2/9/2026, part of her wound care treatment plan included autolytic debridement and a dressing over the affected area. The care plan has now been updated to include "use heel boots to relieve pressure, friction and shear forces against fragile skin and/or an open wound even when no dressing is being used to treat pressure injury to left heal. Chart audits were performed of 100% of residents and it was noted that at this time there is one other resident who currently has a pressure injury (PI). This resident's orders for PI wound care includes the use of barrier cream/paste and hydrocolloidal dressing and this information is included in the current care plan. System changes: The Pressure Injury and Wound Care Policy was reviewed/revised. Directed education and training for all staff is being provided on their roles, responsibilities, and assigned tasks related to pressure ulcer prevention, pressure ulcer management, and the processing of and following of physician's orders. In the policy it is noted that "The nurse assessing a PI will notify the resident's physician of a change in status and obtain any recommend-ed treatment orders; the resident's POA will also be notified of a change in status and orders received; Internal memos within ECS to notify the Dietary Manager/Dietician and the DON about the development of a PI; Interventions should be added to the resident's care plan as soon as possible. Nursing staff will immediately in-service/re-educate CNAs caring for the resident about what specific measures need to be implemented. Visual training materials available as well as the purpose of pressure relieving devices.	3/19/26

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F0686 SS = G	Continued from page 9 one of one sampled resident (3) who was identified at risk for developing a pressure ulcer and developed an unstageable (wound bed not visible due to covering, such as debris, dead tissue, scabbing, or a non-removable dressing) pressure ulcer to her left heel while under their care. Findings include: 1. Observation on 2/10/26 at 10:57 a.m. of resident 3 in the dining room revealed that she was sitting upright in her wheelchair. She was not wearing heel boots (a cushioned boot used to reduce pressure from a person's heel. 2. Observation on 2/10/26 at 2:21 p.m. of resident 3 in her room revealed she was still sitting in her wheelchair without heel boots on. That had been over approximately three hours she remained in the same position. 3. Review of resident 3's care plan (personalized plan that addresses a resident's care needs, goals, and interventions) revealed a focus area documented on 12/9/25 that indicated "I have a skin injury and chronic fragile skin because I can't move around on my own. I have multiple sclerosis (MS) [a chronic autoimmune disease of the central nervous system where the immune system attacks the nerves in the brain, leading to communication issues between the brain and body], and I am confined to a bed or chair (non-ambulatory), I show this by having an existing skin injury (unstageable, pressure injury to left heel), my Braden's [a tool used to assess the risk of developing pressure ulcers] indicate a risk. I need my aides to help me reposition at least every one hour when I'm in a chair and every two hours during the night while I am in bed. Use pressure-reducing devices: air mattress in bed and cushion in wheelchair and recliner, heel boots to the left foot as needed." There was a 2/10/26 physician's order to "cleanse left heel open area with normal saline (NS) and soap then apply therapeutic moisturizing fragrance free crème (due to dryness) twice a day." Another 8/2/22 physician's order indicated the heel boots should be placed on the resident's feet every morning, afternoon, and during the night shifts.	F0686	System changes continued: the revised policy also emphasizes the need for personalized turning schedules as opposed to rigid protocols. Factors such as the resident's overall health, skin condition, and comfort shoud guide the repositioning.2. Nursing staff, Trained Medication Aides CNA's and the ward clerk are being re-educated about the need for each resident's record to reflect current treatment modalities per the physician orders.Monitoring will consist of any changes in physician's orders, or recommended positioning strategies each week by the Interdisciplinary Team at the Medicare Meeting.The DON will verifyt that there has been follow through for each order (changed) treatment. Follow through includes an entry in the resident record, on the MAR/TAR, in the resident care plan, on the CNA worksheet and that the resident and/or POA is aware of the plan of care Performance Monitoring: The DON or her designee will audit compliance with wound treatment modalities twice weekly for 4 weeks and report such findings to the QAPI committee at which time the committee will determine if further monitoring is needed.	3/19/26

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F0686 SS = G	Continued from page 10 Review of resident 3's electronic medical record (EMR) revealed that her Braden assessment scores ranged from 16 to 17, which indicated she had a mild risk for developing pressure ulcers. Her 12/11/25 Brief Interview for Mental Status (BIMS) score was 11 which indicated her cognition was moderately impaired. Review of resident 3's EMR revealed on 7/8/25 there was documentation for a new or sudden onset of left lower leg edema and blister to her left heel. The wound developed into an unstageable pressure ulcer. On 12/22/25 wound measurements revealed 4.0 centimeters (cm) long by 3.0 cm wide. On 2/16/26, the wound measurements were 2.0 cm long by 2.8 cm wide, and 0.1 cm deep. 4. Interview on 2/10/26 at 3:25 p.m. with resident 3 revealed that she did not have any complaints about her cares and she did not have any complaints of pain when the staff were completing her wound care. 5. Interview on 2/10/26 at 4:50 p.m. with licensed practical nurse (LPN) G revealed that resident 3 had an open skin wound on the back of her left heel. She explained that the wound nurse, LPN D, instructed the staff to leave the area open to air (a treatment method where wounds are left uncovered, without bandages or dressings, after initial cleaning) and to use a heel boot for cushioning to prevent it from getting bumped. 6. Observation on 2/11/26 at 8:41 a.m. of resident 3 in her room revealed she was asleep in her wheelchair with no heel boot on her left foot. She was wearing nonskid socks and no shoes. 7. Observation on 2/11/26 at 12:18 p.m. of resident 3 in her room revealed she was sitting in her wheelchair with no heel boot on her left foot. She was wearing nonskid socks and no shoes. 8. Observation on 2/11/26 at 4:37 p.m. of resident 3 in her room revealed that she was sleeping in a recliner. She was wearing a heel boot on her left foot. Director of nursing (DON) B and LPN D entered the resident's room to perform wound care. During the wound care treatment, resident 3 reported no pain in the area. LPN D stated they were leaving the wound open to air due to dry, sloughing skin (dead skin tissue in a wound that	F0686		

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F0686 SS = G	Continued from page 11 slows healing) around the wound. After the wound care was completed, DON B and LPN D did not reapply the left heel boot. Interview at that time with DON B and LPN D revealed that resident 3's pressure ulcer started out as a blister in July 2025 when they were using ACE wraps to try to control the edema (swelling caused by too much fluid trapped in tissues) in her legs. The clinic wound care nurse advised them that the ACE wraps would have to be removed and reapplied about eight times per day to treat the edema. Staff could not keep up with removing and reapplying the ACE wraps that many times per day, which resulted in the blister forming and opening. LPN D stated that wound care was completed once daily and wound assessment with measurements were completed weekly. 9. Observation on 2/12/26 at 8:45 a.m. in resident 3's room revealed that resident 3 did not have a heel boot on her left heel. She was sitting in her wheelchair and was leaning to the left side with her heel resting on the wheelchair footplate. 10. Interview on 2/12/26 at 9:29 a.m. with medication aide (MA) S revealed she was expected to reposition her assigned residents every two hours. She stated that the "CNA Sheets" have the information about each resident and their care needs. 11. Observation on 02/18/2026 at 2:03 p.m. of resident 3 in her room revealed she was lying on her back in bed without heel boots or pillows to offload pressure from her heels off the mattress. 12. Observation on 2/18/26 at 4:35 p.m. of resident 3 in her room revealed she was in the same position as the above observation. She had been lying in that same position for approximately 2 hours and 30 minutes. 13. Interview on 2/19/26 at 9:49 a.m. with certified nursing assistant (CNA) DD revealed that she used the "CNA sheet" (a document that identifies residents' care needs and interventions) to know how often to reposition the residents. She said that for resident 3, she usually laid her down after meals. CNA DD explained that she helped resident 3 put the heel boots on only when the resident was in her wheelchair, but not when	F0686	Administrator	3/19/26

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F0686 SS = G	Continued from page 12 the resident was in bed. She said she did not understand why resident 3 would need the heel boots on in the bed or the recliner, so she did not apply the heel boots in those situations. 14. Interview on 2/19/26 at 9:57 a.m. with CNA H revealed that she was not aware of resident 3's specific care needs, but she would refer to the "CNA sheets" for specific resident care needs such as turning and repositioning and use of pressure relieving devices. 15. Interview on 2/19/26 at 10:05 a.m. with CNA collaborator W revealed that she would refer to the "CNA sheets" for specific resident care needs. If the travel staff were not aware of how to care for a resident she would locate a nurse on duty. 16. Review of the "CNA sheet" revealed that it did not include information regarding resident 3's pressure ulcer interventions to her left heel, including when to reposition her or to use her heel boots. It indicated the staff should monitor her skin for breakdown, lay her down after her meals, use an air mattress on her bed, and place a cushion in her chair. 17. Interview on 2/19/26 at 1:34 p.m. with DON B revealed that she confirmed that resident 3's pressure ulcer on her left heel developed because of the use of ACE wraps for edema. She reported that the wound assessments were completed weekly on resident 3 and the Braden assessments were completed quarterly. She said that residents should "ideally" be repositioned every two hours unless resident 3 requested otherwise. When asked about resident 3's care plan, which directed the staff to reposition her every one hour, DON B responded, "well that is not happening with anyone." She agreed that the care plan should reflect the most current care that a resident needed to achieve the highest level of health and safety.	F0686		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free	F0689		

