STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435038	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEKAKWITHA LIVING CENTER	6 E CHESTNUT , SISSETON, South Dakota, 57262

(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 1/20/26 through 1/22/26. Tekakwitha Living Center was found not in compliance with the following requirements: F576, F578, F689, F699, F761, F801, F812, F851, F880, and F882.	F0000		
F0576 SS = E	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense.	F0576	Cannot correct prior non-compliance for fail of mail delivery in 24 hours. Education provided to Activities and Nursing Staff on timely passing of mail by Administrator or designee on 2/25/2026 Policy created by IDT on Timely Mail Passing. QAC or designee will audit mail pass weekly for 4 weeks and monthly for 2 additional months, and thereafter as determined by the QAPI Committee. QAC or designee will present audit findings at monthly QAPI meeting.	3/8/26

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
Calvin J Cavell	Administrator	2/20/2026

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F0576 SS = E	Continued from page 1 §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is NOT MET as evidenced by: Based on interview and policy review, the provider failed to deliver mail daily to ten of ten residents (10, 14, 15, 18, 24, 30, 31, 35, 37, and 38) within twenty-four hours after it was delivered to the nursing home by the local post office. Findings include: 1. Interview on 1/22/26 at 10:00 a.m. during the resident group meeting revealed: *Residents (10, 14, 15, 18, 24, 30, 31, 35, 37, and 38) stated they did not get their mail daily. *Mail was not delivered on Saturdays because there was no one to pass it out. *Activities director M usually delivered the mail to the residents during the weekdays. 2. Interview on 1/22/26 at 11:30 a.m. social services director C revealed she expected residents to be delivered mail on Saturdays. 3. Interview on 1/22/26 at 11:43 a.m. with activity director M revealed on Saturdays, the charge nurse would get the mail, and then she would pick it up on Mondays and deliver it to the residents because she did not work on Saturdays. 4. Review of the provider's May 2017 Mail and Electronic Communication policy revealed "Mail and packages will be delivered to the resident within twenty-four (24) hours of delivery on premises or to	F0576		

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F0576 SS = E	Continued from page 2 the facility's post office box (including Saturday deliveries)."	F0576		
F0578 SS = D	Request/Refuse/Discntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, document review,	F0578	Corrected residents 3 and 16's charts for correct ADV Directives on 2/1/2026 by DON or designee. All other residents charts checked for correct ADV Directives by DON or designee. Education on Advanced Directives & Code Status Management will be provided to all nurses by DON or designee on 2/25/26. Policy created by IDT for posting accurate documents to correct charts. DON or designee will audit current and new resident charts weekly for 4 weeks and monthly for 2 additional months, and thereafter as determined by the QAPI Committee. DON or designee will present audit findings at monthly QAPI meeting.	3/8/26

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F0578 SS = D	Continued from page 3 record review, and policy review, the provider failed to protect the resident's rights and ensure a resident's advance directive code status (an individual's desire to be resuscitated with cardiopulmonary resuscitation (CPR), specific limited interventions, or not resuscitated (DNR) if their heart stopped) wishes were identified accurately in the medical record for two of seventeen sampled residents (3 and 16). Findings include: 1. Observation, interview, and document review on 1/21/26 at 4:18 p.m. with registered nurse (RN) E at the nurse's station revealed: *Resident paper charts that had a heart with a stethoscope logo on the outside of the chart indicated the resident's code status was a full code, so then CPR would have been performed. If a paper chart did not have that logo, it indicated the resident was a DNR, so CPR would not have been performed. *Resident 3's paper chart had the heart with the stethoscope logo on it. * Resident 3 had an advance directive in his paper chart that was signed on 9/3/25 that indicated he wanted CPR. *RN E would not have performed CPR on resident 3 because she knew he was a DNR, and he was admitted to hospice on 12/15/25. *She stated that someone who did not know resident 3 well may have performed CPR on him because that is what his chart indicated with the logo on it and the 9/3/25 advance directive. She stated, "It must not have been updated". *In resident 3's paper chart, behind his full code advance directive, there was a living will (a document that specifies a resident's preferences about measures that are used to prolong life when there is a terminal prognosis) signed on 9/15/25 that indicated he was to be a DNR. *Resident 16's paper chart did not have the heart with the stethoscope logo on it. *RN E opened residents 16's chart and found an advance directive that indicated CPR should be performed, so she stated she would do CPR.	F0578		

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F0578 SS = D	Continued from page 4 *Upon further review, the advance directive that was in resident 16's chart belonged to a resident who had been discharged. Resident 16's advance directive was found on the backside of another page in his chart and indicated he was a DNR. *She verified that having the wrong resident's advance directive in his chart could have caused an error, and CPR could have been performed when it should not have been. 2. Review of resident 16's electronic medical record revealed: *His 11/10/25 BIMS score was 9, which indicated he had moderate cognitive impairment. *On 1/10/25, he had orders for "DNR". *He had a diagnosis of congestive heart failure (your heart can not pump enough blood to meet your body's needs, causing blood and fluid to back up)(CHF). 3. Observation on 1/22/26 8:55 a.m. outside of resident 3's room revealed there was a heart with a stethoscope logo posted on the wall next to his name. 4. Interview on 1/22/26 at 9:18 a.m. with licensed practical nurse (LPN) G revealed that if resident 3's heart stopped, she would have performed CPR because the logo posted by his name indicated he was a full code. 5. Review of resident 3's electronic medical record revealed: *His 10/22/25 brief interview for mental status (BIMS) score was 12, which indicated he had moderate cognitive impairment. *On 12/13/25, he had orders to be admitted to hospice on 12/15/25. *On 12/15/25, he had orders for "DNR/DNI". *He had diagnoses of left femur fracture (broken hip), a stage four pressure ulcer (skin and/or underlying tissue injury from prolonged pressure that was open with full thickness skin and tissue loss. Bone, tendon, or muscle may be visible) to his sacral region	F0578		

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F0578 SS = D	Continued from page 5 (buttocks), osteomyelitis of his vertebrae and sacral region (infection of the bones of his spine), and CHF. 6. Interview on 1/22/26 at 1:53 p.m. with director of nursing (DON) B revealed: *The social worker completed the advance directive forms with the resident or family. *If there was a change to a resident's advance directive, the nurse was to notify either the DON or social worker, and said," There is a lapse at times" [sometimes it was missed and not updated]. *She stated that resident 3's advance directive should have been updated on his chart, and the logos by his room and chart should have been removed when his code status changed to a DNR and verified that resident 3 could have received CPR in error. *She stated that the discharged resident's advance directive should not have been in resident 16's chart and verified that resident 16 could have received CPR in error. 7. Review of the provider's December 2016 Advance Directive policy revealed: * "Advance directives will be respected in accordance with state law and facility policy." *" Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record." *" The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive." *" Changes or revocations of a directive must be submitted in writing to the Administrator. The Administrator may require new documents if changes are extensive. The Care Plan Team will be informed of such changes and/or revocations so that appropriate changes can be made in the resident assessment (MDS) and care plan."	F0578		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F0689		

