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	435129	A. BUILDING _____ B. WING _____	C 06/26/2025

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DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

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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 6/24/25 through 6/26/25. Dells Nursing and Rehab Center Inc was found not in compliance with the following requirements: F582 and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/24/25 through 6/26/25. The areas surveyed included timeliness of entering and implementing physician orders, skin evaluations and treatments, evening shift staffing, and resident elopements. Dells Nursing and Rehab Center Inc was found in compliance.	F 000		
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each	F 582	Due to prior noncompliance we are unable to correct past medicare notices. Medicare notices were updated immediately to reflect the required format. SSD will be educated by Administrator on Medicare notices by 8/10/25. Administrator or designee will audit accurate medicare notices weekly for 4 weeks and monthly for 2 months to follow or longer as determined by audit results. Administrator will report findings at monthly QAPI meetings until audit is complete and no longer needs to be assessed.	8/10/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Calyn Togel
TITLE: Administrator
(X6) DATE: 7/24/2025

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

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F 582	Continued From page 1 resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to ensure the proper Medicare notices were filled out completely and were in the required format for three of three sampled residents (9, 37, and 294) prior to their discharge	F 582		

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F 582	Continued From page 2 from Medicare Part A skilled services. Findings include: 1. Review of the Entrance Conference Worksheet completed by the provider on 6/25/25 revealed the list of residents identified as having been discharged from Medicare Part A skilled services included the following: *Two residents (9 and 37) remained in the facility following their discharge from Medicare Part A skilled services. *One resident (294) was discharged to home following his discharge from Medicare Part A skilled services. 2. Review of resident 9's SNF (Skilled Nursing Facility) Beneficiary Notification Review form completed by social services designee (SSD) E revealed: *The resident's Medicare Part A Skilled Services Episode start date was 12/16/24. *Her last covered day on Medicare Part A Service was 1/24/25. Review of resident 9's electronic medical record (EMR) revealed: *She was re-admitted to the facility on 12/16/24 after a three-day hospital stay with Medicare Part A covering her stay. *On 1/25/25, after her Medicare Part A stay ended, she remained in the facility as indicated on the Entrance Conference Worksheet. *Her 3/9/25 Brief Interview for Mental Status (BIMS) evaluation was scored at seven which indicated she had severe cognitive impairment (a decline in mental abilities including thinking, learning, remembering, and making decisions). 3. Review of resident 294's SNF Beneficiary	F 582		

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F 582	Continued From page 3 Notification Review form completed by SSD E revealed: *The resident's Medicare Part A Skilled Services Episode start date was 3/4/25. *His last covered day on Medicare Part A Service was 4/4/25. Review of resident 294's EMR revealed: *He was admitted on 3/4/25 with Medicare Part A covering his stay. *His 3/6/25 BIMS evaluation was scored at twelve which indicated he was moderately cognitively impaired. *On 4/5/25, after his Medicare Part A stay ended, he was discharged to his home as indicated on the Entrance Conference Worksheet. 4. Review of resident 37's SNF Beneficiary Notification Review form completed by SSD E revealed: *The resident's Medicare Part A Skilled Services Episode start date was 3/26/25. *Her last covered day on Medicare Part A Service was 4/10/25. Review of resident 37's EMR revealed: *She was re-admitted to the facility on 3/26/25 after a four-day hospital stay with Medicare Part A covering her stay. *On 4/11/25, after her Medicare Part A stay ended, she remained in the facility as indicated on the Entrance Conference Worksheet. *Her 4/11/25 BIMS evaluation was scored at five which indicated she had severe cognitive impairment. 5. Review of the Notice of Medicare Non-Coverage (NOMNC) form CMS-10123, with a revision date of 12/31/11, for residents 9, 37,	F 582		

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F 582	Continued From page 4 and 294, completed by SSD E revealed: *The 12/31/11 NOMNC form was outdated and was not the updated form that was required to be used as of 1/1/25, with an expiration date of 11/30/27. *The first bullet point that explained "Your Medicare provider ... have determined that Medicare probably will not pay for your current {insert type} services ..." was not completed with the type of services ending. -The type of services ending should have been identified as skilled nursing. *The "How to Ask For an Immediate Appeal" section was to provide contact information in the fourth bullet point that indicated to "Call your QIO [Quality Improvement Organization] at: {insert QIO name and toll-free number of QIO} to appeal, ..." was not completed with the name and telephone numbers, including TTY (teletypewriter for people with hearing or speech difficulties) of South Dakota's (SD) QIO. *The "Additional Information (Optional)" section indicated SSD E had spoken by phone with the residents' representatives regarding therapy services ending on the actual date Medicare Part A services would end, the reason why Medicare Part A services were ending, and SSD E's signature. *The form indicated on the Signature of Patient or Representative signature line that the residents' representatives had been contacted verbally by a phone call and the date line indicated the date that phone conversation had taken place. -The information provided had not included all of the information required in the 10/31/24 Medicare Claims Processing Manual's Section 260.3.8 - NOMNC Delivery to Representatives "Exceptions to in person notice delivery."	F 582		