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F0689 SS = D	Continued from page 13 of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on the South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, observation, document review, record review, and policy review, the facility failed to ensure the safety for one of one sampled resident (48) who was identified at risk for elopement (leaving the facility without staff knowledge) and left the building unsupervised on 9/19/25. Findings include: 1. Review of the 9/19/25 FRI report submitted to the SD DOH revealed: *On 9/18/25 at 8:47 p.m., resident 48 exited out of the facility's back door. *Another resident's family member heard the alarm and called a staff member who was not on duty and notified her that the alarm was sounding. That staff member called the facility and told the nurse on duty, and she went out and assisted resident 48 back inside. *The wander guard alarm sounded at the door, at the alarm panel, and an alert was sent to the radio staff wore. *Staff did not hear the alarm going off at the panel because no staff was in that area at that time. Not all staff heard the alert on their radio. -Two certified nursing assistants (CNA) heard the alert on their radio but they were assisting other residents and were not able to immediately respond. -One CNA was on break and had the radio turned down and was unable to hear it. -One CNA had her radio in her pants pocket and the volume had accidentally been turned down. -One nurse did not have a radio, and the other nurse on duty left her radio on the medication cart and was not near it.	F0689	F689 The entry about verifying placement of a Wanderguard sensor in this resident's electronic medical record has been corrected to ensure that its presence has been verified by the nurse or TMA on the shift. Audit of 100% of resident records reveals that there are 6 other residentsusing the Wanderguard system. Verification for each resident having the sensor present is in each medical record. The appropriateness of using the system is reviewed weekly at the IDT Medicare Meeting as well as to determine if there are other residents who may be at risk of wandering towards an exit and/or actively seeing to exit the building. System changes: 1. The "Elopement/Missing Resident Policy" is currently being trained to all departments and is being included as part of the training to be provided at the time of hire. As an additional safety measure, the doors from Farmers Fairway to the dining room are closed following the evening meal and/or around snack 2. The DON will monitor 100% of resident records at least 3 times weekly for those utilizing the wanderguard system. Monitoring will be to ensure documentation is being entered into resident records about the presence of a wanderguard on every shift. ADDENDUM: 4. Audits will be completed for the amount of time it takes staff to respond to manually silence an alarm that was sounded. 5. Audits will be completed to determine the amount of time staff respond to an exit door being held open manually which will not disarm the alarm. The DON and Administrator will conduct the audits once a week for 4 weeks. Performance Monitoring: The DON/designee will monitor system changes to include the audits completed and report findings to the QAPI committee for 2 month at which time the committee will determine if further monitoring is needed. ADDENDUM: In points 4 and 5 above referencing audits these are defined as unannounced drills to show the importance of knowing where residents are, and when the alarm sounds, a physical check must be made. The DON and the Administrator will conduct the audits once a week for 4 weeks and present findings to the QAPI committee who will determine if further drills are advised. F689: Addendum The Administrator had previously trained department heads at a QAPI meeting so further training is now being done to re-educate all staff on the elopement policy.	3/19/26

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F0689 SS = D	Continued from page 14 2. Interview on 2/18/26 at 12:45 p.m. with maintenance director U revealed: *He checked that the wander guard door alarm functioned appropriately monthly by bringing a wander guard near it to see if it alarmed. *If the wander guard alarm sounded, a code needed to be entered on the wander guard panel to turn the alarm off. *There was a keypad next to the front door. If a code was not entered prior to leaving the front door, the door would alarm. The alarm would turn off when the door closed, without staff needing to enter a code. 3. Observation and interview on 2/19/26 at 8:54 a.m. with ward secretary V revealed: *An alarm on the panel by the CNA station alarmed, she reviewed the cameras, did not see anyone or an open door, so turned the alarm off. *She did not need to go check the door. 4. Observation on 2/19/26 at 9:45 a.m. of resident 48 in her room revealed she was sitting in her recliner reading a book, and both of her walkers had a wander guard on them. 5. Observation and interview on 2/19/26 at 9:49 a.m. with CNA DD revealed: *She was a travel CNA, and it had been six months since she had worked at the facility. *She did not receive any education after coming back to the facility. *The alarm on the panel by the CNA station sounded. She stated, "I don't know what this is for", walked over to the panel, pushed a button that silenced the alarm, and did not look into why the alarm was sounding. 6. Interview on 2/19/26 at 10:15 a.m. with CNA collaborator W revealed: *She worked at the facility for about a year.	F0689		

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*When the door panel by the CNA station alarmed, they were to look at the camera to see if they saw anything suspicious on it, and then turn the alarm off if they didn't.

*If they did not see anything on camera then they did not need to go check the door.

*If she heard the wander guard alert over the radio, or the alarm on the wander guard panel sound, she would go and check that door.

*The wander guard alert did not alarm at the CNA station, and it sounded at the door and needed a code to turn it off.

*She recalled talking about elopements at a CNA meeting, she completed a video training, but she did not recall receiving training since September 2025.

*She sometimes carried a radio, if one was available.

*There was a sign that hung at the CNA station that reminded staff how to alert others of a missing resident by overhead page. They were to look for the resident in resident rooms, and to check the sign-out book.

7. Interview on 2/19/26 at10:26 a.m. with CNA H revealed:

*She had worked at the facility for about five months.

*If the door panel alarmed, she was to review the cameras to see if someone was there or if the door was open.

*She was supposed to go check the door to see if anyone had gotten out.

*An alert went to the staff's radios that said wander guard and the location.

*All staff were to carry a radio.

*The CNA sheets (a document that identifies residents' care needs and interventions) identified residents who wore wander guards.

*There was a list of residents who wore wander guards that were in a binder in the report room.

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F0689 SS = D	Continued from page 16 *She recalled having education regarding elopements for her new hire education, and they had monthly CNA meetings. 8. Interview on 2/19/26 at 11:52 a.m. with licensed practical nurse (LPN) G revealed: *She had worked at the facility for a year and a half. *Wander guards were to be checked every shift to ensure they were functioning by bringing the resident who wore the wander guard by the exit to see if the alarm went off. *She was not sure who was responsible for testing the wander guards, and it was not documented on the medication or treatment record. *The wander guard alarm sounded at the panel by the exit door, and it sounded at the control panel by the CNA station. *She took the radio out of her pocket, looked at it, and stated that it was on the incorrect channel, channel 4, and it needed to be on channel 1. *The wander guard did not send an alert to radios, but they used the radios to ask staff to locate residents. *After resident 48 eloped, she recalled receiving education regarding elopements and having the doors to the unit closed in the evenings. *There was a list of residents who wore wander guards in a binder in the report room. 9. Interview and document review on 2/19/26 at 12:09 p.m. and 1:54 p.m. with director of nursing (DON) B revealed: *Resident 48 had an elopement assessment completed last on 10/25/24 that indicated she was at risk for elopement, had eloped once before, and was to wear a safety exit alarm (wander guard), and was to be checked on frequently. *Elopement risk assessments were to be completed upon admission by LPN F, every three months, and as needed by registered nurse (RN) FF. *If a resident was found to be at risk for elopement and was ambulatory, they would wear a wander guard.	F0689	Administrator	3/19/26

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F0689 SS = D	Continued from page 17 *A list of residents who wore wander guards were kept in a binder in the report area. *All departments but housekeeping and maintenance were made aware verbally who was at risk for eloping, and it was discussed at regular resident review meetings. *Ward secretary V was responsible for adding who wore wander guards on the CNA sheets. *The nurse or medication aide was to check that the resident was wearing the wander guard twice a day, and to document it on the medication or treatment record. They had issues with getting that added to the medication or treatment record. *Resident 48's wander guard checks were on the treatment record, it was entered on 11/9/25, and it was only being done at bedtime because it did not pull correctly into the treatment record. *At the time resident 48 eloped on 9/18/25, the provider was "lax" because their main wanderers were no longer there. *After resident 48 eloped on 9/18/25, they started to close the doors to the unit in the evenings to deter her from wandering in that direction. *Resident 48 had worn the wander guard for "quite some time." *When the door alarm panel alarmed she expected staff to check the camera to see who was near the door and to silence the alarm unless there was suspicion to go check the door. *Staff did not need to go check the doors unless the wander guard alarm was going off. *The wander guard alarm sounded by the exit door where it was triggered, and an alert went to the staff's radios to alert them. *All nursing staff on duty were expected to carry a radio and have the volume turned up far enough so they could hear and respond to the alert. *The ward secretary had extra radios at the desk, but did not always listen to them. *The radio needed to be on channel one to receive the alerts and radio communications.	F0689		

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F0689 SS = D	Continued from page 18	F0689		

*Maintenance checked the wander guard panels at the exit doors monthly.

*They did not have a device to check whether the wander guard functioned; they just checked for placement.

*After resident 48 eloped, staff were educated to keep the unit door closed in the evenings, to carry their radios, and to have the volume turned up.

*She was unsure who was all educated, but stated the dietary staff were because they were the ones to close the doors to the unit in the evenings.

*They completed audits that the doors were being closed, brought those to QAPI, and determined they did not need to be continued.

10. Interview and document review on 2/19/26 at 1:45 p.m. with administrator A revealed:

*She did in-service regarding the elopement policy on 9/22/25.

