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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435072	A. BUILDING _____ B. WING _____	C 07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN SISTERS LIVING CENTER	1201 HWY 71 SOUTH HOT SPRINGS, SD 57747

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/22/24 through 7/25/24. Seven Sisters Living Center was found not in compliance with the following requirements: F804 and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/22/24 through 7/25/24. Areas surveyed included nursing services, pharmacy services, and medication errors. Seven Sisters Living Center was found to have past non-compliance at: F755 and F760.	F 000		
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all	F 755		

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

CEO | 8.19.2024

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

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F 755	Continued From page 1 aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) complaint report review, interview, record review, and policy review, the provider failed to ensure prompt identification of loss or potential diversion of controlled (high risk for addiction and dependence) medications and prompt identification of medication errors. Failure to accurately monitor controlled medications and medication errors may have placed the residents at increased risk of adverse effects of not receiving medications as ordered, such as increased pain. This citation is considered past non-compliance based on a review of the corrective actions the provider implemented following the identification of the incident. Findings include: 1. Review of the 6/27/24 SD DOH complaint report revealed: *Resident 1 had not received her Fentanyl (a controlled medication for severe pain) medication as ordered by her physician. -She was supposed to have received a new Fentanyl topical patch every 72 hours (3 days). -She had a new patch applied on 6/8/24 and it	F 755	Past noncompliance: no plan of correction required.	

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F 755	Continued From page 2 had not been replaced until 6/21/24. Four applications were missed over thirteen days. -She had increased pain and migraine headaches during that time. 2. Interview on 7/23/24 at 9:23 a.m. with resident 1 revealed: *She confirmed the above medication error had occurred and stated she had suffered from increased pain and migraine headaches because of the medication error of not receiving that medication. *She stated while a nurse was speaking to her about the medication error, an aide was also in her room and informed her there was another resident (15) who had the same problem with her Fentanyl patches. -She stated the nurse had told the aide to "be quiet and leave the room." She was unable to recall the aide's name. -She stated resident 15 had dementia and was unable to communicate her needs and she was worried about medication errors happening to other residents who were "unable to defend themselves." 3. Review of the provider's January through July 2024 medication error tracking log revealed: *There were 100 medication errors with approximately 60 of those errors related to controlled medications including oxycodone, Tramadol, morphine, Percocet, hydrocodone, Fentanyl (all pain relievers), and Ativan (antianxiety medication). -The "Summary of occurrence" area of the tracking log showed many of those errors were identified as "Pulled med but not documented on Mar". -The number of medication errors had decreased	F 755		

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F 755	Continued From page 3 in July of 2024 with only five documented errors. 4. Interview on 7/25/24 at 9:00 a.m. with assistant director of nursing (ADON)/resident care manager (RCM) C revealed: *The pharmacy tracked the medication errors, and she received their Omnicell (an automated medication dispensing machine) medication error summary reports weekly. -She reviewed every medication error report and tracked them for any trends. -She provided staff reminders in stand-up meetings about medication documentation and accuracy. *She identified one medication aide (MA) as having numerous medication errors. That MA was placed on a performance improvement plan (PIP) and was closely monitored. 5. Interview on 7/25/24 at 9:40 a.m. with medication aide (MA) Y revealed: *All scheduled and as-needed (PRN) controlled medications are retrieved individually from the Omnicell at the time of administration. -There were no controlled substances kept in the medication carts. *Both the nurses and the medication aides had access to the Omnicell to remove controlled medications. 6. Interview on 7/25/24 at 10:30 a.m. with pharmacist F regarding the above findings revealed: *He was aware of the facility's medication errors because he wrote the medication error reports. *He felt many of those errors were documentation errors and not actual medication errors. *He stated he used to only write up error reports on "actual" medication errors (i.e. wrong med,	F 755		

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F 755	Continued From page 4 wrong dose, wrong patient) but within the last month he wrote medication error reports on all the Omnicell discrepancies, including missed documentation, so the discrepancies could be tracked and monitored for diversion more closely. *He stated he provided those reports to the nurse supervisors, and they would have decided what actions were to be taken with the staff. -He stated, "We are now tracking every narcotic medication error and writing up each one." -He identified narcotics (medications for severe pain) retrieved for hospice patients were the medications most frequently not documented on the MARs and he felt the immediate need of the patient likely caused a delay in or absence of documentation. *The pharmacy had increased the monitoring of medication errors from monthly to weekly and included nursing administration, quality assurance, and the safety team, in all reports. *He stated the quality assurance and safety team had been discussing the re-implementation of a medication error committee for increased focus on medication and documentation errors. 7. Review of the provider's 2/7/12 Medication Error Prevention Plan policy revealed: *"3. All medication errors will be reported to the quality assurance, process improvement team for recommendation." *"4. Disciplinary Action may occur after 3 consecutive medication errors in 3 months and/or after any significant medication error. LTC management may decide to implement a Performance Improvement Plan prior to disciplinary actions being taken. " The provider's implemented systemic changes to ensure the deficient practice does not reoccur	F 755		

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F 755	Continued From page 5 was confirmed on 7/25/24 after record review revealed the facility had followed their quality assurance process, followed their policy, provided staff education, and implemented a PIP. Interviews revealed changes had recently occurred that included increased monitoring and of medication documentation and medication errors. Based on the above information, non-compliance at F755 occurred on 6/11/24, and based on the provider's implemented corrective actions for the deficient practice confirmed on 7/25/24, the non-compliance is considered past non-compliance.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) complaints report review, interview, and record review, the provider failed to correctly administer narcotic (pain relieving) medications as ordered for two of two sampled residents (1 and 15). Failure to administer narcotic medications as ordered may have contributed to residents 1 and 15 having increased pain, discomfort, and side-effects of narcotic withdrawal. This citation is considered past non-compliance based on a review of the corrective actions the provider implemented immediately following the discovery of the medication errors. Findings include:	F 760	Past noncompliance: no plan of correction required.	