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F 582	Continued From page 5 Review of the 2018 Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) Form CMS-10055 for resident 9 and 37, completed by SSD E revealed: *The 2018 SNF ABN form was outdated and not the updated 2024 form that was required to be used as of 10/31/24. *The forms indicated the notices had been provided verbally during a phone call to the residents' representatives. 6. Interview on 6/26/25 at 5:08 p.m. with SSD E regarding the above NOMNC forms and SNF ABN forms she had completed revealed she: *Was not aware the forms she had used were outdated and that new, updated forms were required to be used. *Agreed that the type of services ending on the NOMNC forms was not clearly identified. *Agreed that the QIO's name and toll-free phone number had not been provided on the NOMNC forms as required. *Was not aware of the information that was required to be documented on the NOMNC form when a resident's representative was contacted by telephone. *Confirmed she had not filled out the forms completely, according to their instructions. 7. Review of the "cms.gov" website revealed: *On 8/28/2024: "With the help of our contractors, we revised the SNF ABN, Form CMS-10055, and the form instructions." -The SNF ABN form and instructions are located in the download section and are available for immediate use, but will be mandatory for use on 10/31/2024." *On 11/18/2024: "New NOMNC and DENC for Original Medicare and Medicare Advantage":	F 582		

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F 582	Continued From page 6 -"The Office of Management and Budget (OMB) has approved a revised Notice of Medicare Non-Coverage (NOMNC / CMS-10123)..." -"Please note the updated NOMNC...are to be used for both Original Medicare and Medicare advantage..." -"Providers must use the revised NOMNC beginning January 1, 2025..." Review of the "Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123" revealed: *"{Insert type}: Insert the kind of service being terminated, i.e., skilled nursing, home health, comprehensive outpatient rehabilitation service, or hospice." *In the section How to Ask For an Immediate Appeal "Insert the name and telephone numbers (including TTY) of the applicable QIO in no less than 12-point type." Review of the 10/31/24 Medicare Claims Processing Manual's Section 260.3.8 - NOMNC Delivery to Representatives "Exceptions to in person notice delivery" revealed: *"The provider must complete the NOMNC as required and telephone the representative at least two days prior to the end of covered services." *"The NOMNC must be annotated with the following information on the day that the provider makes telephone contact:" -"The beneficiary's last day of covered services, and the date when the beneficiary's liability is expected to begin." -"The beneficiary's right to appeal a coverage termination decision." -"A description of how to request an appeal by a QIO." -"The deadline to request a review as well as	F 582		

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F 582	Continued From page 7 what to do if the deadline is missed." -"The telephone number of the QIO to request the appeal." *"Reflect that all of the information indicated above was communicated to the representative." *"Note the name of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called." *"A copy of the annotated NOMNC should be mailed to the representative the day telephone contact is made and a dated copy should be placed in the beneficiary's medical file."	F 582		
F 880 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	F 880	All medical supplies such as plastic syringes, and containers of normal saline have been removed, labeled, and stored in an appropriate manner. DON or designee will provide education to all CNA's on catheter care, EBP, and any updated policies. Administrator, DON, Infection control nurse, and/or designee in collaboration with medical director will review and revise necessary policies and procedures for catheter care, cleaning, and storage, and EBP. DON or designee will provide education with documentation to all staff about Enhanced Barrier Precautions, hand hygiene, disposing of resident care items, and catheter care, cleaning, and storage.	8/10/25

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F 880	Continued From page 8 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. §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.	F 880	DON or designee will audit catheter care, cleaning, and storage twice weekly across all shifts for 4 weeks, and monthly for 2 months or longer as determined by audit results. DON or designee will audit EBP weekly across all shifts for 4 weeks and monthly for 2 months or longer as determined by audit results. DON or designee will report findings at monthly QAPI meetings until audit is complete and issue no longer needs to be addressed.	