*Every department provided the education to their areas, and staff who were at the meeting read the elopement policy.

*Staff who did not attend that meeting were to read the elopement policy and sign that they had read it.

*Review of the education sign-off sheets revealed thirty-four staff, including nine managers, signed that they received the elopement education. She verified that not all the staff received that education, and they should have.

11. Review of resident 48's electronic medical record (EMR) revealed:

*Her 12/11/25 Brief Interview for Mental Status (BIMS) assessment score was 9, which indicated she had moderate cognitive impairment.

*She had an order entered on 11/9/25 for her wander guard sensor to be checked on both of her walkers three times a day, in the morning, at night, and at bedtime.

*Her 12/9/25 care plan indicated she:

-Was admitted on 6/12/15.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St William's Care Center	**103 N VIOLA ST , MILBANK, South Dakota, 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
F0689 SS = D	Continued from page 19 -Had Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and bodily functions) -Had a BIMS score that indicated moderate cognitive impairment. -Wandered and got lost looking for her room. -Had a wander guard on her merry walker (type of walker). -Was unaware of her own safety, and the staff were to monitor her wander guard and respond if she set that alarm off. 12. Review of the CNA sheets revealed that resident 48 had a wander guard. 13. Review of resident 48's September 2025 through February 2026 treatment record revealed: *September 2025 and October 2025 did not indicate that the wander guard was checked. *On 11/9/25 the wander guard was added to check it three times a day. *11/9/25 through 2/17/26 was signed off as checked once a day at bedtime. 14. Review the provider's 9/19/25 Elopement/Missing Resident policy revealed: *"Each resident at [facility] will be provided a safe environment in which to reside." *"Wandering is a behavior that is characteristically associated with dementia, therefore residents with this diagnosis are observed upon admission..." *"[Facility] does not have a secure or locked unit, therefore the facility has installed a WanderGuard system which consists of sensors (worn by identified residents displaying wandering behaviors) and sensor detector strips that are at or near exit doors." *"These residents are routinely monitor4ed [monitored] to assure they do not purposefully cut the strap and/or that the sensor is activating when it is supposed to do	F0689		

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F0689 SS = D	Continued from page 20 so." "Another safeguard [facility] has implemented is installing auxiliary audible local alarms on interior doors of the facility. These alarms are activated when the interior door is opened which enables staff to reach the resident prior to exiting the building. These alarms sound until staff physically reset them." *"The doors from the resident hallway (Farmer's Fairway) to the dining room will be closed following the evening meal and/or around evening snack. The door at the end of Farmer's Fairway will also be closed as added security."	F0689		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure medications were securely stored and labeled for safe use according to professional standards to ensure:	F0761	F761 Expired medical supplies were immediately discarded. Nursing staff have been been re-educated about the need to rotate stock and verify expiration dates prior to using or storing medical supplies.An "Insulin Administration Policy" was developed that addresses removing insulin from the refrigerator and marking it before putting it in the med cart. The expiration date is calculated according to the manu-facturer's recommendations.Any insulin pens or vials noted to be expiring should be re-ordered so that the resident's medication regimen is unaffected by the need to discard any remaining doses.Should an insulin pen or vial be in the medi-cation cart without a date noted on it, efforts will be made to contact the last nurse administering insulin to see when it was removed from the frig.The policy also notes that according to the user's manual for the glucose monitoring system, control testing needs to be completed when a new box of strips is opened. The container will be dated accordingly. Nursing staff have been re-educated about the need to date inhalers when they are opened. The Amelog insulin pen (for resident 7) was replaced with a new pen that was appropriately dated as it was removed from the frig. The Lantus pen that was not dated has been destroyed. A new pen taken from the Insulin E-kit was labeled and dated. The albuterol inhaler was reordered and new inhaler dated when opened. Alvesco (for resident 48) inhaler reordered and new inhaler dated when open Toujeo Solostar insulin (for resident 32) insulin pen is currently dated according to removal from refrigeration Trelegy Elipta (resident 9) medication supply is currently dated according to date started. The medication room and both medication carts have been checked by the designated TMA to assure that there are no expired medical supplies maintained within them. The night nurse checked the contents of each med cart to ensure insulins, inhalers, and test strips dated.	

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F0761 SS = E	Continued from page 21 *One of one medication room was free from expired medical supplies. *Insulin pens for three of six sampled residents (7,12, and 32) were dated when removed from the refrigerator. *Five of five sampled residents (7,9,35,46, and 48) inhalers were dated when opened. *Two of two glucose test strip bottles were dated when opened. *Two of two medication carts were locked when unattended by two of two nurses (B and R). Findings include: 1. Observation and interview on 2/11/26 at 10:20 a.m. in the medication room with licensed practical nurse (LPN)/director of nursing (DON) in training E revealed: *There was a sign that hung on the refrigerator that stored insulin to indicate how long different types of insulins were good for once opened. *There were thirteen swabs that tested for respiratory infections that expired on 12/20/24. *There was one wound culture that expired on 7/31/24. *There were two urinary catheter drainage bags that expired on 11/7/24 and 3/1/25 *There were three 14 french (fr) self cath (flexible tubing placed in the bladder to drain urine and then removed) kits that expired on 8/26/25 and 10/28/25. *There were sixteen 14 fr female straight catheters that expired on 4/24/24. *The code (medical emergency) box contained one suction yanker (suction instrument) that expired on 10/2/21, four nasopharyngeal airways (emergency airway) that expired 10/20/24, 10/21/25, and 12/14/25, two endotracheal tube (ETT) (emergency airway) that expired on 9/5/22 and 10/30/22, one non-rebreather mask (for oxygen administration) that expired on 8/4/25, and one nasal cannula tubing (for oxygen administration) that expired on 5/19/25. *They used the code box yesterday on a resident. *The overnight nurses were to check the outdates in the	F0761	ADDENDUM: System changes: A designated Trained Medication Aide (TMA) and the facility's purchasing agent are coordinating efforts to assure that the medication room and medication carts are checked for medical supplies that may be nearing expiration dates. At no time will the purchasing agent have access to the medication room or medication carts without an authorized staff person being present. These audits will be at least every 2 weeks for the first month. After the first month, subsequent audits will be monthly. The night nurse is checking medication carts twice weekly and utilizing a list of each resident's prescription medication to ensure that items are dated when opened or removed from the refrigerator (as applicable depending upon type of medication). These audits will ensure that medications are removed at or prior to expiration date. Performance Monitoring: The system changes will be monitored by the DON (or designee) on a weekly basis to assure that each is completing her assigned tasks and understand the requirements. The DON will report findings to the QAPI Committee after 1 month at which time the Committee will determine if further formal monitoring is required and whether it is appropriate to decrease the frequency of checking medication carts and/or medication room. If it is determined that additional formal monitoring is required, the QAPI Committe will determine the frequency and duration of such monitoring. F761 ADDENDUM The policy for Insulin administration was drafted 3/6/26 and nurses were trained their next shift by the DON. Any nurses not being trained as of 3/19/26 will be trained their next shift. Re-education of nursing staff on the need to rotate stock and verify expiration dates prior to using or storing medical supplies was covered informally through shift report and covered formally at nurses meeting on 3/19/26. Any nurse not being trained will receive training by the DON their next scheduled shift.	3/19/26

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F0761 SS = E	Continued from page 22 medication room on their downtime, and medication aide (MA) S checked the outdates weekly. *LPN/DON in training E verified that the expired items should have been removed, and if expired items were used, they could not ensure that the item would function appropriately and could not guarantee sterility. 2. Observation and interview on 2/11/26 at 4:25 p.m. with LPN/DON in training E of the Fisherman/Humming Bird medication cart revealed: *Resident 35 had fluticasone and albuterol inhalers that were opened, used, and not dated. *Resident 7 had a used Amelog Solos Star insulin pen that expired on 2/7/26, a used Lantus insulin pen that was not dated, and an albuterol inhaler that was opened, used, and not dated. *There was one bottle of glucose test strips that was open and not dated to indicate when it had been opened. 3. Observation and interview on 2/11/26 at 4:30 p.m. with LPN/DON in training E of the Farmer/Woodland medication cart revealed: *Resident 48 had an Alvesco inhaler that was opened, used, and not dated. *Resident 12 had a Lantus pen that was not dated once removed from the refrigerator. *Resident 32 had a Toujeo Solostar insulin pen that was opened, used, and not dated. *Resident 9 had a Trelegy Ellipta inhaler that was opened, used, and not dated. *Resident 46 had an albuterol inhaler that was opened, used, and not dated. *There was one bottle of glucose test strips that was opened and not dated to indicate when it had been opened. *LPN/DON in training E expected the insulin pens not to be used past the expiration date as it might not be as effective, and the insulin pens and inhalers to be dated once opened. The medication carts were to be checked for outdated items weekly by MA S and by the	F0761	Type text here	