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F 760	Continued From page 6 1. Review of the two 6/27/24 SD DOH complaint reports revealed: *Resident 1 had not received her Fentanyl (a controlled medication for severe pain) medication as ordered by her physician. -She was supposed to have received a new Fentanyl topical patch every 72 hours (3 days). *Her Fentanyl patch was applied on 6/8/24. -It had not been replaced from 6/8/24 through 6/21/24. *She did not receive four doses. -She had increased pain and migraine headaches during that time. *She had called a friend and was reported to have been crying because of her increased pain and migraine headaches. 2. Interview on 7/23/24 at 9:23 a.m. with resident 1 revealed: *She was receiving hospice care for end-stage kidney failure. *She stated, "I started having pain and looked at the calendar and found out it (Fentanyl patch) hadn't been changed in several weeks. It was supposed to be changed every three days." -She stated she had increased back pain and severe migraine headaches during that time. -She stated, "It was a doozy for a few days. It was a hell of a migraine." *She stated a hospice nurse told her the Fentanyl patch medication was prescribed correctly to indicate it would be replaced every 72 hours (three days), but the pharmacy had changed it to be replaced every 72 days. *She stated that while a nurse was speaking to her about the medication error, an aide was also in her room and informed her there was another resident (15) who had the same problem with her	F 760		

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F 760	Continued From page 7 Fentanyl patches. -She stated resident 15 had dementia and was unable to communicate her needs and she was worried about medication errors happening to other residents who were "unable to defend themselves." 3. Review of resident 1's electronic medical record (EMR) and June 2024 medication administration record (MAR) revealed: *She had received hospice services that had begun in April of 2024 for stage 5 renal failure. *She had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact. *She had an order for: "Fentanyl Transdermal Patch 25 mcg/hr [micrograms per hour]. Apply 1 patch every three days. Remove patch after 72 hours (3 days) and fold in half and dispose of according to facility procedures." -Her MAR indicated the Fentanyl order had been changed on 6/8/24 to "Apply one patch transdermally one time a day every 72 days." *She had a new patch applied on 6/8/24 and it had not been replaced until 6/21/24. Four applications were missed over thirteen days. 4. Review of resident 15's EMR and May 2024 MAR revealed: *She was on hospice care for terminal breast cancer. *She had a BIMS score of 4, which indicated she had severe cognitive impairment and was non-interviewable. *She had an order for: "Fentanyl Transdermal Patch 25 mcg/hr. Apply 1 patch transdermally one time a day every 72 hours." -Her May 2024 MAR indicated the Fentanyl order had been changed on 5/9/24 to state "Apply one	F 760		

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F 760	Continued From page 8 patch transdermally one time a day every 72 days." -She had a new patch applied on 5/9/24 and it had not been replaced until 5/16/24, missing two applications over seven days. 5. Interview on 7/23/24 at 3:24 p.m. with licensed practical nurse (LPN) H and LPN I revealed: *The pharmacy entered medication orders into the EMR's MAR in Point Click Care (PCC). -If the pharmacy was closed, the nurse would have entered the order into PCC and the order would have been verified by the night nurse. 6. Interview on 7/25/24 at 9:00 a.m. with assistant director of nursing (ADON)/resident care manager C revealed: *The Fentanyl orders had been entered into PCC incorrectly and indicated staff were to have applied a patch every 72 days and not every 72 hours as prescribed. The MARs on the computer only showed what was to be given each day, according to what had been entered into PCC, so those Fentanyl orders had not appeared on the daily MAR screen to be given and were missed. *She stated that when the Fentanyl medication errors had been identified, pharmacist F implemented two secondary order verification systems. -All medication orders were verified by a second person in the pharmacy and a MAR was printed to verify the accuracy of new orders. -All Fentanyl orders had a "daily patch monitor" prompt to be signed off on the daily MAR which was separate from the MAR's Fentanyl order. *She was included in all the pharmacy medication error reports and medication errors were reviewed by the pharmacy and nursing administration every week. They were also	F 760		