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F0689 SS = D	Continued from page 6 The facility must ensure that - §483.25(d)(1) The resident environment remains as free 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 interview, document review, and record review, the provider failed to provide adequate supervision to a dental appointment for one of one sampled resident (4) who had severe cognitive impairment and was at high risk for falling. Findings include: 1. Interview on 1/21/26 at 11:17 a.m. with resident 4's granddaughter/power of attorney revealed: *A few months ago, a nursing home staff member called her and told her that her grandmother had a dental appointment in fifteen minutes. *She was unaware of that appointment and was not going to be able to meet her there. *She asked the staff member to reschedule it instead. *She received a phone call from the dental clinic asking her why her grandmother was at the appointment by herself. *Resident 4 rode the community transportation by herself and was dropped off at the dental clinic, where she was by herself for 45 minutes. *She was very upset that resident 4 went by herself to that appointment because of resident 4's cognitive impairment. *She talked to the previous administrator about the incident. 2. Interview and form review on 1/22/26 at 1:53 p.m. and 3:37 p.m. with director of nursing (DON) B revealed:	F0689	Cannot correct prior non-compliance for proper/adequate supervision. Education provided to Administrative and all Nursing Staff on providing proper & adequate supervision when transporting residents given by DON or designee on 2/25/26. Policy created by IDT on Transportation of residents. DON or designee will audit transportation records weekly for 4 weeks and monthly for 2 additional months, and thereafter as determined by the QAPI Committee. DON or designee will present audit findings at monthly QAPI meeting.	3/8/26

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F0689 SS = D	Continued from page 7 *She verified that resident 4 was sent to that appointment by herself. *She stated that resident 4 should not have gone to the appointment by herself, and she expected the appointment to have been cancelled unless they had staff to take her. *Resident 4's granddaughter typically took her to her appointments. *Upon admission, in the admission packet, they have families/residents sign a "Specialty Doctor's Appointments" form. Resident 4 was admitted prior to the forms being implemented and did not have one signed. *The 10/7/25 form stated: "In the event that [resident] needs to go to a specialty doctor's appointment, (which this means any appointment besides when his/her primary care physician comes to the facility to do regulatory check-ups), that you understand your loved one needs to be accompanied by family or friend at the appointment. This applies when your loved one's cognitive impairments make it unsafe for resident to go on his/her own to the appointment and/or if information given to resident at said appointment will not be able to be retained. The facility will work with you to line up these special appointments so that said person can go with and/or meet at that appointment. If you are unable to meet your loved one at said appointment understand that the clinic may cancel the appointment and you acknowledge there is a risk then for injury or information not to be relayed correctly." [There was a space for signatures.] *They did not have a policy regarding taking residents to appointments. 3. Review of resident 4's electronic medical record revealed: *She was admitted on 2/6/23. *Her 12/2/25 Brief Interview for Mental Status (BIMS) score was 3, which indicated she had severe cognitive impairment. *Her 8/13/25 Morse Fall Scale indicated she was at high risk for falling. *Her diagnoses were left femur fracture (hip fracture), dementia (a group of symptoms affecting memory,	F0689		

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F0689 SS = D	Continued from page 8 thinking, and social abilities), major depressive disorder (a serious, long-lasting mood disorder that goes beyond normal sadness), and anxiety disorder (a feeling of worry, fear, or unease about future events or a perceived threat). *A 10/4/25 progress note stated, "Resident is alert with confusion noted....TABs/bed alarm/chair alarm [(a fall prevention device that alarms to notify staff of the resident's movement, such as standing)] on, as she is a high fall risk." *A 10/21/25 progress note stated, "Resident left at 0900 for dental appt. at [dental clinic] via community transit and arrived back 1130." *Review of her 9/12/25 care plan revealed: -"[Resident 4] has the potential to be physically aggressive r/t [related to] Dementia". -"When [resident 4] becomes agitated: Intervene before agitation escalates; Guide away from source of distress." *"[Resident 4] is able to identify her family but not other residents or staff and can follow one-word instructions." *"[Resident 4] needs supervision and assistance with all decision making." *"[Resident 4] uses psychotropic (drugs that affect brain activities associated with mental processes and behavior) medications Quetiapine for Behavior management."	F0689		
F0699 SS = D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and policy review, the facility failed to complete a Trauma Informed Care	F0699		

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F0699 SS = D	Continued from page 9 assessment for one of one sampled resident (5) after they have experienced a loss of a loved one. Findings Include: 1. Interview on 1/20/26 at 3:55 p.m. with resident 5 noted that after each question asked during the interview, she would have discussed her husband passing away. The following statements were said: *"I should have died before him" * "This is his shirt that he used to wear" * "I have to keep busy to not think about him." 2. Observation on 1/21/26 at 11:10 a.m. of resident 5's wound care revealed she continued to reiterate sentiments for her husband passing away and how sad she was he was not here with her. 3. Interview and chart review for resident 5 on 1/22/26 at 11:25 a.m. with director of nursing (DON) B confirmed she did not have a Trauma Informed Care completed and the Social Services Designee was responsible for completing the Trauma Informed Care assessments. 4. Interview and chart review for resident 5 on 1/22/26 at 1:10 p.m. with Social Services designee (SSD) C revealed she could not find Trauma Informed Care on resident 5. She stated, "I must have missed that one". She said she completed this on admission and as needed but completed the mood assessment quarterly within the MDS. 5. Review of the providers 5/10/23 Trauma Informed Care policy revealed: **Purpose: To ensure facilities deliver care and services which meet professional standards, use approaches which are culturally competent, account for resident's expedience and preferences, and address the needs of trauma survivors." **Trauma Survivors – Military veterans, survivors of disasters, survivors of abuse, history of homelessness, history of imprisonment, and traumatic loss of a loved one."	F0699	Corrected resident 5's chart for completed Trauma Informed Consent on 2/1/2026 by Social Service Rep. or designee. All other resident's charts checked for needed Trauma Informed Consent by Social Service Rep. or designee. Education will be provided to Social Services and all Nurses for Trauma Informed Consent on 2/25/26. Policy created by IDT on completing Trauma Informed Consent process. Social Service Rep. or designee will audit current and new residents for Trauma Informed Consent needs weekly for 4 weeks and monthly for 2 additional months, and thereafter as determined by the QAPI Committee. Social Sevice Rep. or designee will present audit findings at monthly QAPI meeting.	3/8/26
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F0761		