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F0761 SS = E	Continued from page 23 night nurses during their downtime. 4. Observation on 2/11/26 at 7:54 p.m. revealed a medication cart was in the hallway by resident rooms, it was not locked, and there were no staff present near it. Registered nurse (RN) R verified it was unlocked, and she thought it was okay to leave it unlocked since she was in a resident room that was across the hall from it. 5. Observation on 2/11/26 at 7:56 p.m. revealed one of the medication carts was left unlocked and unattended near a resident room with a resident sitting in front of the cart. DON B was then observed walking down the hallways towards the medication cart to continue passing medications. 6. Interview on 2/11/26 at 8:04 p.m. with DON B revealed she did not think the insulin pens needed to be dated until they were used, and not when they were taken out of the fridge. 7. Interview on 2/12/26 at 10:07 a.m. with Pharmacist Q revealed that insulin was to be dated once it was removed from the fridge. 8. Interview on 2/19/26 at 12:55 p.m. with DON B revealed that it was best practice to date insulin once it was removed from the fridge, inhalers were to be dated once opened, and the medication carts were to be locked when out of the nurse's vision. Regarding medication and supplies, they only had the Administration of Medication policy. 9. According to the provider's 2/24/25 Administration of Medication policy revealed: *"It is best practice to lock cart prior to walking away from it, but at least visual control of the cart must be maintained to assure hat [that] no one else is able to access it." *"The medication cart is to remain locked at all times when a nurse is not in close proximity."	F0761		
F0803 SS = F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)	F0803		

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F0803 SS = F	Continued from page 24 §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interview, and record review, the provider failed to ensure two of two dietary staff (cook L and dietary aide P) followed the menu serving sizes for each diet offered for two of two observed meals. This had the potential to affect all residents who requested the main menu items. Findings Include: 1. Observation on 2/10/26 at 11:25 a.m. in the kitchen revealed that cook L was preparing to set up the hot-serving table for the lunchtime meal service. Interview at that time with cook L revealed that "most" residents requested smaller portions, but she provided about four ounces of the meat option and two ounces of vegetables or two ounces of the side dish to the residents. She did not reference the dietitian approved menu at that time to verify the correct serving sizes	F0803	F803 Cook L will be trained by the Dietary Manager on proper scoop sizes, and how to ensure adequate serving sizes are provided. iDietary P etary aide P is no longer emDie All staff will receive training on correct scoop sizes to ensure proper serving sizes. A visual guide will be provided at the trayline for staff to reference to ensure the correct scoop is being utilized to provide the correct amount of food as well as a visual of portions for each diet. System Changes: A training will be conducted by the Dietary Manager for all kitchen staff to ensure correct scoop amounts are being utilized to provide the correct amount of food. Additional t raining will be provided if needed. ADDENDUM: The initial training will be completed by 3/19/26; any staff not receiving the training will do so at next scheduled shift. Verification of this will be the signage on the training roster. The training will include scenarios, for example, where staff will need to demonstrate how many scoops are needed for 4 ounces. Following the training, observation will take place by the Dietary Manager and/or the Administrator varying the shifts and staff audited on a weekly basis for 6 weeks to ensure proper food servings are being provided (using the correct scoops). Performance Monitoring: The Dietary Manager and/or Administrator will monitor the system changes invovling observations one time a week for 3 months and report findings to the QAPI committee at which time will determine if further monitoring is needed.	3/19/26

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F0803 SS = F	Continued from page 25 for each prescribed resident diet. 2. Observation on 2/10/26 from 11:50 a.m. to 12:19 p.m. in the dining room during lunch revealed that cook L was placing serving utensils in the food items. She used a four-ounce scoop for the peas, and two-ounce scoops for the pureed peas, stewed tomatoes, and mashed potatoes. When serving the stewed tomatoes, mashed potatoes, and pureed peas, cook L only used one scoop, meaning that only two ounces were served. Cook L served smaller portions of the baked chicken legs to the female residents, and she served the larger bone-in chicken breasts to the male residents. Additionally, cook L was serving residents one scoop (about two ounces) of mashed potatoes, and one scoop (about two ounces) of the pureed peas to residents. The menu indicated four ounces of mashed potatoes, and four ounces of peas should have been served. Cook L served resident 26 one scoop of peas (about four ounces), one scoop of mashed potatoes (about two ounces), one scoop of gravy (about two ounces), one slice of bread, and one small chicken leg. The laminated diet card did not indicate any requests for small-portioned meals. 3. Review of the dietary extension menus revealed the menu for 2/10/26 included three ounces of protein (either the baked chicken or the cube steak), a half-cup of mashed potatoes (four ounces), and choice of a half-cup of stewed tomatoes or a half cup of peas. Residents on the pureed diet were supposed to have received a half-cup of the pureed peas. There was no “small portions” diet. 4. Review of the resident diet orders report revealed that seven residents requested small portions, and two residents were on a pureed diet. 5. Interview on 2/18/26 at 9:58 a.m. with dietary manager K revealed she expected staff to use the menu book that outlined the appropriate serving sizes for each menu item. There was a binder labeled “Cold Orders” in the kitchen for staff to access that contained all the menus and serving sizes for each diet. She expected all dietary staff to know where to find the diet menu spreadsheets and how to use them. 6. Observation and interview on 2/18/26 at 11:51 a.m. with dietary aide P in the dining room revealed that she was using a two-ounce scoop for the mashed potatoes and ground beef. She said that cook L helped her set up the hot-holding table because she just started her job	F0803		

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F0803 SS = F	Continued from page 26 about four days ago. She used only one scoop of mashed potatoes and one scoop of the ground beef to serve the resident's their lunch. 7. Review of the provider's menu for lunch on 2/18/26 revealed that the menu included a half-cup of mashed potatoes (about four ounces) and three ounces of roast beef (three ounces of ground beef for those on the mechanical soft diet).	F0803		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to: *Minimize cross-contamination via glove use during two of three meals observed by cook L and during food preparation by dietary aide T. *Properly store and sanitize food thermometers prior to use by cook L. *Maintain one of one kitchen in a clean and sanitary manner as evidenced by dusty ceiling vents throughout	F0812		

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F0812 SS = F	Continued from page 27 the kitchen, dusty ventilation fans in one of one walk-in cooler, rusty shelves in one of one walk-in cooler, and food scum buildup inside one of one commercial dishwashing machine. *Monitor and document the temperatures for one of one commercial dishwashing machine according to the provider's policy to ensure it reached the minimum rinse cycle temperature of 180 degrees for sanitization of dishes and equipment used to prepare and serve residents' meals. *Ensure safe food storage practices were maintained as evidenced by storing potentially hazardous foods at room temperature for an extended period of time by one of one cook (L) and storing raw bacon above ready-to-eat (RTE) mashed potatoes in one of one walk-in cooler. *Discard visibly spoiled and expired foods on or before the manufacturer's date. Findings Include: 1. Observation on 2/10/26 at 8:40 a.m. in the dining room revealed cook L was serving breakfast. She had on a pair of disposable gloves. She wore the same gloves throughout the observation. She touched several surfaces with those gloves, including the serving utensils, the laminated diet tickets, the serving table, her apron, and the handle of the serving cart. With those potentially contaminated gloves, she touched the food-contact surface of the plates and the slices of toast. She then used her gloved hand to scoop loose brown sugar into two-ounce plastic containers to serve with the hot cereal. She did not use a serving utensil for the toast or the brown sugar. Observation on 2/10/26 at 8:48 p.m. in the kitchen of dietary aide T revealed she was preparing cold deli sandwiches with disposable gloves on her hands. She touched several surfaces with those gloves including the loaf of bread, the sandwich meat, the plastic cling wrap, and the permanent marker to mark the date on the cling wrap. She then exited the kitchen to place the deli sandwiches in the refrigerator in the cafeteria. She came back to her prep area and continued making sandwiches without changing gloves or performing hand hygiene. Interview on 2/10/26 at 8:52 a.m. with dietary aide T about the above observation revealed she prepared those deli sandwiches for both staff and residents. She wrapped the sandwiches in cling wrap and wrote the	F0812	F812 The ceiling vents were cleaned at the time of the survey, rusty shelves are being replaced in the walk in cooler, buildup removed from the dishwasher, meat stored in the cooler is not stored above ready to eat foods, expired items such as food coloring or extracts were discarded. Training on components og F812 will be provided to Cook L and dietary aide T as well as other kitchen staff. This training will include minimizing cross contamination via glove use; proper storing and sanitizing food ther-mometers; maintaining a clean kitchen; monitoring and documenting dishwasher temps; and safe food storage practices. ADDENDUM: time and temperature control relating to the food being left out for an extended period of time will also be trained. The Dietary Manager and the Administrator will complete a walk through of the kitchen area to ensure components of F812 are addressed on checklists. System Changes: Daily, weekly and monthly checklists for F812 were created to be completed by both the Dietary Manager and the Administrator to ensure compliance with components of F812. ADDENDUM: The following checklists were developed as audit tools for compliance with F81 DAILY--food procurement; storage conditions; food prepara-tion; meal service; sanitation and environment. WEEKLY--documentation and logs; deep cleaning tasks; staff competency for glove use MONTHLY--audit supplies for expiration dates and discard as needed. Performance Monitoring: The system changes will be monitored by both the Dietary Manager and the Administrator and findings reported to the QAPI committee for 3 months at which time the committee will determine if further monitoring is needed. ADDENDUM: the audits will be completed as defined above in the daily, weekly and monthly components.	3/19/26