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F 760	Continued From page 9 reviewed by a multidisciplinary team during the monthly quality assurance and safety meetings. -All medication aides and nurses were educated on the new Fentanyl patch monitoring process on 7/1/24. 7. Interview on 7/25/24 at 10:30 a.m. with pharmacist F regarding the above findings revealed: *The physicians would enter their orders in an EMR system called EPIC and the pharmacy staff would enter those orders into PCC. *Both Fentanyl orders were entered incorrectly by pharmacist X. When that repeated medication error was discovered, the two-party verification, printing of MARs, and daily patch monitoring systems were implemented. *The pharmacy had increased the monitoring of medication errors from monthly to weekly and included nursing administration, quality assurance, and the safety team, in all reports. *He stated the quality assurance and safety team had been discussing the re-implementation of a medication error committee for increased focus on medication and documentation errors. The provider's implemented systemic changes to ensure the deficient practice does not reoccur was confirmed on 7/25/24 after record review revealed the facility had followed their quality assurance process, education was provided to the pharmacy and nursing staff regarding the two-person order verification process, pharmacy printing and double checking the MARs for correctness, daily monitoring of resident's Fentanyl patches, and a review of the medication error report revealed no further Fentanyl medication errors had occurred.	F 760		

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F 760	Continued From page 10 Based on the above information, non-compliance at F760 occurred from 5/9/24 through 5/16/24 and again from 6/8/24 through 6/21/24, and based on the provider's implemented corrective actions for the deficient practice confirmed on 7/25/24, the non-compliance is considered past non-compliance.	F 760		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the provider failed to ensure two of two sampled residents (11 and 27) who received a specialized diet were served the correct portion sizes and nutritional values for one of three observed meal services. Findings include: 1. Observation on 7/23/24 from 11:45 a.m. through 12:35 p.m. of the memory care unit lunch meal revealed: *The menu for lunch that day consisted of spaghetti, a lettuce salad, and bread with an alternate meal of chicken and rice soup. *Residents 11 and 27 were served an approximate one-half cup round scoop of ground spaghetti centered in the middle of their plate.	F 804	The dining services manager will review residents (11 and 27) care plans ensuring food preferences are identified and communicated with dining services team members. The registered dietitian will review these resident's nutritional assessments to ensure appropriate interventions are in place for proper nutrition. The dining services manager will review all resident care plans (who receive a special diet) ensuring their food preferences are identified and communicated with dining services team members. The Registered Dietitian will educate the Dining Services Manager on the following topics: -Food handling/safety -Hand washing -Nutritional value -Portion size and recommended daily allowances -Food preparation and presentation -Serving and preparing special diets -Offering substitutions when residents are seen not eating the meal offered. *continued on next page*	9/8/2024

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F 804	Continued From page 11 -No other food items were served with their meal. *Administrator A was present in the dining room and an unidentified aide notified him of their meal portions. -Resident 27's husband was visiting during the meal and administrator A offered more food items to which the husband responded he would wait and see if she ate the spaghetti first. -Resident 27 ate the spaghetti and a prepackaged cup of pudding the husband had offered. *Resident 11 showed little interest in eating her spaghetti. *By the end of the lunch meal, no further offers of food items were made to resident 11 or 27. Interview on 7/23/24 at 11:50 a.m. with resident 27's husband while he sat with her in the memory care dining room revealed: *He stated his wife had lost nearly 60 pounds since she had been sick with COVID-19 and her dementia had worsened. -He stated because of her weight loss and dementia her dentures no longer fit correctly, and she would have refused to wear her dentures even when they did fit. -He stated his wife liked eating soup, but it was rarely offered to her. -He stated she was able to eat soft foods without difficulty and had not understood why they gave her pureed food as she did not like it. Interview on 7/23/24 at 5:00 p.m. with registered dietitian (RD) D and administrator A regarding the above observed meal service revealed: *RD D stated she worked for the provider as a consultant. *RD D agreed the meal served to residents 11 and 27 was not visually palatable, accurate in	F 804	The Dining Services Manager (in partnership with the Registered Dietitian) will educate all dining services team members on these topics. The Registered Dietitian will specifically educate all dining services team members on portion size and nutritional values. The Registered Dietitian will educate all dining services team members on portion sizes for specialized diets and provide a visual reference guide to be available for cooks and other team members during meal services. The dining services manager will monitor resident meals weekly for three months to ensure resident meals are meeting nutritional requirements, the food appearance is palatable, and special diets are received. The dining services manager or designee will report results to the quality assurance team monthly for three months for further recommendation. —	9/8/2024

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F 804	Continued From page 12 portion size, or nutritionally balanced. *Administrator A agreed the full nutritional menu was not served to those residents. -He stated dietary cook R was hired within the last 90 days and he expected the dietary manager (DM E) to have ensured cook R had been educated on serving sizes and specialized diets. -He stated that DM E was newly hired around the same time as cook R and he (DM E) was working on obtaining his dietary manager's certificate. *Their expectation was for all the food groups listed on the menu, or a nutritionally equal substitute, was to have been served in the correct portion sizes. *They both confirmed they had not observed a meal service to ensure the meals were proportioned correctly and served appropriately. Interview on 7/24/24 at 1:30 p.m. with DM E revealed: *He stated he was hired as a cook in January of 2024 and became the DM around March of 2024. -He stated he had not worked as a DM in a long-term care facility before this employment and he was currently working on his dietary manager's certificate. *He stated the past DM had resigned in March of 2024 and the DM training he received from her was "slim to none" and lasted about four days in total. -She had shown him how to order supplies, complete the Minimum Data Set (MDS), and fill out the dietary staff schedules. -He stated he had no training on specialized diets, portion sizes, or the required education he needed to provide to his dietary staff. *He thought dietary cook R had been trained by dietary cook S on specialized diets and portion	F 804		