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F 880	Continued From page 9 §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: A. Based on observation, interview, record review, and policy review, the provider failed to ensure: *One of two certified nursing assistants (CNA) (K) wore appropriate personal protective equipment (PPE) while caring for two sampled residents (22 and 32) who were on enhanced barrier precautions (EBP), which is a type of infection control strategy used in nursing homes to reduce the spread of multidrug-resistant organisms. *One of one CNA (N) practiced appropriate infection control techniques during catheter cares for one of one observed resident (22). *Four of four CNAs (L, M, N, and O) were knowledgeable of the provider's revised catheter care policy and had the skills to implement that policy. *Medical supplies, such as plastic syringes and containers of normal saline found in one of one resident rooms (22) and two of three supply rooms (Rising Sun whirlpool room and the medical supply room), were labeled, stored, and disposed of in an appropriate manner. Findings include: 1. Observation on 6/24/25 at 8:28 a.m. in room 117 revealed: *There was a magnet that read "EBP" at the top of the doorway. *There was PPE hanging on the back of the door. *A poster from the Centers for Disease Control and Prevention (CDC) explaining what EBP was and what direct care staff were required to	F 880		

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F 880	Continued From page 10 perform was posted next to the PPE. The poster read: -"ENHANCED BARRIER PRECAUTIONS -EVERYONE MUST: --Clean their hands, including before entering and when leaving the room. -PROVIDERS AND STAFF MUST ALSO: --Wear gloves and a gown for the following High-Contact Resident Care Activities. --Dressing --Bathing/Showering --Transferring --Changing Linens --Providing Hygiene --Changing briefs or assisting with toileting --Device care or use: central line, urinary catheter, feeding tube, tracheostomy --Wound Care: any skin opening requiring a dressing." 2. Observation on 6/24/25 at 8:31 a.m. in residents 15 and 22's room revealed: *There was a magnet that read "EBP" at the top of the doorway. *There was PPE hanging on the back of the door. *There was no EBP poster with instructions for staff as described above. *To the left of the handwashing sink, there was a black plastic trash bag tied to the towel rod. -Approximately three feet of clear plastic tubing was hanging out the trash bag. -There was moisture on the inside of the tubing. -There was a urinary catheter collection bag inside of the trash bag. *To the right of the handwashing sink, there were two black metal storage shelves with personal care products that included: -Two opened containers of normal saline were on each shelf. Neither container was labeled with the	F 880		

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F 880	Continued From page 11	F 880		

date opened or with the resident's initials to identify which resident it belonged to.
-One opened plastic package that contained a plastic syringe was on the bottom shelf.

Observation on 6/25/25 at 10:23 a.m. in residents 15 and 22's room revealed:
*The black plastic trash bag was still tied to the towel rack to the left of the sink.
*The catheter tubing was no longer hanging out of the trash bag.
*There was moisture buildup on the inside of the catheter collection bag and tubing.

Interview on 6/25/25 at 2:50 p.m. with registered nurse (RN) I about resident catheter bags revealed:
*He indicated he was a travel nurse and had been working at that facility for four weeks.
*Surveyors went with RN I to residents 15 and 22's room to discuss the catheter bag stored there.
-It was his understanding that the catheter collection bags should not have been reused.
-He indicated that the black plastic trash bag that was tied to the towel rack to the left of the resident's sink contained a urinary catheter collection bag, and it still had traces of urine.
-He confirmed that the catheter collection bag was not labeled or dated, and the end of the tube was not capped to protect it from potential contamination.
-He confirmed that was not the proper way to store the catheter collection bag.

Interview on 6/25/25 at 3:24 p.m. with CNA M about the catheter in residents 15 and 22's room revealed:
*CNA M recently passed her CNA certification

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F 880	Continued From page 12 exam and had been working as a CNA for a couple of weeks. *She confirmed that resident 22 had a suprapubic (SP) catheter and wore a urinary catheter collection bag on her leg (leg bag). *She indicated that she was instructed to keep the leg bag on her leg during the night, rather than switching to a larger bed bag at night. *She confirmed that she also noticed resident 22's urinary catheter collection bag that was in a plastic trash bag and was tied to the towel rack in the resident's room. -She did not know how long that had been stored there like that. Interview on 6/25/25 at 3:35 p.m. with CNA N about catheter care procedures revealed: *Resident 22's leg bag was secured to her right leg during the day. *A "bed bag" was used to collect urine at night for the resident. *Their normal practice was to rinse and reuse urinary catheter collection bags. -The urinary catheter collection bags were stored in the black plastic garbage bag that was tied to the towel rack in the resident's room. *She explained that a blue solution was used to sanitize the catheter tubing and collection bag. -She did not know what the blue solution was called. -The cleaning solution was supposed to have been stored in the black metal storage shelves located opposite of the towel rack in the resident's room. -She confirmed there was no cleaning solution in resident 22's room. *The blue solution was squeezed through the catheter tubing and into the collection bag. The bag would be filled with about one inch of	F 880		

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cleaning solution.
-She explained that they allowed the cleaning solution to sit in the collection bag during the day while it was stored in the plastic garbage bag.
-The bag was emptied and rinsed with water before switching from one collection bag type to the other.