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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
F0812 SS = F	Continued from page 28 preparation date on the cling wrap using the permanent marker. Observation on 2/10/26 at 11:55 a.m. during lunch service in the dining room revealed cook L wore a pair of disposable gloves. She touched the serving utensils, the serving table, and the laminated diet cards. With those potentially contaminated gloves, she touched the food-contact surface of the plates and slices of bread. Continued observation on 2/10/26 at 11:58 a.m. during lunch service in the dining room revealed dietary aide M wore a pair of disposable gloves. He touched the serving table and the laminated diet cards. With those potentially contaminated gloves, he touched the drinking surface of the cups. Review of the provider's 2023 Hand Washing policy revealed that staff should wash their hands "when switching between working with raw food and working with ready to eat food." Review of the provider's 2023 Bare Hand Contact with Food and Use of Plastic Gloves policy revealed that "staff will use clean barriers such as single use gloves, tongs, deli paper and spatulas when handling food. Gloved hands are considered a food contact surface that can become contaminated or soiled. If used, single use gloves shall be used for only one task such as working with ready-to-eat (RTE) food or with raw animal food, used for no other purpose and discarded when damaged or soiled, or when interruptions occur in the operation." Additionally, "hands are to be washed when entering the kitchen and before putting on the single use gloves (before beginning to work with food) and after removing single use gloves." 2. Observation on 2/10/26 at 8:58 a.m. in the kitchen revealed that two thermometer probes were kept in a cup with an unidentified clear liquid. The container had food debris floating around the liquid. Interview on 2/10/26 at 9:02 a.m. with cook L revealed that the above unidentified clear liquid was a sanitizer solution. She said it was changed daily, but she had not changed it yet from the previous day. Testing of the sanitizer solution concentration revealed that it was within acceptable range for proper sanitation. There were food particles floating within the sanitation solution. The sanitization solution was then changed. Observation on 2/10/26 at 11:30 a.m. in the kitchen revealed cook L was preparing to measure the	F0812		

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F0812 SS = F	Continued from page 29 temperature of the chicken that was to be served for lunch that day. She used one of the above-mentioned thermometer probes. She wiped the probe on a cloth that had been sitting on top of a container of papers near the microwave. She did not use an alcohol wipe to sanitize the probe before inserting it into the chicken. There were alcohol wipes available on a neighboring food prep table. Interview on 2/18/26 at 9:58 a.m. with dietary manager K revealed that the sanitizer solution used to store the thermometer probes should have been changed every shift. She expected staff to clean the thermometer probes with an alcohol wipe before inserting the probe into the food. She explained it was not acceptable to use a potentially soiled cloth found in the kitchen to wipe the thermometer probe prior to use. She also expected staff to refrain from touching food with potentially contaminated gloves. If each food item had a serving utensil, then the staff would not need to wear gloves. Review of the provider's 2023 Resource: Taking Accurate Temperatures policy revealed "to take temperatures, a clean, rinsed, sanitized and air-dried thermometer that is the metal stem type, numerically scaled and accurate to plus or minus 2 degrees Fahrenheit is needed." 3. Observation on 2/10/26 at 8:53 a.m. in the kitchen revealed that the two ceiling vents above the walk-in cooler and freezer were caked with a thick layer of dust. Observation and interview on 2/10/26 at 9:21 a.m. in the dish room with dietary aide N revealed that the inside of the dishwasher doors had a thick layer of food scum and limescale buildup. That buildup was also present to the left of the dishwasher, underneath the seam of the dishwasher track where it connected with the dirty dish table. Dietary aide N stated that the dishwasher was delimed once per week, but they did not use any cleaning tools, such as a cloth wipe or dish brush, to scrub areas where the food scum accumulated. Observation on 2/18/26 at 9:41 a.m. in the walk-in cooler revealed there were four fans used to circulate refrigerated air throughout the cooler. All four fans and the grates covering them had a collection of dust. There were streaks of dust buildup on the ceiling. There was more dust buildup on the light fixtures. Continued observation on 2/18/26 at 9:51 a.m. in the walk-in cooler revealed several of the storage shelves were rusty and the chrome or paint coating was chipping	F0812		

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F0812 SS = F	Continued from page 30 away. Several RTE food items were below the rusty parts of the shelves, such as fresh vegetables and fruit. Interview on 2/18/26 at 9:58 a.m. with dietary manager K revealed there was not a designated person in the facility to clean the ceiling vents or the fans in the walk-in cooler. She also indicated the rusty shelves might have to be replaced due to the potential for physical contamination of rust falling on the RTE vegetables on the shelf below. Review of the provider's dishwasher deliming schedule for 2025 revealed from July to December 2025, 26 of 31 scheduled cleanings were completed. In December 2025, deliming was completed only once. Review of provider's 2023 Food Storage policy revealed "Racks and other storage surfaces should be clean and protected from splashes, overhead pipes, or other contamination (ceiling sprinklers, sewer/waste disposal pipes, vents, etc.)" 4. Review of provider's dishwashing temperature logs (August 2025 to February 18, 2026) revealed several missed opportunities for temperature documentation. Each monthly log had spaces to record the dishwasher temperature after each meal. There was a total of three temperatures required per day according to the log. In August 2025, there were 10 missing temperature documentations out of 93 opportunities. In September 2025, there were 36 missing out of 90 opportunities. In October 2025, there were 38 missing out of 93 opportunities. In November 2025, there were 32 missing out of 90 opportunities. In December 2025, there were 52 missing out of 93 opportunities. In January 2026, there were 61 missing out of 93 opportunities. From 2/1/26 to 2/18/26, there were 32 missing temperature documentations out of 54 opportunities. Interview on 2/18/26 at 9:58 a.m. with dietary manager K revealed that she expected staff to complete the temperature logs for the commercial dishwashing machine after each meal service when the dishes were cleaned. Interview on 2/18/26 at 11:50 a.m. with dietary aide O revealed that he was assigned to the dishwashing duties that shift. He stated that he did not check the temperature of the dishwashing machine and added, "but I probably should." He further stated that he "did not remember the last time he checked the dishwashing temperatures." Review of provider's 2023 Cleaning Dishes/Dish Machine policy revealed that "staff will monitor dish machine	F0812		

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F0812 SS = F	Continued from page 31	F0812		

Continued from page 31
temperatures through the dishwashing process. Staff will record dish machine temperatures for the wash and rinse cycles at each meal. The director of food and nutrition services will spot check this log to assure temperatures are appropriate and staff is correctly monitoring dish machine temperatures. Staff will be trained to report any problems with the dish machine to the director of food and nutrition services as soon as they occur. The director of food and nutrition services will promptly assess any dish machine problems and take action immediately to ensure proper sanitization of dishes."

5. Observation on 2/10/26 at 8:55 a.m. in the kitchen revealed there were several different covered containers of food, and an uncovered sheet pan of cooked beef patties sitting on the counter. Testing of the food temperatures revealed that the covered container of beef tips in gravy was at 56.1 degrees Fahrenheit, and the beef patties were at 68.9 degrees Fahrenheit.

Interview on 2/10/26 at 9:28 a.m. with cook L revealed that the containers of food were designated for lunch that day. They usually prepare the lunch food before breakfast was served, panned it into containers, and placed the containers back in the cooler before they went to serve breakfast. She confirmed the food had been sitting out at room temperature since before she went out to serve breakfast, which she started serving at 7:30 a.m. She stated that it was not normal practice for the lunch food to sit on the counters during breakfast service. She usually put the food back into the cooler, but she had not done so that morning. She planned on using that food for lunch, and her goal final cooking temperature was "at least 160 degrees [Fahrenheit]."

Observation on 2/10/26 at 11:22 a.m. revealed that the final cooking temperatures for the above-mentioned lunch foods were all above the minimum 165 degrees Fahrenheit temperature for reheated food.

Observation on 2/18/26 at 9:49 a.m. in the walk-in cooler revealed raw bacon was stored in a cardboard box above a box of RTE mashed potatoes. This potentially exposed the mashed potatoes to cross-contamination from raw meat juices.