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F 804	Continued From page 13 sizes. Interview on 7/24/24 at 2:30 p.m. with dietary cook S revealed she: *Had worked as a cook for about one and a half years. -Had been trained on serving sizes by dietary cook T and had not received any formal training from a DM or a dietitian. *Stated she had trained cook R for nearly two weeks and had provided her with "some" training on plate presentation, serving sizes, recording temperatures, and specialized diets. *Was unable to identify the portion sizes for ground or pureed foods and stated she usually "filled up a bowl until it would look like a four-ounce portion". -Stated there were no guides on portion sizes for specialized diets located in the kitchen. *Stated, "Some people don't eat as much so we give smaller portions to them." -Was not aware if the dietitian had been notified of this practice. *Stated, "We need more education on this (portion sizes)." Interview on 7/24/24 at 2:40 p.m. with RD D regarding the above dietary staff interviews revealed: *She stated she was not aware the current DM and cooks had not been properly trained on portion sizes or dietary types and was not aware there were no serving guides available to staff. *She was not aware the cooks were serving smaller portions to those who did not eat well and had initiated a review of each resident's diet and food consistency orders. -She stated the only time residents should have been served smaller portions was if they had a	F 804		

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F 804	Continued From page 14 specific order for smaller portions. *She agreed there was a need for further food service monitoring and dietary staff education. Review of resident 11's medical record revealed: *She received Hospice services and had a diagnosis of a major neurocognitive disorder due to Parkinson's disease with behavioral disturbance. -She had a brief interview for mental status (BIMS) of 99, which indicated she was severely cognitively impaired and was unable to participate in the assessment. *Her diet order was for an NDD3 (National Dysphagia Diet level 3) texture that omitted dry, hard, crispy foods. *She was to receive an Ensure nutritional supplement drink three times a day. *On 01/23/2024, the resident weighed 117 lbs. On 07/20/2024, the resident weighed 95.5 pounds which was an -18.38 % weight loss. -A decrease of 10% or greater in 180 days was considered a significant weight loss. Review of resident 27's medical record revealed: *She was diagnosed with a major neurocognitive disorder due to Alzheimer's disease with behavioral disturbance, anxiety, depression, and hallucinations. *She had a BIMS of 04, which indicated she had a severe cognitive impairment. *Her diet order was for a "regular diet as tolerated with mechanical texture, regular consistency, gravy on meat, pureed vegetables, and finger foods." -She also had an order for a nutritional supplement drink three times a day. *On 01/22/2024, the resident weighed 134 lbs. On 07/22/2024, the resident weighed 116 pounds	F 804		

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F 804	Continued From page 15 which was an -13.43 % weight loss. -A decrease of 10% or greater in 180 days was considered a significant weight loss. Review of the provider's 2012 Weight Assessment and Intervention policy revealed: *"The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents." -"2. The Physician and the multidisciplinary team will identify conditions and medications that may be causing anorexia, weight loss, or increasing the risk of weight loss. For example: f. Increased need for calories and/or protein; i. Inadequate availability of food or fluids." Review of the provider's initial hire and annual dietary training revealed DM E, cook S, and cook R, had not received training on the following topics: Food Safety, Serving/Distribution, Leftovers, Time/Temp Controls, Nutrition/Hydration, and Sanitation.	F 804		
F 880 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:	F 880	The Resident Care Manager will review treatment administration records for residents 43 and 51 update these to include nasal cannulas will be replaced according to policy. The Resident Care Managers will review all residents receiving oxygen therapy ensuring their treatment administration records are updated, and new nasal cannulas are replaced according to policy. *continued on next page*	8/23/2024

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F 880	Continued From page 16 §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 §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880	All residents have the potential to be affected by infection prevention and control practices. The Director of Nursing or designee will review and update infection control policies including the following: Infection Control Hand Hygiene to include hand hygiene and glove use when moving from a dirty procedure to a clean procedure when providing resident care; Catheter Care, Urinary policy and procedure to address process of routine emptying of the urine collection bag, Supra pubic catheter care, disinfection of the drainage port, and hand hygiene and glove use procedures during routine catheter care; Infection Control Linen Handling to include placing soiled linen directly into a container or bag at point of care in the resident care area for transport to the dirty linen hamper; Nasal Cannula in Adult policy updated to specify that nasal cannulas should be changed every 14 days or if visibly soiled; Cleaning and Disinfection of Resident-Care Items and Equipment reviewed to include that durable medical equipment is to be cleaned and disinfected before reuse by another resident; and EVS Standard Procedure updated to include routine care of the resident care environment to include cleaning, and disinfection of environmental surfaces, beds, bedrails, bedside equipment, and other frequently touched surfaces on a routine basis. Caregiver education will be conducted to review updated policies, procedures and caregiver roles and responsibilities for infection prevention and control. *Continued on next page*	8/23/2024