Interview on 6/25/25 at 4:35 p.m. with CNA L about catheter care procedures revealed:
*She confirmed that when she helped resident 22 get ready for bed, she would disconnect the resident's leg bag and connect the resident's bed bag for the night.
*They stored the bed bag in the black plastic garbage bag that was tied to the towel rack during the day when she was using the leg bag.
*The catheter bags they were reusing were cleaned with a liquid in the hopper room (a room where soiled laundry was processed).
-She could not find the liquid in the hopper room or in resident 22's room.
-She did not know what the liquid was called.
-The liquid was bluish-purple in color.

Interview on 6/25/25 at 4:48 p.m. with CNA O about catheter care procedures revealed:
*She confirmed that residents' urinary catheter leg bags and bed bags were reused.
*She would rinse the bags and tubing with water when she changed from one bag to another.
-She indicated that she would request other CNAs to clean the catheter tubing and bags because she did not know the procedure for cleaning them.
-She had only been a CNA for a few months at the time of the survey.
*She did not know what solution was used to clean the catheter tubing and bags.

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F 880	Continued From page 14 Observation and interview on 6/26/25 at 9:06 a.m. with CNA N while she assisted resident 22 get out of bed revealed: *CNA N confirmed that she and another CNA had assisted the resident to transfer from her bed to her wheelchair. *Resident 22's bed bag was sitting directly on the floor. *CNA N put on a gown, gloves, and a face mask. *CNA N removed a new leg bag from its sterile packaging, uncapped the end of the tubing, and wiped it with an alcohol wipe. -She accidentally touched the resident's leg, the SP catheter tubing, and the bed bag tubing with the end of the new catheter tubing as she struggled to disconnect the bed bag tubing from the SP catheter tubing, potentially contaminating the end of the new catheter tubing. *Once she successfully disconnected the bed bag and connected the leg bag, she brought the bed bag to the bathroom and poured the urine contents into a graduated cylinder (a type of measuring cup) on the floor. She left the graduated cylinder containing urine on the floor in the bathroom, indicating that she would come back after resident 22's shower to clean the cylinder. *She brought the empty bed bag to the sink and said, "Where's your garbage bag?" -She then grabbed a new black plastic garbage bag and placed the soiled bed bag and tubing inside and tied the garbage bag to the towel rack. *She indicated that she would clean the bed bag after she helped resident 22 take a shower. *She removed her PPE and did not perform hand hygiene before helping resident 22 put her glasses on and brushed her hair out of her face. *She did not perform hand hygiene upon exiting	F 880		

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F 880	Continued From page 15 the resident's room. Continued observation and interview on 6/26/25 at 9:46 a.m. with CNA N revealed: *She wanted to correct her comments from the previous day about the catheter cleaning solution. -She learned that the process recently changed to using three parts vinegar to one part water as a cleaning solution. *She went to the medical storage room, grabbed a covered specimen cup and a new plastic syringe, and filled the cup about three-fourths of the way with vinegar. *She brought those supplies to resident 22's room. *Upon entering the room, it was discovered that the graduated cylinder containing urine was no longer there. She stated that someone else must have emptied the cylinder. *She filled the specimen cup of vinegar with water until it was full. *After squeezing the vinegar-water solution through the catheter tubing and into the collection bag, she explained that the new policy was to swish the solution around in the bag and empty it. They were no longer supposed to leave the cleaning solution in the bag throughout the day or overnight. *After pouring the contents of the catheter bag into the toilet, she wiped the end of the catheter tubing with an alcohol wipe and placed it back into the same potentially soiled garbage bag that it had been stored in before she cleaned it. *She stated she sometimes changed the resident's catheter bag to a new one on the resident's bath days, and it was changed at least monthly. Interview on 6/26/25 at 10:39 a.m. with Minimum	F 880		