Observation on 2/18/26 at 9:53 a.m. in the walk-in freezer revealed a box of frozen beef patties that was uncovered and left open to air on the bottom shelf of the storage rack. This potentially exposes the beef patties to physical, chemical, or biological

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F0812 SS = F	Continued from page 32 contamination in addition to quality concerns with freezer burn. Interview on 2/18/26 at 9:58 a.m. with dietary manager K confirmed that raw foods should not have been stored above RTE foods. She was not aware of the box of frozen beef patties that was left open to air in the freezer. She further explained that if food was left out on the counter and entered the “temperature danger zone [41 to 135 degrees Fahrenheit]”, it should have been discarded because they did not know how long that food had been sitting out. Dietary manager K explained that food that had been sitting out for over an hour could cause residents to become ill with a foodborne illness. She had not heard of any gastrointestinal illnesses amongst the residents lately. Review of the provider’s 2023 Use of Leftovers policy revealed, “Leftovers should be covered, labeled, and dated; then stored appropriately (refrigerated or frozen if necessary) immediately after the end of the meal service. Leftovers that have not been properly stored will be discarded. (When in doubt, throw it out.)” 6. Observation on 2/10/26 at 9:10 a.m. in the kitchen revealed there was a shelving unit with various baking ingredients like food coloring, flavor extracts, and coffee syrups. Several items were past the manufacturer’s “Best By” or expiry dates, including: Watkins branded butter extract with an expiry date of 3/3/25, Watkins branded lemon extract with an expiry date of 3/18/25, “egg shade” yellow food coloring that had a delivery receipt of 1/6/11, Torani branded sugar-free caramel coffee syrup with “Best If Used By 11/24/22,” Torani branded coconut coffee syrup with “Best If Used By 12/28/25,” another bottle of egg shade food coloring with a delivery date of 10/22/13, a bottle of dried cilantro with “Best By 2/27/2025,” and a bottle of “Crème de Menthe” coffee syrup with an expiry date of 1/17/21. Observation on 2/18/26 at 9:45 a.m. in the walk-in cooler revealed there was a gallon jug of sweet pickle relish and a gallon jug of thousand island dressing. The cover on the pickle relish was not fully secured and had an unidentified white substance on the inside surface of the lid. The jug of thousand island dressing had what appeared to be mold growing on the outside of the container, on the inside of the lid. and on the handle. There was no “opened” date written on that container. Interview on 2/18/26 at 9:58 a.m. with dietary manager	F0812		

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F0812 SS = F	Continued from page 33 K revealed that they did not use the food coloring, flavor extracts, or coffee syrups often in their baked goods. She was not aware that those items were past the "best by" dates. She was also not aware of the potentially moldy jug of dressing in the cooler. She guessed the white substance on the inside of the pickle lid could have been something like mayonnaise, but she was not sure. Review of the provider's 2023 Food Storage policy revealed that "All stock must be rotated with each new order received. Rotating stock is essential to assure the freshness and highest quality of all foods. Food should be dated as it is placed on the shelves if required by the state regulation. Date marking should be visible on all high-risk food to indicate the date by which a ready-to-eat TCS [time and temperature control for safety] food should be consumed, sold or discarded. …All containers or storage bags must be legible and accurately labeled and dated. All foods should be covered, labeled and dated and routinely monitored to assure the foods (including leftovers) will be consumed by their use by dates, or frozen (where applicable) or discarded. All foods should be covered, labeled and dated…"	F0812		
F0868 SS = D	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	F0868	F868 The Medical Director was informed of the deficient practice on 3/11/26. System Changes: An agreement will be reached between the Administrator and the Medical Director for his attendance requirement at QAPI meetings at least every quarter. It has been proposed that this be accomplished by attendance every other month and paired with the dates he does rounds. The Administrator will provide the Medical Director with the dates and times of the meetings Performance Monitoring: The Administrator will monitor the system changes and report findings to the QAPI committee on a monthly basis for 6 months at which time the QAPI committee will determine if further monitoring is needed. ADDENDUM 3/19/26 F868 The Medical Director (MD) and the Administrator have agreed that the Medical Director will attend a minimum of every other month. The Administrator will call him prior to each meeting to verify hisavailability, and if he is not able to attend, he will provide a date where he is doing rounds, or will be at the Facility, and the QAPI meeting will be re-scheduled to accommodate his attendance. The monitoring has no change	3/19/26

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F0868 SS = D	Continued from page 34 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. 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 interview, record review, and policy review, the provider failed to ensure medical director EE attended and meaningfully participated in the provider's Quality Assurance and Assessment (QAA) meetings at least quarterly. Findings include: 1. Interview on 2/19/26 at 11:25 a.m. with administrator A revealed that the QAA committee meets monthly. She texted medical director EE monthly to remind him of when the meetings were, and he usually texted topics he wished the committee to discuss. He sometimes would attend via telephone. He did not have a nurse practitioner or physician's assistant to attend in his absence. She confirmed she was aware that the medical director was required to attend at least quarterly. 2. Review of the provider's QAA committee binder at that time with administrator A revealed that medical director EE attended the QAA committee meeting via telephone on 1/29/26 (their most recent QAA committee meeting), and he attended in person on 8/13/25. All other months throughout 2025 he either did not attend or only sent a text to administrator A with topics he wanted them to discuss. 3. Review of the provider's July 2025 QAPI (Quality	F0868		

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F0868 SS = D	Continued from page 35 Assurance and Performance Improvement) policy revealed that the medical director was on the QAA committee, and the committee would meet at least quarterly.	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 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	F0880	F880 The Water Management Plan policy has been reviewed/updated to reflect changes to F880; ADDENDUM Revisions completed by the DON/Infection Control Nurse. This plan will be inserviced ADDENDUM by the DON/Infection Control Nurse to the Maintenance Director, the DON, and the Infection Control Specialist. Checklists will be reviewed and assignments delivered to ensure water temperatures are maintained at appropriate levels, that water is ran through areas where stagnate water may be found (unused bathrooms). Chlorine test strips have been ordered to ensure our levels are adequate. ADDENDUM--The checklist for monitoring the temp at water heater displays the date, temp, time of day, and initials of staff. This will be done for 30 days and thereafter completed weekly. The checklist for monitoring the temp in the bedrooms is also implemented and will be done one time a week. System Changes: This plan ADDENDUM--has been inserviced to the Maintenance Department, the DON, and the Infection Control Specilaist, and the Infection Control Consultant. ADDENDUM: A checklist for the monitoring of temp at water heater is formalized and implemented. A checklist for monitoring temps at the rooms is formalized and implemented and to be completed weekly by Maintenance. Checklists will be reviewed and assignments delivered to ensure water temps are maintained at appropriate levels, and water is ran through areas where there may be stagnate conditions (unused bathrooms) ADDENDUM--Housekeeping staff will run water through sinks, tubs of unoccupied rooms on a weekly basis--both cold and hot water will be ran from 2-5 minutes, and toilets flushed at least twice per session. Chlorine test strips have been ordered to ensure levels are normal range and will be used upon receipt. Chlorine levels will be tested monthly by Housekeeping and Maintenance Supervisors in rooms that are not in use for more than 1 month. Performance Monitoring: The system changes will be monitored by the Infection Prevention Specialist in conjunction with the Infection Control Consultant and the Maintenance Director. The system changes will include the water temps at water heater; water temps in resident rooms; running of water in unoccupied rooms Each area (housekeeping, maintenance will maintain their specific information and provide it to the Infection Prevention Specialist for review at the QAPI meeting. This information will be presented to QAPI for 3 months at which time the committee will determine if further monitoring is needed.	3/19/26

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F0880 SS = F	Continued from page 36	F0880		

(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.

§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, document review, and policy review, the provider failed to ensure a water management program was in place to mitigate the growth and spread of Legionella (a type of bacterium commonly found in natural water sources). This had the potential to affect all residents, staff, and visitors within the facility.

Findings include:

1. Interview on 2/18/26 at 12:45 p.m. with maintenance director U revealed:

*He checked the in-line water heater temperature every morning, and the temperature range was to be no more than 125 Fahrenheit (F), so he kept it at 117-118 degrees F.

*They did not add any chemicals to their water for the prevention of Legionella.

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F0880 SS = F	Continued from page 37 *The building's water was not tested for chlorine levels. *He or housekeeping sometimes ran the water and flushed the toilets in the empty rooms, but he did not have a formal plan or documentation for running stagnant water. 2. Review of the November 2025 through February 2026 water heater temperatures revealed that the water heater temperatures were always at 117 degrees F. The water temperature was required to be 122 degrees F to 125 degrees F for control of Legionella. 3. Interview on 2/19/26 at 9:00 a.m. with city water employee HH revealed he did chlorine testing at the nearby upstream facility daily, but not at this nursing home. 4. Interview on 2/19/26 at 12:55 p.m. with director of nursing/infection preventionist B revealed she expected maintenance to follow the federal guidelines for the prevention of Legionella. 5. Interview with administrator A on 2/19/26 at 1:30 p.m. revealed: *She expected maintenance to follow the guidelines to prevent Legionella. *There was a changeover in staff, and no one was monitoring that it was being done. *They did not have a formal process for running stagnant water or making sure the water was the correct temperature to kill Legionella. *She was responsible for ensuring the water management process was followed. 6. The 10/2025 Infection Prevention and Control Policy did not contain information regarding Legionella management and prevention.	F0880		

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

FORM APPROVED
OMB NO. 0938-0391

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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 2/10/26. St William's Care Center was found in compliance.	E0000		

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
Rene Thrift	Administrator	3/13/26

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435122	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING 0...** B. WING	(X3) DATE SURVEY COMPLETED **02/10/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St William's Care Center	**103 N VIOLA ST , MILBANK, South Dakota, 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
K0000	INITIAL COMMENTS A recertification survey was conducted on 2/10/26 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 K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0712 SS = D Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedure (Closing corridor doors). Findings include: 1. Observation beginning on 2/10/26 at 11:56 p.m. revealed a drill for a simulated fire in room 212 was being conducted. Further observation at that same time revealed the certified nursing assistant (CNA) who responded to the activated nurse call light needed prompting to initiate the response to the simulated fire. Upon discovery of the simulated fire that CNA stated " I don't know what to do" to the maintenance	K0712	K0712 Corrective Action: This specific staff was instructed of the correct process during the survey . The Administrator also reviewed the process with her 3/13/26. Other staff will participate in bi-monthly drills until there are no errors in the process.	