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F0761 SS = E	Continued from page 10 §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 observations, interviews, and policy review, the facility failed to ensure proper storage and disposal of expired medications in one of one medication room and one of one medication cart that had expired medications and treatments. *One of one medication room and One of One medication cart (north) had expired medications and treatments. Findings include: 1. Observations on 1/22/26 at 11:00 a.m. with Licensed Practical Nurse (LPN) G in the Medication Room revealed expired medications and treatments. * Tuberculin Purified Protein Derivative (PPD) solution vial was ordered from the pharmacy on 10/27/25. The vial cap was removed and open with no open date. With no open date marked on box or vial, the opened vial should be discarded. 2. Observation on 1/22/26 at 11:25 a.m. of the North	F0761	Corrected prior non-compliance for expired medications and biologicals. Those found during the survey and after have been disposed of properly. All medications assessed by DON or designee in the Med Room, Med Cart, and Treatment Cart. Education provided to all licensed Nursing Staff on expired medications by DON or designee on 2/25/26. Policy reviewed and revised by IDT for Expired Medications. DON or designee will audit for expired medications weekly for 4 weeks and monthly for 2 additional months, and thereafter as determined by the QAPI Committee. DON or designee will present audit findings at monthly QAPI meeting.	3/8/202

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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
F0761 SS = E	Continued from page 11 Medication Cart revealed expired medications. * Resident 3's Novolog expired on 1/15/26 and had 1/3 of the used medication vial remaining and per the open date and written expiration date on the vial was expired. * Stock bottle of Senna Plus expired in November 2025 with approximately half of the bottle (500 tabs) remaining. * Stock Liquid Pain Relief expired in December 2025 with approximately half of the bottle remaining. 2. Interview with Licensed Practical Nurse (LPN) G at 1/22/26 at 11:35 a.m. revealed: * The medications should have expiration dates on them when they were opened and discarded. The night shift staff are who usually go through and check the expiration dates. * The medications should have been checked by the nursing staff to ensure they do not expire prior to giving them to a resident. * If the medication was expired, it should be pulled from use and reordered. 3. Interview with Director of Nursing (DON) B on 1/22/26 at 2:18 p.m. revealed: * Her expectation was that medications were checked for expiration dates prior to giving the medication and pulled from the medication cart if expired. 4. Review of the providers' Medication Storage in the Facility policy revealed: * "Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications." * "H. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal (See Section IE: DISPOSAL OF MEDICATIONS AND MEDICATION-RELATED SUPPLIES), and reorder from the pharmacy (SEE IC3: ORDERING AND RECEIVING NON-CONTROLLED MEDICATIONS FROM	F0761		

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F0761 SS = E	Continued from page 12 THE DISPENSING PHARMACY), if a current order exists." " "Expiration Dating (Beyond-use dating) D. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 1. The nurse shall place a "date opened" sticker on the medication and enter the date opened and the new date of expiration (NOTE: the best stickers to affix contain both a "date opened" and "expiration" notation line). The expiration date of the vial or container will be [30] days unless the manufacturer recommends another date or regulations/guidelines require different dating (See APPENDIX 29 – MEDICATIONS WITH SHORTENED EXPIRATION DATES)."	F0761		
F0801 SS = D	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual	F0801	Cannot correct prior non-compliance for open position of Dietary Manager. Open position being actively advertised and promoted. Administrator or designee will continue to actively search for candidate to fill open position	3/8/26

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F0801 SS = D	Continued from page 13 will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is NOT MET as evidenced by:	F0801		

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F0801 SS = D	Continued from page 14 Based on interview, the provider failed to employ a full-time, qualified registered dietitian or dietary manager who met the requirements to serve as the director of food and nutritional services. Findings include: 1. Interview on 1/20/26 at 1:23 p.m. with dietary aide/cook I and restorative supervisor N revealed: *The facility did not have a dietary manager. *Restorative supervisor N was working as the dietary cook, she had been a cook there prior to her current role. *The previous dietary manager worked there for a few years, and after she quit, a certified nursing assistant (CNA) took over for a few weeks, but did not want to do it anymore, and went back to working as a CNA. *The administrator ordered food for the kitchen; they just wrote down for him what was needed. 2. Interview on 1/21/26 at 8:30 a.m. with cook O revealed: *She confirmed there was no dietary manager to oversee the process of the kitchen. *She would go to administrator A if there were issues. *She was not a certified dietary manager (CDM). *She completed the ServSafe training. *The regular registered dietitian (RD) was out on maternity leave. -There was a RD covering for her during her leave, and she was there a few weeks ago, wrote a few things down, and then left. 3. Interview on 1/22/26 at 8:45 a.m. and 2:08 p.m. with administrator A revealed: *Their previous dietary manager left her position on 1/7/26, after being in that role for a few weeks. -The dietary manager before her, left her position on	F0801		

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F0801 SS = D	Continued from page 15 8/19/25. *They had the dietary manager position posted. *When asked who could answer dietary questions, he stated, "I guess that would be me." *He was not a CDM. *Consultant RD was not full-time and came to the facility monthly. *Their regular registered dietitian (RD) was out on maternity leave, and another dietitian was covering for her.	F0801		
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 interview, observation, document review, and policy review, the provider failed to ensure the staff followed proper sanitation and food handling practices regarding: *Handwashing and glove use standards were followed by	F0812	Cannot correct prior non-compliance for proper sanitation & food handling practices. Education provided to Dietary and other staff on proper sanitation and food handling practices by Registered Dietician or designee on 2/19/26. Education provided to Dietary Staff on proper temperature for sanitation purposes while using the commercial dishwasher 2/19/26. Current Policies & Procedures reviewed by IDT and Registered Dietician for proper sanitation & food handling practices. Necessary revisions made as needed. Registered Dietician or designee will audit proper sanitation & food handling practices, along with washroom temperatures, weekly for 4 weeks and monthly for 2 additional months, and thereafter as determined by the QAPI Committee. Registered Dietician or designee will present audit findings at monthly QAPI meeting.	3/8/26