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F 880	Continued From page 16 Data Set (MDS) coordinator/infection preventionist C and director of nursing (DON) B revealed: *It was their expectation that residents' catheter bags should not have been directly on the floor to protect them from potential damage and contamination. *If the insertion tube on a catheter was potentially contaminated by touching other objects, it was their expectation that it should have been sanitized with an alcohol wipe before inserting it into the resident's SP catheter tube. *It was their expectation that staff should have cleaned the SP catheter tube after disconnecting the old collection tube. *They had not used the blue cleaning solution for cleaning catheter bags in "a long time." -DON B indicated that she had been working at the facility for one and a half years and they had always used the vinegar solution to clean the catheter bags. *The management team had recently been updating policies and they implemented a new catheter care policy the previous week. -They placed the new policies in the policy binder at the nurse's station on Monday 6/23/25. -They informed staff to review the new policies both verbally and via a sign by the staff's clock-in station. -Once staff reviewed the new policies, they should have signed a piece of paper in the policy binder indicating that they reviewed the policies. *They recently started completing nursing staff competencies in April 2025 by recommendation of their nurse consultant. -Their first nursing staff competency was focused on peri cares (the hygiene and cleaning of the perineal area, which includes the genitals and anal area) due to the high rate of urinary tract	F 880		

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F 880	Continued From page 17 infections amongst residents. *They expected staff to drape the catheter bag and tubing over the towel rack to drain and dry and place a bin beneath to catch any liquids draining from the bag. -They indicated that placing the catheter bag into the black plastic garbage bags for storage when not in use was acceptable for dignity purposes, if that still allowed for adequate draining and drying of the catheter bag. *They expected staff to perform hand hygiene before putting on PPE, and after taking off PPE. *Staff should have been dating and labeling the resident's products like the containers of normal saline, and staff should not be reusing plastic syringes. -DON B confirmed that staff used the containers of normal saline to flush the resident's SP catheter. -DON B discarded the opened and unlabeled containers of normal saline and the open syringe package from resident 22's room at that time. *When they were informed that CNA N had made a three-parts vinegar to one-part water solution rather than the three-parts water to one-part vinegar solution as their new policy stated, they did not have any comments. Interview on 6/26/25 at 4:33 p.m. with MDS coordinator/infection preventionist C revealed: *When asked how they ensured staff were aware of and educated on new policies and procedures, she repeated that they placed the policies in the policy binder, staff were to review it and sign it, and if they had questions, they were to find one of the nurse managers. *They review policies at all-staff meetings. Review of resident 22's electronic medical record	F 880		

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F 880	Continued From page 18 revealed: *There were no physician's orders describing when the resident's urinary catheter collection bag should have been changed, such as changing the leg bag to a bed bag at night. *She had the following physician's orders: -"Flush catheter every night at bedtime and as needed with 60mL [milliliters] saline or sterile water. as needed for catheter [maintenance]." Ordered and started on 3/27/25. -"Flush catheter every night at bedtime and as needed with 60mL saline or sterile water. at bedtime for catheter maintenance." Ordered on 3/27/25. Started on 3/28/25. *Her suprapubic catheter was last changed on 6/10/25. *Her care plan did not include directions for when the urinary catheter collection bags should have been changed, such as changing the bed bag to a leg bag during the day. *Her care plan included the following interventions: -"EBP are used for high contact cares such as transfers, catheter cares, showers." Initiated on 6/10/25. -"Perform catheter cares per facility policy." Initiated on 6/10/25. -"Please use enhanced barrier precautions when caring for me." Initiated on 6/1/25. -"PPE for enhanced barrier precautions is only necessary for performing high-contact care activities such as transfers, peri cares, dressing, and bathing." Initiated on 6/1/25. Review of the provider's 6/19/25 Changing the Urinary Collection System revealed: *"Policy: The urinary collection system shall be changed at the time of a new catheter insertion per provider order or as needed based on clinical	F 880		

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F 880	Continued From page 19 assessment (e.g., visible damage, leakage, or malfunction). Aseptic technique must be maintained throughout the procedure to preserve the integrity of the closed urinary drainage system and minimize infection risk." *"Required Supplies -Clean non-sterile gloves -Alcohol swabs -Barrier (e.g., disposable pad or paper towel) -Graduated cylinder (for measuring urine) -New sterile urinary drainage bag/system" *"Procedure -1. Preparation -- ...b. Perform hand hygiene. --c. Gather all required supplies and place a barrier on the working surface. -2. Apply Gloves and Empty Current System --a. Don [Put on] clean gloves. --b. Place the graduated cylinder below the drainage spout and empty the contents of the current urinary drainage bag. --c. Record the amount and appearance of the urine per facility protocol. -3. Setup of New System --a. Open packaging of the new sterile urinary drainage bag/system, maintaining sterility of the connection port. -4. Disconnection and Cleaning --a. Clamp the catheter (if applicable per manufacturer guidance) to prevent leakage. --b. Disconnect the old urinary drainage bag from the catheter tubing. --c. Discard the old system appropriately. --d. Using an alcohol swab, cleanse the catheter tubing connection site thoroughly. -5. Connecting New Drainage System --a. Remove the protective cap from the new drainage tubing, being careful not to contaminate it.	F 880		