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
Rene Thrift	Administrator	3/13/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **435122**	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING 0...** B. WING	(X3) DATE SURVEY COMPLETED **02/10/2026**

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K0712 SS = D Bldg. 01	Continued from page 1 director. At that time the maintenance director running the fire drill had to walk the who responded CNA through each of the R.A.C.E. (Rescue, Alarm, Confine/Contain, and Evacuate) steps prior to the CNA taking any action. That CNA had to be further prompted by the maintenance technician as to where a manual fire alarm pull station was, as well as how and what to page on the building's public announcement system. Through this process no staff tested the door to the room where the simulated fire was in or attempted to mitigate the effects of the simulated fire in that room. Interview with the administrator during the exit interview confirmed the findings that the CNA who responded was not familiar with the provider's fire drill procedures. She also stated she believed they did not pass the drill. The deficiency had the potential to affect 100% of the building occupants	K0712	All residents have the potential to be affected. New staff hired since survey end date 2/19/26 will be instructed in fire drill process. Systemic changes: 1. Newly hired staff will complete a walk through fire drill within the first 30 days of employment. 2. Fire drills simulations will be conducted with current staff until no errors are noted in the process. The Maintenance department will work with the Staff Trainer in the new hire process. Performance monitoring: The Staff Trainer will report findings to the QAPI committee for 2 monthsat which time the committee will determine if further monitoring is required.	3/19/26

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 ______	02/19/2026

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 2/10/26 through 2/12/26, and 2/18/26 through 2/19/26. St. Willam's Care Center was found not in compliance with the following requirements: S157, S169, S206, S210, S236, S296, and S301.	S 000		
S 157	44:73:02:13 Ventilation A facility shall provide electrically powered exhaust ventilation in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation for three randomly observed locations (resident rooms 214, 228, and 239). Findings include: 1. Observation and testing on 2/10/26 at 2:38 p.m. revealed the exhaust ventilation in the bathroom of resident room 239 was not functioning. Testing of the grille with tissue paper at the time of the observation confirmed that finding. Additional testing at that same time revealed the same condition existed in the adjacent rooms. 2. Observation and testing on 2/10/26 at 2:47 p.m. revealed the exhaust ventilation in the bathroom of resident room 228 was not functioning. Testing of the grille with tissue paper	S 157	S157 Corrective Action: The Maintenance Director checked the exhaust ventilation in the bathroom of resident room 214, 228 and 239 following the inspection using the tissue grilletest—all were functional. The Maintenance Director also purchased clear plastic boxes and installed them over the switches which controls the ventilation system. Identificaiton of other residents: An audit of the bedrooms, bathrooms, and adjacent rooms was completed and any corrections necessary were completed. Bedroom vents were cleaned, vacuumed and ensured they were open and functional System Changes: The Maintenance Department will check the switches visually for 2 weeks to ensure they are functional. (ADDENDUM) The Maintenance Department will make weekly checks of the vents in the bedroom to make sure the vents are operational. (ADDENDUM) The Maintenance Department will check the vents on the roof quarterly to make sure they are operational/functional--to include belts, motors, and covers Performance Monitoring: The Maintenance Director will report findings on the system changes at the QAPI meetings for 3 months at which time the QAPI committee will determine if further monitoring is needed.	3/19/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rene Thrift
TITLE: Administrator
(X6) DATE: 3/19/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ST WILLIAM'S CARE CENTER	103 N VIOLA ST MILBANK, SD 57252

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S 157	Continued From page 1	S 157		

at the time of the observation confirmed that finding. Additional testing at that same time revealed the same condition existed in the adjacent rooms.

3. Observation and testing on 2/10/26 at 2:54 p.m. revealed the exhaust ventilation in the bathroom of resident room 214 was not functioning. Testing of the grille with tissue paper at the time of the observation confirmed that finding. Additional testing at that same time revealed the same condition existed in the adjacent rooms.

Interview with maintenance director U at the time of the above observations confirmed those findings. He revealed he was unaware why the exhaust ventilation was not working at those locations. He added they check the exhaust in the building at least semi-annually.

S 169 44:73:02:18(5-7) Occupant Protection — S 169

The facility shall:
(5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks;
(6) Install an electrically-activated audible alarm on all unattended exit doors. Any other exterior doors must be locked or alarmed. The alarm must be audible at a designated staff station and may not automatically silence when the door is closed;
(7) Prohibit the use of a portable space heater, portable halogen lamp, household-type electric blanket, or household-type heating pad in the facility;

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ST WILLIAM'S CARE CENTER	103 N VIOLA ST MILBANK, SD 57252

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S 169	Continued From page 2 This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to install or maintain door alarming as required for two randomly observed exterior doors (maintenance stair door and main entrance). Findings include: 1. Observation on 2/10/26 at 2:05 p.m. revealed the door leading into the maintenance stairs was equipped with a door alarm. Testing the alarm by opening the door revealed the alarm would sound when the door was open but would automatically silence when the door was closed. Further observation at that same time revealed the door just beyond the alarmed door, on the opposite side of the stairwell, allowed direct access to the exterior of the building and was not equipped with any alarm. Interview with maintenance director U at the time of the observation and testing confirmed that condition. He went on to state they had just recently fixed the keypad at that location because "it had not been working correctly". 2. Observation on 2/10/26 at 2:57 p.m. revealed the main entrance door was equipped with a door alarm. Testing the alarm by opening the door revealed the alarm would sound when the door was open but would automatically silence when the door was closed. Interview with maintenance director U at the time of the observation and testing confirmed that condition. He went on to state he was unaware that alarm could not reset automatically when the	S 169	S169 A time limited waiver was requested from the SD DOH with an end date of ADDENDUM 8/1026 so that an updated/new system can be evaluated and installed. Potential affects on residents: There are 5 doors affected by this regulation--all 5 of these doors will be inspected by the vendor to arrive the week of 3/16-20/26. System Change: Director of Maintenance has appointment with a vendor from Sioux Falls to obtain information on how to update current system or to install a new system or recommend a different vendor. The appointment is scheduled for the week of 3/16-20/2026. Performance monitoring: The Maintenance Director will report findings to the QAPI committee on the progress of obtaining the proper alarm system at each QAPI meeting. The QAPI committee will request more information as needed and will determine if further monitoring is needed.	

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S 169	Continued From page 3 door closed.	S 169		
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 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 personnel record review, employee training record review, and interview, the provider	S 206	S206 Corrective Action: The topics of Advanced Directives and Care of Residents with Unique Needs has been added to the current training curriculum. Staff Z will receive the training by 3/19/26. Staff Y, X and BB will receive the appropriate training on Advanced Directives and Care of Residents with Unique Needs by 3/19/26. Staff AA is no longer employed. ADDENDUM 3/18/26: Staff X will also receive training on resident rights by 3/19/26 Identification of other affected: An audit of the curriculum showed that Advanced Directives and Care of Residents with Unique Needs was not addressed so training was developed addressing these areas and will be given to all staff by 3/19/26. System Changes One staff has been assigned for Staff Training. She will monitor the 12 areas of required training to ensure that our current system includes them, and she will monitor staff participation in the yearly training. She will also provide initial orientation training to new employees. Performance Monitoring: The Staff Trainer will report findings on the system changes to QAPI committe on a monthly basis for 3 months at which time QAPI committee will determine if further monitoring is needed.	3/19/26

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S 206	Continued From page 4 failed to ensure that five of five newly hired employees reviewed (X, Y, Z, AA, and BB) completed the required orientation training topics within 30 days of hire. Findings include: 1. Review of employee Z's personnel file revealed she was hired on 4/21/25. There was no record that she completed any of the 12 required training topics within 30 days of hire. 2. Review of employee AA's personnel file revealed she was hired on 11/14/25. There was no record that she had been trained on the topics of "care of residents with unique needs" or "advanced directives." 3. Review of employee Y's personnel file revealed he was rehired on 11/17/25. There was no record that he had been trained on the topics of "care of residents with unique needs" or "advanced directives." 4. Review of employee X's personnel file revealed she was hired on 12/1/25. There was no record that she had been trained on the topics of "resident rights," "care of residents with unique needs," or "advanced directives." 5. Review of employee BB's personnel file revealed they were hired on 1/1/26. There was no documentation that they were trained on the topics of "care of residents with unique needs" or "advanced directives." 6. Interview on 2/12/26 at 11:20 a.m. with human resources director (HRD) I and administrator A revealed that neither of them knew if employee Z was properly oriented or trained. The former	S 206		

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S 206	Continued From page 5 director of nursing (DON) oversaw her training. They explained that employee X was an overnight employee, and at times had difficulty with getting the overnight employees to complete the required training. The former DON put together the orientation and training packet. Administrator A confirmed that she knew that "advanced directives" was a newer requirement and that was not currently in their orientation packet. Administrator A confirmed that the "care of residents with unique needs" topic was not in their orientation packet. 7. Interview on 2/19/26 at 11:25 a.m. with administrator A revealed that they had identified a gap in their employee orientation and training process in their quality assurance and performance improvement (QAPI) committee. Their previous director of nursing (DON) oversaw new employees' orientation and training, and it fell by the wayside after that DON left. They recently signed up for a paid nursing home orientation and training service that they were using for the annual training requirements but had not used it for the initial training.	S 206	S210 Corrective Action: For staff Z, N, X and BB, there health evaluations will be reviewed by the Staff Trainer/LPN and signatures obtained. Staff AA no longer employed. Employee Y will complete a health eval with signature from nurse An audit of new hires since survey end date 2/19/26 has been completed with 1 new re-hire. His health eval has been signed off by a nurse. System changes: An update to our current Isolved system is being completed which will reflect the necessary paper work required for initial employment. It will have the capability for appropriate personnel to sign off respective areas. Until this has been installed,updated, the Staff Trainer will coordinate signing of the health evaluation Any training aspects of staff orientation have been assigned to one staff, the Infection Control Specialist./Staff Trainer. She will provide new hire staff orientation	3/19/26
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	S 210	ADDENDUM: Performance Monitoring The Staff Trainer will coordinate along with the Human Resource Director the required documents necessary for employment such as the health eval form and signature, training to be completed upon initial hire, TB tests etc. The HR Director will provide the necessary forms, and the Staff Trainer will ensure the forms are completed properly and timely. The Staff Trainer will also monitor and provide the initial training required for employment. She will report these findings to the QAPI committee for 3 months at which time the committee will determine if further monitoring is needed.	