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F0812 SS = F	Continued from page 16 dietary aide/cook I, dietary aide J, cook O, restorative supervisor N, and certified nursing assistant (CNA) H during one of one evening meal service and one of one lunch time service. *The steam tables in the north kitchenette were clean. *Dishwasher temperatures and sanitization levels were monitored and documented after each meal. Findings include: 1. Interview on 1/20/26 at 2:40 p.m. with dietary aide/cook I in the kitchen revealed: *They had a dispenser of multi-range sanitizer that was premixed with water. *They used that sanitizer solution to clean the counters in the kitchen and the tables. *They did not test and did not have sanitizer testing strips to test the sanitation level of the sanitation solution. 2. Observation on 1/20/26 at 5:07 p.m. with dietary aide J in the north kitchenette revealed: *Dietary aide J was in the kitchenette, put on gloves, opened the door to the dining area, and pushed a cart that contained a big bowl of lettuce, styrofoam bowls, and salad dressing to the dining area. She then served the salad to the residents at their tables. *With those same gloved hands, dietary aide J grabbed a handful of lettuce with those dirty gloves and put it in a styrofoam bowl, put the salad dressing on it, and served it to a resident. *With those same dirty gloves hands, dietary aide J touched a resident's arm, the handle on the resident's wheelchair, the handle on the cart, and two more residents' arms, and then used those same gloves to grab a handful of lettuce, put it in the styrofoam bowl, put salad dressing on it, and served it to those residents. *She continued to serve the lettuce in the same manner throughout the dining service with those same gloves. *Restorative supervisor N removed the soups from the steam table, food particles were floating in the water	F0812		

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F0812 SS = F	Continued from page 17 in the steam table, and the water appeared dirty and hazy. 3. Interview on 1/20/26 with restorative supervisor N and dietary aide J revealed: *They were not sure how often the steam table needed to be cleaned. *Dietary aide J stated she thought it was done weekly, and the water was changed at that time. 4. Continued observation on 1/20/26 at 5:34 p.m. of dietary aide J in the east dining room revealed: *Dietary aide J put on gloves and pushed the cart that contained the big bowl of lettuce, styrofoam bowls, and salad dressing. *With those same gloved hands, she touched the resident's table, then grabbed a handful of lettuce, applied the salad dressing, and served it to the residents. *With those same gloved hands, she touched the handle on the cart when she pushed it to another table, touched a resident's arm, the handle on a resident's wheelchair, grabbed a handful of lettuce, put it in the styrofoam bowl, put the salad dressing on it, and served it to the residents. She continued in that fashion until all the residents were served the lettuce. 5. Observation on 1/20/26 at 5:36 p.m. of restorative supervisor N in the east kitchenette revealed: *She did not wash her hands before putting on a clean pair of gloves. She checked the temperature of the soup with a digital thermometer. *With those same gloved hands, she grabbed a wrap or a sandwich and put it on the resident's plate for them to eat, and then touched the ladle to put soup into a bowl. She did this throughout the dining and servicing process. 6. Observation on 1/20/26 at 5:43 p.m. of dietary aide/cook I in the east kitchenette revealed: *She had gloves on her hands. She pushed a cart with	F0812		

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F0812 SS = F	Continued from page 18 drinks on it, and served the drinks to the residents. *She removed her gloves, did not wash her hands, and put on a new pair of gloves, took out a slice of bread from the bread bag, and served it to a resident. 7. Interview on 1/21/26 at 8:30 a.m. with cook O in the kitchen revealed: *They used the sanitizer from the premixed dispenser to wipe off the counters in the kitchen, and they did not have testing strips to test the sanitation level of that solution. *She confirmed that, without the testing strips, she was unsure if the solution was at the appropriate sanitation level to sanitize the counters. *She stated, "The manager before said it was fine [not to test the sanitation level]." *Dietary staff were to wash their hands with soap and water when coming into the kitchen, before handling food, between handling certain foods, before putting gloves on, and after taking gloves off. 8. Observation on 1/21/26 at 12:03 p.m. of the north kitchenette steam table revealed there was dirty water and food floating in it. 9. Observation on 1/21/26 12:10 p.m. of the dining service in the north dining room revealed: *Dietary aide J and dietary aide/cook I had gloves on. *While getting a resident's order, dietary aide J touched the resident's arm with her gloved hand, she obtained the plate of food, and with those same gloved hands, she used the resident's silverware to cut up her food. *With those same gloved hands, dietary aid J received another plate of food, touched a resident's wheelchair handle, touched the top of the resident's glass, and cut up the resident's food. *While getting a resident's order, dietary aide/cook I touched a resident's chair with her gloved hands, received a plate of food, and served that to a resident.	F0812		

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F0812 SS = F	Continued from page 19 *Dietary aide I put a clothing protector on a resident and, with those same gloved hands, poured drinks for residents. *Cook O took off her gloves, did not wash her hands, used utensils to plate a resident's food, touched her hand to her pants, and then touched the plate. She stated, "I do not have gloves," and received a pair of gloves from the nurse, did not wash her hands, put on those gloves, and used utensils to plate food. 10. Observation on 1/21/26 at 12:30 p.m. of the east dining room service revealed: *CNA H was standing at the steam table waiting to serve residents, she touched her hair, went over and got a resident's order, touched that resident's arm, obtained a plate of food, served it to the resident, and cut up the resident's food. *CNA H served a resident a plate of food, touched the table top, served another plate of food, did not wash her hands, put on a pair of gloves, and used her gloved hands to take chicken off the bone for a resident. *Cook O put on a pair of gloves, opened a cupboard door with those gloves, removed those gloves to get an apron, did not wash her hands, put on a pair of gloves, and plated food using utensils. *While plating food, cook O served a couple of residents their food, and without changing her gloves or performing hand hygiene, continued to plate other residents' food. *Dietary aide J came into the dining room, did not wash her hands, served residents their drinks and fruit cups, and touched a resident's arm, and continued to serve fruit cups and drinks to other residents. 11. Interview on 1/21/26 at 12:46 p.m. with cook O and dietary aide T in the east dining room revealed: *The steam table in the east kitchenette did not take water. *The CNAs were to clean and change the water in the steam table in the north kitchenette every two weeks, and it has just been done.	F0812		