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F 880	Continued From page 20 --b. Immediately connect the sterile tubing to the catheter. --c. Unclamp the catheter to allow drainage to resume. --d. Secure the drainage bag to the bed frame or mobility device, keeping it below the level of the bladder to maintain gravity drainage. Ensure there are no kinks in the tubing. -6. Completion --a. Dispose of gloves and used materials in accordance with facility policy. --b. Perform hand hygiene. -7. Documentation: Document the following in the resident's medical record: --Date and time of the urinary drainage system change --Reason for the change (e.g., routine with catheter replacement, damaged bag)" Review of the provider's 6/19/25 Urinary Bag Cleaning & Storage policy revealed: *"Policy: Urinary bags to be properly cleaned and stored between use." *"Purpose: -1. Maintain asepsis of urinary catheter bags. -2. To prevent introduction of micro-organisms into the urinary drainage system. -3. To prevent urinary tract infections." *"Equipment needed: -1. Alcohol Swabs -2. Vinegar solution (3:1 ratio of water to vinegar) - stored in oxygen room -3. Specimen Cup- Stored in the resident room, changed every 3 months with supplies. -4. Graduated cylinder -5. Clean Gloves -6. Paper Towels -for barrier -7. Clean plastic bag- if transport is necessary" *"Procedure:	F 880		

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F 880	Continued From page 21 -1. Preparation -- ...Prepare a cleaning solution using three parts water to one part vinegar in a clean specimen cup. - ...5. Attach New Bag --Attach a clean urinary drainage bag to the catheter tubing. Label bag with resident initials and room number. -6. Clean Used Bag --Take the used bag to the designated sink. --With the draining port open, flush the bag and tubing thoroughly with the vinegar solution. --Allow excess liquid to drain fully. -7. Hand Hygiene --Remove gloves and perform hand hygiene." *"Storage Instructions for Cleaned Urinary Bags -Hang the clean urinary bag on the towel rack near the sink. -Place a basin (labeled with resident initials/room number & urinary drainage basin) below the urinary bag lined with clean paper towels beneath to absorb residual moisture. -Replace paper towels after each cleaning." Review of the provider's Education Signature Sheet that was located at the front of the policy binder at the nurse's station revealed: *"Education: Updated Policies/Procedures 6/23/25" *Only two people had signed that they had reviewed the updated policies by the end of the survey on 6/26/25. *CNAs L, M, N, and O had not signed the sheet, indicating they had reviewed the policies. 3. Observation on 6/24/25 at 8:49 a.m. in the whirlpool room on the Rising Sun hallway revealed: *The room appeared to have been used as a	F 880		

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F 880	Continued From page 22 storage room. *There was a package of wet wipes that was open to air sitting on the edge of the handwashing sink. It was not labeled with which resident it belonged to. *An opened bottle of barrier cream was sitting on the sink that was not labeled for a specific resident. *There was an unidentified dried brown substance on the faucet handles. *On the shelving unit, there was a bin labeled "[hospice provider's name] Hospice Extra Supplies" that contained: -One bottle of hand sanitizer that had an expiration date of "08/22." There was an unknown dried brown substance smeared on the bottom of the bottle. -One opened bottle of baby powder that was not labeled for a specific resident. Observation on 6/25/25 at 4:00 p.m. in the medical supply room on the Rising Sun hallway revealed the following expired supply items: *Two Dover brand silicone two-way hemostatic catheters with expiration dates of 1/9/25. *Approximately 25 Cure brand male catheters with expiration dates of 3/28/25. *One package of Tri-Flo Suction Cath-N-Glove catheter kit with an expiration date of 2/8/25. 4. Observation on 6/25/25 at 11:44 a.m. of CNA K assisting resident 32 to transfer from her recliner to her wheelchair revealed CNA K: *Confirmed that resident 32 was on EBP for the opened wounds on her bottom. *Explained that the resident would often remove the bandages from her wounds. *Did not put on a protective gown before helping resident 32 stand up from the recliner and pivot to	F 880		