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S 210	Continued From page 6	S 210		

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 personnel record review and interview, the provider failed to ensure a health evaluation (an employee evaluation reviewed by a licensed healthcare professional to ensure no personnel was infected with any reportable communicable disease that posed a threat to others) was completed within fourteen days of hire for six of six newly hired employees (N, X, Y, Z, AA, and BB).

Findings include:

1. Review of the personnel records revealed that the employee health evaluation forms had not been reviewed by a licensed health professional for employees Z (hired 4/21/25), N (10/14/25), AA (11/14/25), X (12/1/25), and BB (1/1/26). These employees had completed their portions of the health evaluation forms, but none were signed by a licensed health professional. Employee Y, who was rehired on 11/17/25, did not complete a health evaluation form.

2. Interview on 2/18/26 at 4:52 p.m. with director of nursing (DON) B revealed that the former infection preventionist had been responsible for

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S 210	Continued From page 7 reviewing and signing the employee health evaluation forms, but she left in September or October. They did not have a process in place for a different licensed health processional to review the forms. 3. Interview on 2/19/26 at 11:25 a.m. with administrator A revealed that the director of nursing (DON) was supposed to have been responsible for reviewing the employee health evaluations. Their previous DON had been completing those forms, but she was not sure if their current DON had picked up that responsibility.	S 210	S236 Corrective Action: Employee Y, X and BB will have TB tests completed per established regulation. Resident 44 will have TB test admininstered and filed per TB protocols. An audit of new hires since end of survey date 2/19/26 shows one new hire. His TB test is verified as completed. System changes: An Infection Control Nurse will administer and monitor TB testing for each new resident and for each new staff. Alternate is the DON, or the Admission Nurse Coordinator. Nursing staff inserviced on importance of documenting on hard copy and electronically in current system. Performance monitoring: Infection Control and/or designee will report new hires and new admissions with dates of such, when test administered and read for both and report results to the QAPI committee for the next 3 months at which time the committe will determine if further monitoring is needed.	3/19/26
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	S 236		

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S 236	Continued From page 8	S 236		

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;

This Administrative Rule of South Dakota is not met as evidenced by:
Based on employee personnel record review, resident electronic medical record review, and interview, the provider failed to ensure three of five sampled employees (X, Y, and BB) and one of five sampled residents (44) were tested for tuberculosis (TB) (a serious infection that primarily affects the lungs and is spread through the air by coughs and sneezes) within the required timeframe.

Findings include:

1. Review of employee Y's personnel record revealed that he was rehired on 11/17/25. There was no documentation indicating he had been tested for TB, or if information was obtained from his previous employer regarding a negative TB result within the past 12 months.

2. Review of employee X's personnel record revealed that she was hired on 12/2/25. Her TB test was not finished until 1/6/26, which was more than 21 days after she was hired.

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 ____	02/19/2026

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 236	Continued From page 9 3. Review of employee BB's personnel record revealed that they were hired on 1/1/26. The first step of the TB test was administered and read appropriately. However, the second step was administered on 1/11/26 and read on 1/15/26, which was more than 48 hours after the second step was administered. 4. Review of resident 44's electronic medical record (EMR) revealed she was admitted to the facility on 8/13/25. The first step of the TB test was not documented in the EMR. However, the first step was read on 8/15/25. The second step was administered on 8/22/25 and read on 8/24/25. 5. Interview on 2/18/26 at 4:52 p.m. with director of nursing (DON) B revealed that she did not know if employee Y had provided a negative TB test from his previous employer dated within the past 12 months. She said that employee X was an overnight staff, and it was sometimes difficult to get the overnight staff to complete the required orientation and TB screening items. She confirmed that TB tests were supposed to have been read between 24 to 48 hours after the test was administered, and that employee BB's TB test should have started over. She was not able to find documentation of when resident 44's TB test was first administered.	S 236		
S 296	44:73:07:11 Director of Dietic Services A facility shall have a full-time dietary manager	S 296		

South Dakota Department of Health

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S 296	Continued From page 10 who is responsible to the administrator and who shall direct the dietetic services. The dietary manager must: (1) Be a certified dietary manager; (2) Be a certified food service manager; (3) Have a similar national certification for food service management and safety from a national certifying body; or (4) Have an associate's or higher degree in food service management or hospitality from an accredited institution of higher learning that has a course of study in food service or restaurant management. Any dietary manager who does not must enroll, within ninety days of the dietary manager's hire date, in programming necessary to achieve one of the qualifications, and achieve the qualifications within eighteen months of hire. The dietary manager and at least one cook shall possess a current certificate from a ServSafe Manager Food Protection Program offered by various retailers, the Certified Food Protection Professional's Sanitation Course offered by the Association of Nutrition and Foodservice Professionals, or an equivalent training program as determined by the department. Individuals seeking ServSafe recertification are only required to take the national examination. The dietary manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each resident are met. If the dietary manager is not a dietitian, the facility must schedule dietitian consultations onsite at least monthly. The dietitian shall approve each menu, assess the nutritional status	S 296	S296 Corrective action: At least one cook on each shift will be enrolled in the Serve Safe Manager course by 3/19/26. System Change: If employment would end for any of these employees (either the am or pm cook or the Dietary Manager,) the oncoming staff would take the ServSafe Manager course to stay in compliance. The dietary manager and/or Administrator will monitor completion of the Serv Safe Manager course for the 2 employees; it is expected that enrollment will be complete by 3/19/26 and the course within 30 days of enrollment. Any certifications of the Serv Safe program will be copied in the file of respective employees upon hiring. Performance Monitoring: The Dietary Manager and/or Administrator will monitor the system changes and report findings to the QAPI committee on a monthly basis for 3 months at which time the committee will determinie if further monitoring is needed.	3/19/26

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S 296	Continued From page 11	S 296		

of each resident with problems identified in the assessment, and review and revise dietetic policies and procedures during scheduled visits.

The facility shall have sufficient personnel to meet the dietetic needs of the residents and provide dietetic services for a minimum of twelve hours each day.

This Administrative Rule of South Dakota is not met as evidenced by:
Based on record review and interview, the provider failed to ensure that at least one cook had a ServSafe Food Manager certificate.

Findings include:

1. Review of the provider's ServSafe certified employees revealed that only dietary manager K had a ServSafe Food Manager certificate.

2. Interview on 2/18/26 at 9:58 a.m. with dietary manager K revealed that two of the dietary employees had the ServSafe Food Handler certificate, but she was the only one to have the ServSafe Food Manager certificate.

S 301 — 44:73:07:16 Required Dietary Inservice Training — S 301

The dietary manager or the dietitian shall provide ongoing inservice training for all personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for all dietary or food-handling personnel. The training must include the following subjects:
(1) Food safety;
(2) Handwashing;
(3) Food handling and preparation techniques;

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S 301	Continued From page 12 (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee training review and interview, the provider failed to ensure one of one newly hired dietary aide (N) was trained on nine of nine required dietary inservice training topics within 30 days of hire. Findings include: 1. Review of dietary aide N's employee record revealed that he was hired on 10/14/25. His file did not contain any documentation that he had been trained on the nine required dietary inservice training topics within 30 days of hire. There was record that he attended the annual dietary inservice meeting that occurred in December 2025 and was trained on the nine topics, but that was more than 30 days after he was hired. 2. Interview on 2/19/26 at 11:37 a.m. with administrator A revealed that they had identified training as an area to improve upon in the facility's quality assurance and performance improvement (QAPI) committee. She explained that dietary manager K transitioned into the manager position in January 2026.	S 301	S301 Corrective Action: Employee N will receive refresher training on the 9 required training components. He will also receive, within the annual hire date timelines, his yearly training course. An audit of new hires since end date of survey 2/19/26 shows no new hires. System change: The Dietary Manager will compile an orientation packet outlining the 9 required components of training for new staff. Within 20 days of hire, the Dietary Manager will test the new hire on thecomponents and file in respective file Performance Monitoring: The Dietary Manager will report findings of the system changes to the QAPI committee on a monthly basis for 3 months at which time the committee will determine if further monitoring is needed.	3/19/26