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F0812 SS = F	Continued from page 20 *They did not have documentation that it had been cleaned. 12. Review of the provider's Chemical Sanitizing Dishmachine Temperature and PPM Log revealed: *" INSTRUCTIONS: Please log WASH (140-160 degrees F [Fahrenheit]) and PPM [parts per million] test result when washing dishes after each meal, to ensure that the water temperature and sanitizer solution are properly controlled and monitored. The log should be filled in and... by those who are directly involved in the dishwashing process." *In October 2025, the wash temperature and the sanitization level were not documented 42 times. *In November 2025, the wash temperature and the sanitization level were not documented 41 times, and on 11/24/25, the wash temperature was 118 degrees. *In December 2025, the wash temperature and the sanitization level were not documented 20 times, and on 12/20/25, the wash temperature was 115 degrees, and on 12/28/25, the wash temperature was 118 degrees. *In January 2026, the wash temperature and the sanitization level were not documented 26 times. 13. Interview on 1/22/26 at 2:08 p.m. with administrator A revealed: *He expected the dishwasher temperature and sanitation level and the bucket sanitizer solution to be documented to ensure appropriate sanitation levels were reached when cleaning dishes and counters in the kitchen, and he agreed that with no documentation, it could not be ensured that the dishes or counters were being sanitized appropriately, which could cause foodborne illness. 14. Review of the providers' undated Handwashing for Food Safety policy revealed: *" Inadequate handwashing has been identified as a contributing factor to foodborne illness, especially when preparing raw meat and poultry. Hands can move germs that can cause illness found in raw meat and poultry, around the area you are preparing food, which can lead to foodborne illness. Washing our hands often is one of the best ways to stop the spread of harmful	F0812		

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F0812 SS = F	Continued from page 21 germs that can cause illness, including foodborne illness." 15. Review of the provider's undated dishwasher 2.0 Operator Procedures guide revealed: "" Fill the machine with water using "Fill Switch". If water temperature gauge has not reached 120 degrees F (49 degrees C [Celsius]) when the water level is just below overflow, drain water from the machine and continue to fill until proper temperature is attained." "Free chlorine rinse should be 50 ppm or more." 16. Review of the provider's 4/24/24 Dishwasher for ADS (American Dish Service) AF-C policy revealed: "" Operating Procedure: -[dishwasher service company] inspects Dishwasher machine monthly. They verify a minimum of 120 degrees F that gets cycled into the machine. If temperature drop below, notify maintenance. -Sanitizer levels are at a minimum of 100 PPM. -Refer to Manufacturer guidelines for daily start-up." 17. A sanitization bucket and steam table cleaning policies were requested and not received before exiting the facility.	F0812		
F0851 SS = F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care	F0851	Cannot correct prior non-compliance for fail of reporting PBJ to CMS. PBJ education and training provided to Administrator on reporting Quarterly PBJ to CMS on 2/12/2026 by fellow Administrator or designee. Administrator or designee will audit PBJ reporting quarterly for 1 year and report to QAPI committee.	3/8/26

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F0851 SS = F	Continued from page 22 management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: Based on Certification and Survey Provider Enhanced Reports (CASPER) data review, staff schedule review,	F0851		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEKAKWITHA LIVING CENTER	6 E CHESTNUT , SISSETON, South Dakota, 57262

(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
F0851 SS = F	Continued from page 23 timecard review, and interview, the provider failed to ensure Payroll Based Journal (PBJ) (information of the provider's daily staffing hours for the care of the residents) data was accurately completed before submission to the Center for Medicare and Medicaid Services (CMS) for four of four federal fiscal quarters (Quarter 1, 2025; Quarter 2, 2025; Quarter 3, 2025; and Quarter 4, 2025). Findings include: 1. Review of the PBJ data submitted to CMS for the four quarters listed above revealed: *The following items were triggered: -Failed to submit data for the quarter. -One star staffing rating. *The following items were suppressed due to no nursing hours being reported: -Excessively low weekend staffing. -No RN hours. -Failed to have licensed nursing coverage 24 hours per day. 2. Review of the provider's October, November, and December 2025 employee staffing schedules and timecards revealed they had licensed nursing coverage 24 hours per day and eight continuous hours of RN coverage. 3. Interview on 1/20/26 at 1:49 p.m. with administrator A regarding Payroll Based Journal (PBJ) staffing data and reporting revealed:*He knew the PBJ hours were not getting reported.*He confirmed the staffing schedules were correct and they had met the requirements for PBJ staffing*The former health information manager (HIM) was responsible for submitting the staffing data..*That employee stopped working for the facility in October 2024.He was told by his supervisor there would be some training on that in the future.He agreed the PBJ hours were not being completed as required. 4. Interview on 1/22/26 at 11:26 a.m. with regional director L regarding PBJ staffing data and reporting revealed:*He was aware the PBJ hours were not being completed.*The HIM person who was entering the PBJ hours had resigned about a year ago..*after the HIM resigned, the PBJ education for reporting was passed on to the former administrator.The former administrator did not complete	F0851		

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F0851 SS = F	Continued from page 24 the education to complete the PBJ reporting by the time she resigned in December 2025.*Regional director L stated there was a PBJ education packet for administrator A to complete so he could input the PBJ hours.*Regional director L confirmed the PBJ staffing hours had not been submitted, as required, for the past four quarters. A policy for PBJ hours reporting was requested on 1/21/26 at 2:30 p.m. and the administrator stated there was no such policy in the facility.	F0851		
F0880 SS = E	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;	F0880	Corrected listed items of non-compliance for Proper Infection Control Practices on 2/1/2026 by Env. Services Lead/Maintenace or designee. Education provided to Env. Services Lead/Maintenace and Housekeeping staff on Proper Infection Control Practices given by DON or designee on 2/25/26. Policy created by IDT on cleaning practices for Infection Control. DON or designee will audit cleaning records for Proper Infection Control weekly for 4 weeks and monthly for 2 additional months, and thereafter as determined by the QAPI Committee. DON or designee will present audit findings at monthly QAPI meeting.	3/8/26

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F0880 SS = E	Continued from page 25 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §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 observation, interview, and policy review, the provider failed to ensure proper infection control practices were followed for: *Cleaning one of one ice maker located outside of the kitchen. *Cleaning the refrigerator in one of one family room. Findings include: 1. Observation on 1/20/26 at 1:00 p.m. of the ice machine outside of the kitchen revealed that it was not clean. There was a dirty light green powder like substance on the outside corners of the machine above	F0880		

