STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 10/6/26. Eastern Star Home of South Dakota, Inc was found in compliance.	E0000		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deborah Bowar	Administrator	11/06/2026

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10670	A. BUILDING: _____ B. WING _____	10/08/2026

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N ST HOME OF SOUTH DAKOT , INC	126 W 12TH V DFIELD, SD 57469

4) ID PREFIX TA	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TA	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 10/6/26 through 10/8/26. Eastern Star Home of South Dakota, Inc. was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah Bowar
TITLE: Administrator
(X6) DATE: 11/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 10/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 10/6/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Eastern Star Home of South Dakota, Inc was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K324, K353, and K914 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000	K 0324 Cooking Facilities Since it is the responsibility of the facility to inspect the kitchen hood exhaust ductwork for cleanliness bi-annually, the following actions have been completed to ensure compliance. 1. On 10/06/2026, the Administrator met with the Maintenance Director concerning the above non-compliance. 2. On 10/08/2026, the qualified contracted vendor, Hood and Duct Cleaning, completed the required inspection and cleaning of our hood exhaust ductwork. 3. The qualified contracted vendor, Hood and Duct Cleaning, will complete inspection services/ cleaning every six months with the next scheduled date prior to April 8, 2027. 4. Kitchen Hood Inspection and Cleaning policy was revised, and implementation of the Kitchen Hood Monthly Inspection form was completed on 10/28/2026. 5. The Maintenance Director will complete monthly kitchen hood visual inspections ensuring that there is no heavy build-up of grease or oily sludge on filters, fans, or outside of hood, exhaust is functional, inspection/ maintenance tags are attached and current, and belts are in good condition. The Maintenance Director will report to the qualified contracted vendor immediately if any required cleaning or maintenance is necessary due to any concerns with the completed monthly kitchen hood visual inspections. 6. The Administrator will be responsible for completing 1 monthly spot checks to ensure that the Maintenance Director completes monthly visual kitchen hood inspections with proper follow-up if required and report these findings to the QAPI Committee monthly for 3 months then quarterly until the QAPI Committee advises otherwise.	11/06/2026
K0324 SS = B Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by:	K0324		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deborah Bowar	Administrator	11/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 10/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469