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F 880	Continued From page 17 §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, record review, and policy review, the provider failed to ensure: *Proper hand hygiene, glove use, containment of soiled linen, and disinfection of a mechanical lift, by two of two staff (M and N) during one of one sampled resident's (46) mechanical lift transfer and personal hygiene care. *Proper hand hygiene, glove use, containment of soiled linen, and suprapubic catheter (connected through the abdomen to the bladder) care by one of one medication aide (Q) during one of two sampled resident's (1) catheter care observations. *Proper hand hygiene and glove use by two of two dietary aides (O and W) while assisting two of two residents (8 and 11) during two of three dining room observations. *Oxygen tubing was changed according to facility policy for two of four (43 and 51) sampled oxygen-dependent residents. *Cleaning and sanitization of five of six multi-use facility recliners and one of one couch located in the memory care unit. Findings include:	F 880	The Director of Nursing or designee will educate all caregivers. This education will include procedures for the following: hand hygiene and glove use for the assigned task (including meal times); containment and disposal of soiled linens; maintenance and disinfection of mechanical lifts between use; technique with suprapubic catheter care; maintenance and exchange of oxygen cannulas; cleaning and sanitization of multi-resident use furnishings. This will include licensed and unlicensed team members regarding their roles and responsibilities for infection prevention. Random audits will be completed by the Infection Preventionist weekly for a month then monthly for three months. These audits will include monitoring appropriate hand hygiene, glove use compliance during personal care, glove use and hand hygiene during meal times, and containment and disposal of soiled linens, disinfection of mechanical lifts between use, and proper infection control practices during catheter care. These audits will be completed weekly for a month then monthly for three months. The Director of Nursing or designee will report results to the quality assurance team on a monthly basis for three months for further recommendation. The Resident Care Manager will monitor all residents receiving oxygen therapy monthly for three months to ensure oxygen nasal cannula tubing is changed every 14 days according to policy and documented. The Director of Nursing or designee will report audit results to the quality assurance team monthly for three months for further recommendation. *continued on next page*	8/23/2024

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F 880	Continued From page 18 1. Observation on 7/23/24 at 10:29 a.m. with nurse aide (NA) M and certified nurse aide (CNA) N during a mechanical lift transfer and personal hygiene care of resident 46 revealed: *A multi-resident use mechanical lift was removed from the hallway and brought into resident 46's room. *NA M and CNA N sanitized their hands, applied clean gloves, and transferred resident 46 onto her bed using a sling attached to the mechanical lift. -Her open-backed skirt was partially wet with urine, was removed by NA M and placed directly onto the floor. *CNA N removed the resident's urine-soaked incontinence brief and cleansed the resident's genital and rectal areas. -Using those same gloved hands, he applied a barrier cream to the resident's rectal area first and then her genital skin folds. *NA M removed his gloves and without cleansing his hands he: -Opened the resident's closet door and obtained a clean incontinence brief and clothing. -Applied a clean pair of gloves and assisted CNA N while they applied the resident's incontinence brief and clothing. -Removed the trash and placed her soiled clothing in a plastic bag for transport. *They both removed their gloves and without cleansing their hands they: -Adjusted her bed linens. -Touched the bed's remote and adjusted the bed height. -Moved the overbed table closer to her bed and placed her drink cups within her reach. -Opened the hallway door, removed the mechanical lift from the room, and placed it in the hallway. *They then sanitized their hands in the hallway,	F 880	The Environmental Services Director will educate environmental services team members on appropriate cleaning, sanitation, or disposal of multi-resident use furnishings. This education will include environmental cleaning procedures of the resident care environment including: cleaning, disinfecting environmental surfaces, beds, bedrails, bedside equipment, frequently touched surfaces and multi-resident furnishings. The furnishings identified during the time of survey have been either cleaned or discarded. The Environmental Services Director or designee will monitor all multi-resident furnishings weekly for three months verifying the cleanliness of the furnishings. The Environmental Services Director or designee will report audit results to the quality assurance team monthly for three months for further recommendation. ---	8/23/2024

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F 880	Continued From page 19 but had not sanitized the mechanical lift. Interview on 7/23/24 at 10:50 a.m. with NA M and CNA N regarding resident 46's personal hygiene, hand sanitization, glove use, and mechanical lift cleaning revealed: *CNA N stated he was a contract CNA and had been working for the provider for about three months. -Stated he was trained by other staff while working "on the floor." -Verified he had "some" new hire orientation but was unable to recall what it was. *NA M stated he was taught hand hygiene and glove use during his new hire orientation. *They both stated hand hygiene and glove use should have been performed before and after resident care. -Neither one had identified hand hygiene and glove use when going from a dirty task to a clean task. *NA M identified he had placed the resident's soiled linen directly on the floor and stated he was, "Sorry about that." -He stated he thought the mechanical lift should have been sanitized after each resident use, but was not sure if that was what they were supposed to do. 2. Observation on 7/24/24 at 2:10 p.m. of medication aide (MA) Q during resident 1's suprapubic (SP) urinary catheter care revealed: *Resident 1 was on enhanced barrier precautions due to having an indwelling SP urinary catheter. *MA Q stated the resident had a bowel movement and had requested to be cleaned up before the surveyor's entrance into the room. -The soiled bed linens were folded and lying directly on the floor next to the bed.	F 880		