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F0880 SS = E	Continued from page 26 the level of the ice dispenser that fell off the machine during ice dispensing. There was heavy water spotting on the splash guard and visible rust on the metal grate above the water drain. 2. Observation on 1/21/26 at 9:35 a.m. of the mini refrigerator in the family room there was a four-ounce serving of ice cream on the refrigerator's top shelf that had melted and spilled onto all the shelves in the refrigerator. 3. Interview on 1/22/26 at 11:00 a.m. with housekeeper K revealed that she had been employed at the facility for less than a year. When asked if cleaning the family room refrigerator or ice machine was her responsibility, she did not think it was her responsibility. When asked how she knew what her responsibilities were as a housekeeper, she replied that there was a notebook with an outline of the daily responsibilities. She then provided a copy of the outline. 4. Interview on 1/22/26 at 11:20 a.m. with licensed practical nurse (LPN) G revealed that she was not sure who's responsibility it was to clean the family room refrigerator or the ice machine. She thought that it were either maintenance or housekeeping. 5. Interview on 1/22/26 at 12:30 p.m. with maintenance lead D revealed that he had been employed at the facility for less than a year and was the housekeeping supervisor. He reported that he did not receive much training on his responsibilities. He reported that housekeeping staff were responsible for cleaning the family room refrigerator, but he did not think they were responsible for cleaning the ice maker. He stated that the responsibility of maintenance was to "just blow off the dust" on the top of the ice maker. 6. Interview and observation on 1/22/26 at 12:55 p.m. with director of nursing (DON) B revealed that she was unsure who's responsibility it was to clean the ice maker. She reported that she was not sure if it was the responsibility of the CNAs or housekeeping to clean the family room refrigerator. When she observed the ice maker, the appearance did not meet her expectations of cleanliness. She expected the surfaces to be clean, the grates to be clean and not rusted, and the dirt/debris on the outside corners to be clean. 7. Review of the provider's undated housekeeping checklist revealed that number 4. "Clean ice machine daily. Initial Sheet." Number 16. "Check room fridge temps and chart daily (Clean and defrost TLC	F0880		

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F0880 SS = E	Continued from page 27 [Tekakwitha Living Center] fridges as needed." 8. Review of the provider's February 2025 Infection Control and Prevention policy revealed a purpose of "To establish comprehensive guidelines for preventing and controlling infections within the facility, protecting the health and safety of residents, staff and visitors." and principles of infection control were to "Adhere to evidence-based practices for infection control."	F0880		
F0882 SS = E	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the provider failed to have a qualified infection preventionist for the facility. Findings include: 1. Interview on 1/22/26 at 12:25 p.m. with director of nursing (DON) B revealed that she was in charge of the facility's infection prevention program but had not completed an approved infection preventionist (IP) course. She reported that she had been working on the IP course but had not found the time to complete it. She confirmed that she oversaw the facility's infection prevention program during the last recertification	F0882	Cannot correct prior non-compliance for failure to have qualified Infection Preventionist. Nurse enrolled in current Infection Preventionist class. Program to be completed by 3/8/26 or prior. Administrator or designee will audit class progress weekly for 4 weeks and monthly as needed for completion of course. Administrator or designee will present audit findings at monthly QAPI meeting.	3/8/26

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F0882 SS = E	Continued from page 28 survey and had not completed the IP course then either. 2. Review of the provider's infection control program binder revealed that the provider did not have an infection preventionist.	F0882		

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	10685	A. BUILDING: _____ B. WING _____	01/22/2026

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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 1/20/26 through 1/22/26. Tekakwitha Living Center was found not in compliance with the following requirement: S157, S206, S210, S238, 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 in two randomly observed rooms (toilet rooms for resident rooms 204 and 214). Findings include: 1. Observation on 1/21/26 at 12:10 p.m. revealed the exhaust ventilation for the toilet room of room 204 was not functioning. Testing of the grille with tissue paper at the time of the observation confirmed that finding. Interview with the maintenance director at that same time confirmed that finding. He revealed he was unaware as to why the exhaust ventilation was not working at that location. He added he had checked all the exhaust fans for the building within the last month and they were working at that time.	S 157	Correction/repair to rooms 204 & 214 exhaust ventilations in toilet room in process for prior non-compliance for failed exhaust ventilation. All other exhaust ventilations to be audited by Env. Service Lead/ Maintenance or designee on a weekly basis for 4 weeks and monthly for 2 additional months, and thereafter as determined by the QAPI Committee. Env. Service Lead/Maintenance or designee will present audit findings at monthly QAPI meeting.	3/8/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Calvin T Cerall — TITLE: Administrator — (X6) DATE: 2/20/2026

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S 157	Continued From page 1 2. Observation on 1/21/26 at 12:12 p.m. revealed the exhaust ventilation for the toilet room of room 204 was not functioning. Testing of the grille with tissue paper at the time of the observation confirmed that finding. Interview with the maintenance director at that same time confirmed that finding. He revealed he was unaware as to why the exhaust ventilation was not working at that location. He added he had checked all the exhaust fans for the building within the last month and they were working at that time. Those rooms are required to have exhaust ventilation directed to the exterior of the building.	S 157		
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;	S 206		

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S 206	Continued From page 2 (11) Abuse and neglect; and (12) Advanced directives. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section. The facility shall provide additional personnel education based on the facility's identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee record review and interview, the provider failed to ensure three of three sampled employees (H, P, and Q) had completed the required annual training topics. Findings include: 1. Review of certified nursing assistant (CNA) H's employee file revealed she: *Was hired on 3/19/20. *Had not completed the following required ongoing training topics within the last twelve months (annually): -Abuse, neglect, misappropriation (deliberate, wrongful taking of money or belongings), and mistreatment. -Advance directives. 2. Review of CNA P's employee file revealed she: *Was hired on 6/2/20. *Had not completed the following required ongoing training topics within the last twelve months (annually): -Emergency preparedness/procedures. -Accident prevention safety procedures. -Proper restraint use. -Resident rights.	S 206	Cannot correct prior non-compliance of annual training topics. Education on required annual training topics reviewed and updated to include all 12 topics for year. Year 2026 sign off sheet created and placed into a single file for each employee. Abuse and Neglect presented at 1/28/26 All-Staff meeting. Those not attending completing training sheets on their own and returning to sign off for education. Administrator or designee will audit staff training files monthly for the year and thereafter as determined by QAPI committee. Administrator or designee will present Audit findings at monthly QAPI meeting	3/8/26

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S 206	Continued From page 3 -Mandatory reporting, incidents and diseases. -Care of residents with unique needs. -Dining assistance, nutritional risks, hydration. -Abuse, neglect, misappropriation, and mistreatment. -Advanced directives. 3. Review of CNA Q's employee file revealed she: *Was hired on 6/27/17. *Had not completed the following required ongoing training topics within the last twelve months (annually): -Emergency preparedness/procedures. -Mandatory reporting, incidents and diseases. -Abuse, neglect, misappropriation, and mistreatment. -Advanced directives. 4. Interview on 1/22/26 at 2:08 p.m. with administrator A and director of nursing (DON) B regarding annual employee training revealed CNA's H, P, and Q were expected to come in and do that required education, and they did not do it. 5. Employee training policy was requested on 1/22/25 at 12:15 p.m. and was not received before the team exited the facility.	S 206		
S 210	44:73:04:06 Personnel Health Program The facility shall have a personnel health program for the protection of the residents. Before assignment to duties or within fourteen days after employment, a licensed health professional must evaluate all personnel to ensure no personnel is infected with any reportable communicable disease that poses a threat to others. The evaluation must include an assessment of previous vaccinations and tuberculin skin tests.	S 210		