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F 880	Continued From page 23 her wheelchair. *Put on a protective gown before taking the resident to the bathroom. -While in the bathroom, CNA K confirmed the resident had taken her bandage off of the wounds. *Did not offer hand hygiene for resident 32 after she brought her out of the bathroom. Interview on 6/25/25 at 12:00 p.m. with CNA K about the above observation revealed: *She confirmed she was aware of what EBP was and the need for using PPE when assisting those residents with care. *She confirmed she had not put on PPE for transferring resident 32 from her recliner to her wheelchair. -She thought if resident 32 was dry and had not been incontinent, she was not required to put on the protective gown before transferring her. *She indicated that the EBP poster was supposed to be on the back of the resident's door that explained what staff were supposed to do. -She could not find the EBP poster in resident 32's room. -She showed the surveyors the EBP poster in resident room 117. *When she read on the poster that staff were supposed to wear a gown during transfers, she said, "My bad." Review of resident 32's care plan revealed she had the following interventions: *" ...Please use enhanced barrier precautions when caring for me. EBP are used for high contact cares such as transfers, catheter cares, showers." Initiated on 6/8/25. Revised on 6/25/25. *"PPE for enhanced barrier precautions is only necessary for performing high-contact care	F 880		

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F 880	Continued From page 24 activities such as transfers, peri cares, dressing, and bathing." Initiated on 6/10/25. B. Based on policy review and interview, the provider failed to ensure the infection prevention and control program (IPCP) had policies and procedures that described as required the following areas: -A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility -When and to whom possible incidents of communicable disease or infections should be reported. -The duration of isolation precautions. -A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. -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. -A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. Findings include: 1. At the start of the survey on 6/23/25, the survey team was provided with a "DOH Survey Binder" that contained items requested from the entrance conference that was conducted at 8:18 a.m. with administrator A and DON B. *The survey team requested to review the provider's infection prevention and control program policies and procedures. *Three different policies were provided titled "Infection Prevention Precautions Policy,"	F 880		

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F 880	Continued From page 25 "Infection Control," and "Antibiotic Stewardship Program." 2. Review of the provided policies did not address, describe, or explain the following: *A system of infection surveillance. *A system for recording incidents and the corrective actions taken. *When and whom to report communicable diseases to. *Under what circumstances the facility must prohibit employees with communicable diseases from direct contact with residents or their food. *The duration of isolation precautions. *An explanation that isolation precautions should be the least restrictive possible for residents. 3. Interview on 6/26/25 at 2:36 p.m. with administrator A and DON B revealed: *They confirmed they did not have a policy on reportable diseases. -She explained that they used the South Dakota Department of Health's Reportable Diseases list for that. 4. Interview on 6/26/25 at 4:08 p.m. with MDS coordinator/infection preventionist C revealed: *She confirmed they did not have a policy on reportable diseases. *She indicated that their chosen clinical laboratory was required to report diseases on the Reportable Disease list, so they did not report the required reportable diseases, such as syphilis. *When asked about the missing policies above, she was able to describe actions that addressed the requirements, but confirmed they did not have written policies or procedures for those areas. -For example, when asked about how they identified staff with communicable diseases and	F 880		

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	435129	A. BUILDING _____ B. WING _____	C 06/26/2025

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F 880	Continued From page 26	F 880		

prohibited them from direct contact with residents and their food, she indicated that staff would contact their direct supervisor if they did not feel well, and sometimes requested them to come in to be assessed by a nurse or required a doctor's note.

5. Review of the provider's 6/19/25 Infection Prevention Precautions Policy revealed:
*The policy described standard precautions, airborne precautions, contact precautions, and droplet precautions.
*The policy did not describe the duration of the isolation, depending upon the infectious agent or organism involved, and a requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

6. Review of the provider's 6/19/25 Infection Control policy revealed:
*The policy described the following topics:
-Standard precautions.
-Staff training requirements.
-Hand hygiene.
-Glove use.
-Different types of PPE and when to use each type.
-Handling of resident care equipment.
-Cleaning of environmental surfaces.
-Handling and transporting linens.
-Needle safety.
-Aseptic techniques when handling injection equipment.