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F 880	Continued From page 20 *MA Q sanitized her hands and applied a disposable plastic gown and clean gloves. -She removed a split gauze dressing that was located around the SP tubing insertion site on the resident's lower abdomen. -She cleansed the skin and catheter tubing around the insertion site with a specialized disposable wipe made for that purpose. *With those same gloved hands, she: -Opened a cabinet door, removed a clean split gauze dressing package, opened it, and applied the gauze dressing to the catheter tubing insertion site. -Adjusted the resident's dressing gown over the site and pulled up the bed linens to cover the resident. -Retrieved a urinal from the bathroom, opened the catheter bag's drainage port, and drained the urine into the urinal. -Returned the drainage port into a plastic holder on the catheter's drainage bag without having cleansed the drainage port. -Emptied the urinal's contents into the toilet, then turned on the sink's faucet handle and rinsed the urinal with water, and again dumped the urinal contents into the toilet. -Flushed the toilet. *She removed her gown and gloves then touched that same faucet handle to wash her hands. *With ungloved hands she: -Removed the soiled linen off the floor and placed it into a plastic transport bag. -Removed the resident's garbage bag for transport. -Opened the resident's hallway door and carried those items to a soiled linen closet located in the hallway. Interview on 7/24/24 at 2:20 p.m. with MA Q	F 880		

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F 880	Continued From page 21 regarding the above observation of resident 1's SP catheter care revealed: *She identified she had not cleansed the catheter bag's drainage port after emptying the urine into the urinal stating, "I missed that." *She was not aware she had missed the following hand hygiene and glove use opportunities: -When she moved from a dirty task to a clean task during the resident's SP catheter dressing change. -When she touched the resident's clothing cabinet, clean dressings, SP tubing, clothing, bed linens, faucet handle, and toilet handle with soiled gloves. -When she placed soiled linens directly onto the floor and when she handled those soiled linens without wearing gloves. -When she opened the hallway door without sanitizing her hands after she handled the soiled linens. Review of the provider's 2009 Cleaning and Disinfection of Resident-Care items and Equipment revealed: *"3. Durable medical equipment (DME) must be cleaned and disinfected before reuse by another resident." *"4. Reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturers' instructions." Review of the provider's 2010 Catheter Care, Urinary, policy revealed: *"Infection control." -"Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag." *The policy had not addressed the step-by-step	F 880		

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F 880	Continued From page 22 procedure for routine emptying of the urine collection bag, SP catheter care, disinfection of the drainage port, or hand hygiene and glove use protocols during routine catheter care. Review of the provider's undated Hand Hygiene policy revealed: *"Procedure" -"1. All employees will perform hand hygiene before: b. Administering patient care." -"2. All employees will perform hand hygiene after: a. Toileting self or assisting patients. b. Handling body secretions. c. Giving care to patient or handling equipment. d. Removing gloves." -"3. b. Gloves will be changed after each patient/resident encounter." *The policy had not addressed hand hygiene and glove use when moving from a dirty procedure to a clean procedure when providing resident care. 3. Observation on 7/22/24 at 5:15 p.m. of certified nursing assistant (CNA) O during the dinner meal revealed she: *Removed a glove from her right pants pocket. *Put that same glove on without sanitizing her hands. *Wiped her face with the back of her gloved hand. *Then wiped her face, wiped resident 11's mouth, touched another resident's straw, moved her hair behind her ear, and assisted resident 8 with eating, all with the same gloved hand. Observation on 7/23/24 at 12:10 p.m. of CNA W during the noon meal revealed she: *Had gloves on, removed them and started to feed residents. *Did not sanitize her hands and touched resident	F 880		

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F 880	Continued From page 23 utensils. *Touched resident 8's hand with her unclean. Resident 8 then put her hand in her mouth. Review of the provider's undated Hand Hygiene policy revealed: *"2. All employees will perform hand hygiene after: d. Removing gloves." *"3. All employees providing direct patient care will: a. Use gloves since gloves reduce hand contamination by 70-80%, prevents cross contamination and protects, patients/residents and staff from infection." 4. Observation and interview on 7/23/24 at 8:56 a.m. to 7/25/24 at 8:21 a.m. with resident 51 in her room revealed: *She was on oxygen therapy and used a nasal cannula (tubing that delivers oxygen into the nose). *She did not know when it was last replaced. *Tape was applied to the nasal cannula (NC) tubing and had the date "7/01/24" written on it. Observation and interview on 7/23/24 at 9:29 a.m. with resident 43 in his room revealed: *He was on oxygen therapy and used NC tubing. *The NC tubing had a piece of tape with the date "6/2/24" written on it. *He did not know when it was last replaced. Record review of both resident 43's and resident 51's revealed, there was no documentation of when the nasal cannula had been replaced. Interview on 7/24/24 at 4:55 p.m. with licensed practical nurse (LPN) K regarding NC tubing	F 880		