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S 210	Continued From page 4 The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease that may endanger the health of residents, and fellow personnel may not return to duty until the personnel is determined by a physician, physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee record review, interview, and policy review, 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 two of five employees (H and Q). Findings include: 1. Review of certified nursing assistant (CNA) H's employee file revealed: *She was hired on 3/19/20. *She did not have a completed health evaluation in her employee file. 2. Review of CNA Q's employee file revealed: *She was hired on 6/27/17. *She did not have a completed health evaluation in her employee file. 3. Interview on 1/22/26 at 2:08 p.m. with administrator A and director of nursing (DON) B revealed:	S 210	Corrected employee records for H & Q on 2/16/26 to include a new Health Evaluation form by Administrator or designee. All other staff/employee files to be checked and updated with current Health Evaluation Form in their file by 3/2/2026. Policy reviewed and updated by IDT on obtaining accurate health information for evaluating employees. Administrator or designee given state policy for education on 2/25/2026. Administrator or designee will audit weekly for 4 weeks and monthly for 2 additional months and thereafter as determined by QAPI committee. Administrator or designee will present audit findings at monthly QAPI meeting.	3/8/26

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S 210	Continued From page 5 *They verified CNA H and Q did not have a health evaluation in their employee files. 4. Review of the provider's February 2025 Infection Control and Prevention policy revealed it did not address employee health evaluations.	S 210		
S 238	44:73:04:12(3) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare personnel or residents are as follows: (3) Each healthcare personnel or resident with a history of a positive reaction to the tuberculin skin test or blood assay must be evaluated annually by a physician, physician assistant, nurse practitioner, clinical nurse specialist, or nurse, and a record must be maintained of the presence or absence of symptoms of TB. If this evaluation results in suspicion of active tuberculosis, the person must be referred for further medical evaluation to confirm the presence or absence of tuberculosis; and This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure: *One of one resident (4) who was identified as a Tuberculosis (TB) (a contagious bacterial infection, usually of the lungs) carrier had chest x-rays completed yearly, as indicated in her electronic medical record (EMR). *One of four sampled residents (20) had a TB screening completed within 21 days of admission. Findings include: 1. Review of resident 4's EMR revealed:	S 238	Corrected resident 4's chart to include current x-ray screening for Tuberculin on 2/4/2026 by DON or designee. All other resident charts checked for TB screening by DON or designee. Education provided to all nurses on 2/25/2026. Policy created by IDT on TB Screenings. DON or designee will audit TB Screenings weekly for 4 weeks, and monthly for 2 additional months and thereafter as determined by QAPI committee. DON or designee will present audit findings at monthly QAPI meeting.	3/8/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10685	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEKAKWITHA LIVING CENTER	6 E CHESTNUT SISSETON, SD 57262

(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 238	Continued From page 6 *She was admitted on 2/6/23. *She had a special instructions message on her electronic profile that stated, "TB carrier-needs yearly chest X-Ray." *Her 9/12/25 care plan had the following special instructions listed: "TB carrier-needs yearly chest X-ray." 2. Review of resident 20's EMR revealed: *He was admitted on 3/27/23. *He did not have a TB test completed. 3. Interview on 1/22/26 at 1:53 p.m. with director of nursing (DON) B revealed: *She confirmed resident 4's last chest X-ray was completed in 2023. *Resident 4 was to have a chest X-ray completed yearly due to her being a carrier of TB and stated, "It slipped by me". *She does not complete yearly respiratory assessments. *She could not find that resident 20 had a TB test completed within 21 days of admission. 4. Review of the provider's February 2025 Infection Control and Prevention policy revealed: *" A two-step skin test will be completed on all new admits within 14 days of admission unless there is documentation of a two-step results within the past year. 1. Those who are positive responders will either complete a Gold Assay blood test or have a chest x-ray to be cleared by an MD for admission."	S 238		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all personnel	S 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10685	A. BUILDING: _____ B. WING _____	01/22/2026

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S 301	Continued From page 7 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; (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 record review and interview, the provider failed to ensure three of three newly hired dietary staff (I, O, and R) completed dietary training within 30 days of hire, and two of two dietary staff (J and N) completed the required annual dietary training. Findings include: 1. Review of dietary aid/cook I's employee record revealed: *She was hired on 10/24/25. *She did not have the following dietary training completed within 30 days of hire: -Food safety. -Handwashing. -Food handling/prep. -Foodborne illness. -Serving/distribution. -Leftovers. -Time/temp controls.	S 301	Cannot correct prior non-compliance of newly hired dietary staff training and annual dietary training. Education provided to all dietary staff on 2/19/26 for Proper Sanitation & Food Handling Practices by Registered Dietician or designee. Current policies reviewed by IDT and necessary revisions made as needed. Registered Dietician or designee will audit education weekly for 4 weeks, and monthly until all training topics have been covered or thereafter as determined by QAPI committee. Registered Dietician or designee will present audit findings at monthly QAPI meeting.	3/8/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10685	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEKAKWITHA LIVING CENTER	6 E CHESTNUT SISSETON, SD 57262

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S 301	Continued From page 8 -Nutrition/hydration. -Sanitation. 2. Review of cook O's employee record revealed: *She was hired on 4/28/25. *She did not have the following dietary training completed: -Food safety. -Food handling/prep. -Foodborne illness. -Serving/distribution. -Leftovers. -Nutrition/hydration. 3. Review of dietary aid R's employee record revealed: *He was hired on 9/18/25. *He did not have the following dietary training completed within 30 days of hire: -Food safety. -Handwashing. -Food handling/prep. -Foodborne illness. -Serving/distribution. -Leftovers. -Time/temp controls. -Nutrition/hydration. -Sanitation. 4. Review of dietary aid J's employee record revealed: *She was hired on 9/19/24. *She did not have the following annual dietary training completed: -Food safety. -Handwashing. -Food handling/prep. -Foodborne illness. -Serving/distribution. -Leftovers.	S 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10685	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 301	Continued From page 9 -Time/temp controls. -Nutrition/hydration. -Sanitation. 5. Review of the restorative supervisor N's, who was the cook on 1/20/26, employee record revealed: *She was hired on 3/1/81. *She did not have the following annual dietary training completed: -Food safety. -Handwashing. -Food handling/prep. -Foodborne illness. -Serving/distribution. -Leftovers. -Time/temp controls. -Nutrition/hydration. -Sanitation. 6. Interview on 1/22/26 at 12:45 p.m. and again at 2:08 p.m. with administrator A revealed: *Their previous dietary manager resigned on 1/7/26, after being in that role for a few weeks. -The dietary manager before her resigned on 8/19/25. *When asked who could answer dietary questions, he stated, "I guess that would be me." "This is all the education they [dietary staff] have done." 7. Employee training policy was requested on 1/22/25 at 12:15 p.m. and was not received before the team exited the facility.	S 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435038	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEKAKWITHA LIVING CENTER	6 E CHESTNUT , SISSETON, South Dakota, 57262