7. Review of the provider's January 2025 Antibiotic Stewardship Program revealed:
*There was a section for "Reporting and Surveillance" that included
-"a. Report all infections to the Infection

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F 880	Continued From page 27 Preventionist or designee. -b. Monitor infection rates and trends by surveillance. -c. Investigate outbreaks and take the necessary corrective actions."	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/24/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	**1400 THRESHER DR** **DELL RAPIDS, SD 57022**

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K 000	INITIAL COMMENTS A recertification survey was conducted on 6/24/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Dells Nursing and Rehab Center Inc was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 6/24/25. Please mark an F in the completion date column for the K241 deficiency identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 241 SS=C	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced by: Based on observation and document review, the provider failed to maintain at least two conforming exits from each floor level of the building. The	K 241		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Calyn Togel	Administrator	7/11/25

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
	435129	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/24/2025**

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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
K 241	Continued From page 1 basement had only one conforming exit. Findings include: 1. Observation on 6/24/25 at 11:38 a.m. revealed the basement had only one conforming exit directly to the exterior of the building. The second egress routes were through hazardous areas of the boiler and laundry rooms to an area equipped with a fixed ladder. Review of previous survey data confirmed that the condition existed since the original construction. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000. This deficiency would not affect any of the residents and minimal staff within the facility.	K 241		
K 712 SS=D	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 and interview the provider failed to ensure staff were familiar with the provider's fire drill procedures (Evacuating	K 712	Unable to correct past noncompliance. All staff will be educated on fire drill procedures by 8/10/25. Fire drills will be increased to weekly for 4 weeks and bimonthly for 2 months to follow. Maintenance director or designee will audit fire drills weekly for 4 weeks and monthly for 2 months or longer as determined by audit results. Maintenance director or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	8/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/24/2025**

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K 712	Continued From page 2 residents and closing resident room corridor doors during a fire event). Findings include: 1. Observation on 6/24/25 at 11:20 a.m. of a drill for a simulated fire in resident room 162 revealed a CNA responded to the nurse call light in the simulated fire location. That CNA then left the affected room holding the simulated fire without the resident. After the CNA walked a few feet down the corridor the maintenance supervisor reminded her to remove the resident. At that point the CNA returned to the room to remove the resident. Following the removal of the resident no staff member responding to the fire drill closed the affected rooms' corridor door. Additionally, the door to the adjacent room (resident room 160) was not closed during the drill. Corridor doors to resident rooms are required to be closed to limit the effects of smoke during a fire event. Interview with the maintenance supervisor directly following the fire drill confirmed those findings. He acknowledged that the door to the affected room and the room adjacent to it, were not closed in accordance with the facility's fire response policy. The deficiency had the potential to affect 100% of the building's occupants.	K 712		

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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 6/24/25. Dells Nursing and Rehab Center Inc was found in compliance.	E 000		

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

TITLE
Administrator

(X6) DATE
7/14/2025

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

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	10613	A. BUILDING: _____ B. WING _____	06/26/2025

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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 6/24/25 through 6/26/25. Dells Nursing and Rehab Center Inc was found in compliance.	S 000		
S 000	Compliance/noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 6/24/25 through 6/26/25. Dells Nursing and Rehab Center Inc was found not in compliance with the following requirement: S206.	S 000		
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	S 206	Unable to correct noncompliance on initial staff training. All necessary staff will be trained on advance directives by 8/10/25. Personnel training process for new employees will be reviewed and revised as needed and all staff responsible for new employee training will be re-educated for correct compliance by 8/10/25. Business Office manager or designee will audit area identified to ensure compliance for all new hires weekly for 4 weeks and monthly for 2 months. Business office manager or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advised to discontinue monitoring.	8/10/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Calyn Togel

TITLE: Administrator

(X6) DATE: 7/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 206	Continued From page 1 hydration needs of residents; (11) Abuse and neglect; and (12) Advanced directives. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section. The facility shall provide additional personnel education based on the facility's identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee personnel records review, training transcript review, and interview, the provider failed to ensure mandatory training was completed on all the required training subjects for four of five sampled employees (D, Q, R, and S). Findings include: 1.Review of employee personnel records revealed: *Employee D was hired on 2/4/25. *Employee Q was hired on 5/16/24. *Employee R was hired on 4/28/25. *Employee S was hired on 1/31/25. 2. Review of employee training records and online training transcripts revealed there was no documentation that employees D, Q, R, and S had received training on advance directives. 3. Interview on 6/26/25 at 10:47 a.m. with administrator A regarding staff education revealed: *She knew staff education had to be completed within 30 days of hire and annually. *She was unaware advance directives was a	S 206		

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S 206	Continued From page 2 required subject for employee training. *She confirmed advance directives was not provided to staff during initial orientation and annual training according to the requirements. *The provider did not have a policy for staff orientation and annual education.	S 206		