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F 880	Continued From page 24 replacement revealed: *The NC tubing were replaced monthly and documented in the treatment administration record (TAR). *She was not able to find documentation in the TAR for NC tubing replacements for resident 43 or resident 51 nor able to produce the policy for NC tubing replacement. Interview on 7/25/24 at 8:33 a.m. with LPN L revealed she: *Thought that NC tubing replacements were documented in the TAR. *Was not able to find any documentation of NC tubing replacement for residents 43 or 51. Interview on 7/25/24 at 9:46 a.m. with LPN H revealed he: *Placed the tape on resident 8's nasal cannula with the date 7/1/24. *Assumed the tubing was replaced at the beginning of the month but was not certain. *Said the changes were notated in the TAR. *Was not able to find documentation for the nasal cannula changes for either of the above residents. *Was not able to produce a policy for when nasal cannula or oxygen tubing was to be changed. Interview on 7/25/24 at 11:59 a.m. with RN/ infection control coordinator U revealed she: *Was not sure when nasal cannulas or oxygen tubing was to be changed. *Did not know about any policy involving tubing changes. *Said that staff should not touch their face or hair prior to resident cares. *Said staff are trained annually on proper hand hygiene.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435072	A. BUILDING _____ B. WING _____	C 07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN SISTERS LIVING CENTER	1201 HWY 71 SOUTH HOT SPRINGS, SD 57747

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 25 Interview on 7/25/24 at 2:01 p.m. with assistant director of nursing (ADON)/ resident care manager (RMC) C revealed: *Her expectations were that staff would conduct proper hand hygiene and change oxygen tubing in accordance with the facility policy. *She said that nasal cannula tubing was to be changed at the beginning of the month. Interview on 7/25/24 at 10:59 a.m. with administrator A revealed: *Oxygen tubing was to be changed at the beginning of the month. *He could not find the facility policy for oxygen tube changing. Review of the provider's February 2006 "Nasal Cannula in Audit" provided by administrator A revealed: *He provided a copy of the adjacent hospital's nasal cannula audit. *"Infection Control: - Nasal Cannulas should be changed every 14 days or if visibly soiled." 5. Observation on 7/22/24 at 4:30 p.m. in the memory care unit revealed: *Two of the three recliners had dark brown discoloration on the headrest and the armrest. *One of those recliners had a worn-down discolored spot on the headrest and was worn-down along the seams at the armrests. *Two high-back chairs had multiple spots on the seat and the back cushions of the chairs. *One of one couch had multiple unidentified light brown stains on the armrest and down the front of the armrest and multiple light brown spots on the seat and back cushions.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435072	A. BUILDING _____ B. WING _____	C 07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 26 Interview on 7/25/24 at 9:30 a.m. with the environment service supervisor G revealed: *He had been the manager for nine years. *The housekeepers have a cleaning checklist that they completed daily. *The housekeepers should have done a deep clean immediately when they saw the stains on the chairs and couch. *He would have expected the housekeepers to have notified him that one of the recliners had a worn-down discolored spot on the headrest and was worn-down along the seams at the armrests. -He would have discarded that recliner immediately. A review of the provider's housekeeping daily cleaning checklist revealed: *They wiped down the chairs in the day room daily. *There was no mention of cleaning the couch in the day room. *There was no mention of deep cleaning the chairs or the couch in the day room. An undated Standard Precautions Policy revealed: F. "Environmental Control 1. See Environmental cleaning procedures for the routine care, cleaning, and disinfection of environmental surfaces, beds, bedrails, bedside equipment, and other frequently touched surfaces, and manager is to ensure that these procedures are being followed." Interview on 7/25/24 at 4:30 p.m. with RN/infection control coordinator U about hand hygiene and glove use revealed she: *Had been doing monthly audits.	F 880		

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	435072	A. BUILDING _____ B. WING _____	C 07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN SISTERS LIVING CENTER	1201 HWY 71 SOUTH HOT SPRINGS, SD 57747

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F 880	Continued From page 27 *Had identified hand hygiene was an issue. *Had opened a performance improvement project (PIP) for hand hygiene as a priority and planned to have opened a glove use PIP.	F 880		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435072	A. BUILDING **03 - SEVEN SISTERS** B. WING _____	**07/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN SISTERS LIVING CENTER	**1201 HWY 71 SOUTH HOT SPRINGS, SD 57747**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 7/23/24. Seven Sisters Living Center was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for Existing Health Care Occupancies upon correction of deficiencies identified at K211 and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 712 SS=C	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 REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the provider failed to ensure all staff were familiar with fire drill procedures. Findings include: 1. Observation on 7/23/24 at 2:40 p.m. revealed the fire drill was held at resident room 177. The	K 712	Fire policy and procedure will be reviewed to ensure policy meets regulation and emergency response standards. All caregivers will be educated regarding fire emergency preparedness procedures. The Environmental Services Director or designee will conduct fire drills weekly for one month (on each shift) then monthly (on each shift) for three months to ensure caregivers are responding according to procedure. The Environmental Services Director or designee will continue to conduct fire drills at least quarterly on each shift. The Environmental Services Director or designee will report fire drill outcomes monthly for three months to the quality assurance team for further recommendation.	9/8/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 8.19.2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435072	A. BUILDING **03 - SEVEN SISTERS** B. WING _____	**07/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN SISTERS LIVING CENTER	**1201 HWY 71 SOUTH HOT SPRINGS, SD 57747**