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 1/21/26. Tekakwitha Living Center was found not in compliance with the following requirements: E004.	E0000		
E0004 SS = D	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at	E0004	Cannot correct prior non-compliance for EP Plan, Review & Annual Update. EP Plan reviewed and updated agreements to be obtained for transportation/transfer; drinking water supply; and heating oil/fuel supply. Administrator or designee will audit yearly in January that contracts have been renewed for upcoming year. Administrator or designee will present audit findings at February QAPI meeting.	3/8/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Calvin F Carroll	Administrator	2/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435038	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEKAKWITHA LIVING CENTER	6 E CHESTNUT , SISSETON, South Dakota, 57262

(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 1/21/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Tekakwitha Living 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 K211, K233, K251, and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0211 SS = E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is NOT MET as evidenced by: Based on observation, and interview, the provider failed to maintain egress free from obstructions at two randomly observed exits (east wing south exit and north dining west exit). Findings include: 1. Observation on 1/21/26 at 1:38 p.m. revealed the east wing south exit (adjacent to the east dining room) was obstructed by a chair placed in front of the door and was not free for full use in case of emergency. Interview with the maintenance director at the time of the above observations confirmed that condition. He stated he was aware that chair was in that location	K0211	Corrected non-compliance findings as stated on 2/1/2026 for maintaining egress/exits free from obstructions. All other egress/exit areas check for obstructions by Env. Service Lead/ Maintenance or designee. Education will be provided to All Staff on keeping egress/exits free from obstructions given by Env. Service Lead/Maintenance or designee. Env. Service Lead/Maintenance or designee will audit egress/exits for obstructions weekly for 4 weeks and monthly for 2 additional months, and thereafter as determined by the QAPI Committee. Env. Services Lead/Maintenance or designee will present audit findings at monthly QAPI meeting.	3/8/26

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
Calvin F Carroll	Administrator	2/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435038	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0211 SS = E	Continued from page 1 obstructing that exit. He believed a resident had placed that chair in that location. Further interview with the administrator that same day during the exit conference revealed he was aware a chair was being placed in that location. He believed it had been a staff person placing that chair in that location. 2. Observation on 1/21/26 at 2:55 p.m. revealed the west exit for the north dining room was obstructed by several stools placed in the nook in front of that door and was not free for full use in case of emergency. Interview with the maintenance director at the time of the above observations confirmed that condition. He stated he was not aware those stools were in that location and obstructing that exit. Further interview with the administrator that same day during the exit conference revealed he was aware stools were being placed in that location. Failure to provide working egress doors as required increases the risk of death or injury due to fire. The deficiency affected 100% of the smoke compartment occupants. Ref: 2012 NFPA 101 Section 19.2.2.2.1, 7.2.1.4.5.1(2)	K0211		
K0233 SS = C	Clear Width of Exit and Exit Access Doors CFR(s): NFPA 101 Clear Width of Exit and Exit Access Doors 2012 EXISTING Exit access doors and exit doors are of the swinging type and are at least 32 inches in clear width. Exceptions are provided for existing 34-inch doors and for existing 28-inch doors where the fire plan does not require evacuation by bed, gurney, or wheelchair. 19.2.3.6, 19.2.3.7 This STANDARD is NOT MET as evidenced by:	K0233		F

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435038	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0233 SS = C	Continued from page 2 Based on observation and record review, the provider failed to maintain clear door widths of at least thirty-two inches for one randomly observed set of exit access doors (double-door number 7). Findings include: 1. Observation on 1/21/26 at 2:36 p.m. revealed the leaves for double-door number 7 between the stairwell and the corridor were only thirty inches wide. They did not provide a clear opening width of thirty-two inches. Record review of the previous survey report confirmed the doors were part of the original construction. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct the deficiencies identified in K000.	K0233		F
K0251 SS = D	Dead-End Corridors and Common Path of Travel CFR(s): NFPA 101 Dead-End Corridors and Common Path of Travel 2012 EXISTING Dead-end corridors shall not exceed 30 feet. Existing dead-end corridors greater than 30 feet shall be permitted to be continued to be used if it is impractical and unfeasible to alter them. 19.2.5.2 This STANDARD is NOT MET as evidenced by: Based on observation, measurement, and interview, the provider failed to maintain exit and exit access, so any dead-end corridor (south corridor by kitchen) did not exceed thirty feet. Findings include: 1. Observation and measurement on 1/21/26 at 12:03 p.m. of the south corridor from the south, east-west corridor to resident rooms 207, 208, 209, and 210 were not provided with an exit. The dead-end corridor measured seventy-two feet in length. Interview with the maintenance director at the time of the observation and measurement revealed during a remodel of that area years ago the exterior door had been removed. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's	K0251		F

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435038	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0251 SS = D K0712 SS = D Bldg. 01	Continued from page 3 intent to correct the deficiencies identified in K000. 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 record review and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (conducted quarterly for each shift). Findings include: 1. Record review on 1/21/26 at 3:51 p.m. revealed there was no documentation of second or third shift fire drills were conducted for quarter two (April, May, June) or quarter three (July, August, September) or quarter four (October, November, December) in 2025. Interview with the administrator at the time of the record review confirmed those findings. He stated he was unaware the minimum number of fire drills per the required frequency had not been met for each of those shifts for 2025. The deficiency had the potential to affect 100% of the occupants of the building.	K0251 K0712	Cannot correct prior non-compliance fail of appropriate fire drill procedures. Education provided to All Staff on Fire Drill Procedures given by Env. Service Lead/Maintenance or designee. Extra fire drills will be conducted/ completed for the purpose of ensuring all staff are involved in at least one fire drill each quarter of the year. Policy reviewed and updated as necessary by IDT for proper procedures. Env. Service Lead/Maintenance or designee will audit Fire Drill records weekly for 4 weeks and monthly for 6 additional months, and thereafter as determined by the QAPI Committee. Env. Service Lead/Maintenance or designee will present audit findings at monthly QAPI meeting.	3/8/26