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K 712	Continued From page 1 staff person responding to the call light found a simulated fire event with a member of maintenance acting as a resident in the room. The staff person left the resident and did not shut the door. The drill was announced after a long delay. After the announcement, the resident was removed and the door to the room with the simulated fire in it was closed. From the initiation of the simulated event, four minutes passed before the fire alarm was sounded. Corridor doors were not closed until after the alarm had been sounded. Review of the fire alarm documentation for 2023 and 2024 revealed the provider was performing drills on a one drill per shift per quarter (the minimum required) except for two drills for the second shift (January and February 2023) and two drills for the first shift (April and May 2023) and two drills for the second shift (February and March 2024). This deficiency has the potential to affect 100% of the resident occupants.	K 712		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435072	MULTIPLE CONSTRUCTION A. BUILDING: 03 - SEVEN SISTERS B. WING	DATE SURVEY COMPLETE: 7/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN SISTERS LIVING CENTER	1201 HWY 71 SOUTH HOT SPRINGS, SD

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 211	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 REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain unobstructed egress at one location (chapel entrance). Findings include: 1. Observation on 7/23/24 at 1:45 p.m. revealed the double doors to the entrance of the chapel from the egress corridor were held open by a bag and a chair. The bag and chair could impede egress by obstructing the operation of the doors for exiting the chapel. Interview with the director of environmental services at the time of the observation confirmed that finding. He stated the doors had hold-opens which sometimes released if bumped by a passerby. The deficiency has the potential to affect egress exit ability for occupants of the chapel. Plan of Correction - Date of Completion 9/8/2024 Items used to hold open the double doors to the chapel have been removed. The Environmental Services Director or designee will educate all team members about the egress requirement. The Environmental Services Director or designee will monitor doors in the care center monthly for three months to ensure a means of egress is unrestricted. The Environmental Services Director or designee will report findings to the quality assurance team monthly for three months for further recommendation.

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The above isolated deficiencies pose no actual harm to the residents

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435072	A. BUILDING _____ B. WING _____	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 7/23/24. Seven Sisters Living Center was found in compliance.	E 000		

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

CEO 8.21.2024

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

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
	10630	A. BUILDING: _____ B. WING _____	07/25/2024

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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 7/22/24 through 7/25/24. Seven Sisters Living Center was found not in compliance with the following requirement: S301.	S 000		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure three of three dietary staff members (dietary manger (DM) E, cooks S and R) had not completed six of nine required dietary trainings that included food safety, handwashing, food handling and preparation, food borne illness, serving and distribution procedures, leftover food handling, time and temperature controls for food preparation and services, nutrition and hydration, and sanitation was offered and completed on an annual basis for all dietary staff. Findings include: 1. Review of provider's dietary department records revealed: *One required annual dietary training for sanitation had been completed on 02/06/24. *There was no documentation the remaining	S 301	The Registered Dietitian will educate the Dining Services Manager on the following topics: -Food handling/safety -Hand washing -Nutritional value -Portion size and recommended daily allowances -Food preparation and presentation -Serving and preparing special diets -Offering substitutions when residents are seen not eating the meal offered. The Dining Services Manager (in partnership with the Registered Dietitian) will educate all dining services team members on these topics. The Registered Dietitian will specifically educate all dining services team members on portion size and nutritional values. The Registered Dietitian will also educate all dining services team members on portion sizes for specialized diets and provide a visual reference guide to be available for cooks and other team members during meal services.	9/8/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 8.19.2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10630	A. BUILDING: _____ B. WING _____	07/25/2024

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S 301	Continued From page 1 required dietary trainings had been offered in the past year. Interview on 7/25/24 at 10:37 a.m. with the DM E and registered dietitian D revealed: *They were responsible for the training of the dietary staff. *They confirmed the dietary staff which included cooks S and R had not received all the required annual dietary training during the past year. *They agreed a system to account for dietary education was needed. 2. Review of the provider's "New Employee Orientations in Dietary Department" revealed: *Procedure: -"4. The dietary department will be in-serviced annually on the following topics: -Food safety. -Hand washing. -Food handling an preparation techniques. -Food-borne illness. -Serving and distribution procedures. -Leftover food handling policies. -Time and temperature controls for food preparation and service. -Nutrition and hydration. -Sanitation requirements."	S 301	The dining services manager will monitor resident meals weekly for three months to ensure resident meals are meeting nutritional requirements, the food appearance is palatable, and special diets are received. The dining services manager or designee will report results to the quality assurance team monthly for three months for further recommendation. The dining services manager will educate dining services team members monthly, (choosing specific topics each month) to ensure each of the topics is educated annually. The dining services manager will monitor the completion of caregiver education monthly for one year to ensure all team members have completed the required education annually. The dining services manager will include education on these topics within 30 days of being hired: -Food handling/safety -Hand washing -Nutritional value -Portion size and recommended daily allowances -Food preparation and presentation -Serving and preparing special diets -Offering substitutions when residents are seen not eating the meal offered.	
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 7/22/24 through 7/25/24. Seven Sisters Living Center was found in compliance.	S 000	The dining services manager will document new hire orientation/education and report completion/results to the quality assurance team monthly for one year for further recommendation. --end S301 --	