(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
K0324 SS = B Bldg. 01	Continued from page 1 Based on record review and interview, the provider failed to inspect the kitchen hood exhaust ductwork for cleanliness bi-annually as required. Findings include: 1. Record review on 10/6/26 at 9:15 a.m. revealed there was no documentation of inspection of the kitchen range hood exhaust duct for cleanliness every six months for 2024 and 2025. Interview with the maintenance director at the time of the record review confirmed that finding. The duct must be inspected for grease buildup from the grease filters above the range up to the rooftop ventilator in the ductwork and cleaned if necessary. The deficiency affected one of numerous requirements for the kitchen range and related equipment.	K0324	K 0353 Sprinkler System Maintenance and Testing It is the responsibility of the facility to ensure that the automatic sprinkler and standpip systems are inspected, tested, and maintained in accordance with NFPA 25, Standards of Inspection, Testing, and Maintaining of Water-Based Fire Protection Systems. It is also the responsibility of the facilty to ensure records of the system design, maintenace, inspection and testing are maintained in a secure location and readily available. To ensure compliance the following actions have been completed. 1. On 10/06/2026, the Maintenance Director informed the Administrator that the copy of the NFPA 25 was located on the shelf in the maintenance room. This copy was then placed by the red sprinkler control box in the maintenance room. 2. On 10/13/2026, the Maintenance Director completed the quarterly standard inspection/testing of the sprinkler system.	
K0353 SS = B Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on record review, observation, and interview, the provider failed to maintain the automatic fire	K0353	3. On 10/28/2026, the Administrator met with the Maintenance Director and reviewed the Sprinkler System Policy and the Sprinkler/Tamper Test Charting documentation. The Sprinkler System Policy was revised to include the location where the copy of the NFPA 25 will be stored. Note that the copy of the NFPA 25 was in the facility at the time of the survey. 4. The Administrator will be responsible for completing weekly spot checks to ensure compliance with the location of the facility's copy of the NFPA 25 copy (placed by the red sprinkler control box in the maintenance room) and report these findings to the QAPI Committee monthly for 3 months then quarterly until the QAPI Committee advises otherwise. 5. The Administrator will be responsible for completing quarterly spot checks to ensure compliance with the completion of proper standard inspection/testing of the sprinkler system by the Maintenance Director and report these findings to the QAPI Committee quarterly x 12 months.	11/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - BUILDING 0...** B. WING	(X3) DATE SURVEY COMPLETED **10/06/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
K0353 SS = B Bldg. 01	Continued from page 2 sprinkler system as required (quarterly flow testing, NFPA 25 reference material). Findings include: 1. Record review on 10/6/26 at 9:30 a.m. revealed there was no documentation of quarterly flow testing for September 2025, following the 3/31/26 and 6/15/26 quarterly flow testing dates. 2. Observation on 10/6/26 at 9:35 a.m. revealed there was no copy of NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems on the premises. 3. Interview with the maintenance director at the time of the observation confirmed those findings. The deficiency affected two of numerous requirements for automatic fire sprinkler system maintenance.	K0353	K 0914 Electrical Systems - Maintenance and Testing It is the responsibility of the facility to ensure that records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. The following was completed to ensure compliance. 1.On 10/28/2026, the Administrator met with the Maintenance Director and reviewed the Emergency Generator Testing policy and the Emergency Generator Monthly Test Log. No changes made to the Emergency Generator Testing policy. Emergency Generator Monthly Test Log has a line entitled "Volts During Test" with no record of entry. 2. On 10/28/2026, the Maintenance Director completed the weekly Emergency Generator Test Log and completed the "Volts During Test" (battery conductivity reading) which revealed the result of 12.6 volts which was then documented under the "Volts During Test" on the Emergency Generator Test Log. 3. The Administraor will be responsible for completing 1 monthly spot check to ensure that the required monthly battery conductivity reading ("Volts During Test" line section) and properely documents such findings and report thse findings to the QAPI Committee monthly for 3 months then quarterly until the QAPI Committee advises otehrwise.	11/06/2026
K0914 SS = B Bldg. 01	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is NOT MET as evidenced by:	K0914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - BUILDING 0...** B. WING	(X3) DATE SURVEY COMPLETED **10/06/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
K0914 SS = B Bldg. 01	Continued from page 3 Based on record review and interview, the provider failed to test and document the generator battery conductivity monthly with the monthly load runs. Findings include: 1. Record review on 10/6/26 at 9:00 a.m. revealed the generator log sheets did not have a line item for the monthly generator battery conductivity reading documentation. The battery must be tested monthly for conductivity and subsequently documented. Interview with the maintenance director at the time of the observation confirmed that finding.	K0914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS An extended recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 10/6/26 through 10/8/26. Eastern Star Home of South Dakota, Inc was found not in compliance with the following requirements: F636, F637, F638, F686, F761, F880, and F909.	F0000		
F0686 SS = SQC-H	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to implement pressure ulcer (skin and/or underlying tissue injury from prolonged pressure) prevention and treatment interventions for three of four sampled residents (11, 13, and 15) who were identified as having risk for developing pressure ulcers and developed facility-acquired pressure ulcers. Findings include: 1. Observation on 10/6/26 at 8:45 a.m. in the day room revealed that certified nursing assistants	F0686	F 0686 Treatment/Svcs to Prevent/Heal Pressure Ulcer It is the responsibility of the facility to ensure a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. The following has been implemented to ensure compliance: 1. On 10/30/2026, the Administrator met with the QAPI team (Medical Director, Dietitian, Board Member, Restorative CNA, Director of Nursing, Activity Director, Maintenance Director, MDS RN/ Coordinator/IP/Wound RN, and Assisted Living Nurse Manager . Dietary Aide, CNA, and Charge Nurse Job Descriptions were reviewed with no revisions made. Implementation of a separate Wound RN Job Description was implemented on 10/30/26. 2. QAPI team assisted with the writing and implementation of the following policies on 10/30/2026: Documentation of Wound Treatments, Use of Support Services, Skin Assessments, Pressure Injury Prevention and Management, Pressure Injury Risk Assessment, Turning and Repositioning, and Pressure Injury Prevention Guidelines.	

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE	Addendum Date
Deborah Bowar	Administrator	11/06/2026	11/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0686 SS = SQC-H	Continued from page 1 (CNAs) I and N transferred resident 13 from his wheelchair into a recliner using a full-body lift (a mechanical lift and sling used to lift a person's full body). The staff did not move his pressure-reducing cushion from his wheelchair to the recliner. Resident 13 was positioned in a reclined position on his back. Observation on 10/6/26 at 9:50 a.m. in the day room revealed that resident 13 remained in the same spot, reclined and positioned on his back in the recliner. Observation on 10/6/26 at 11:04 a.m. in the day room revealed that resident 13 remained in the same position. It appeared that he had slid down in the recliner, as his feet were dangling more off the footrest. Observation on 10/6/26 at 11:09 a.m. in the day room revealed that CNAs N and O used the full-body lift to transfer resident 13 from the recliner to his wheelchair. The pressure-reducing cushion was in his wheelchair. Observation on 10/6/26 at 2:25 p.m. of resident 13 in his room revealed that he was lying in bed on a pressure-relieving air mattress. He was positioned flat on his back. The air mattress was turned on. There were no positioning devices, like a pillow or a wedge, placed underneath him to relieve pressure. Observation on 10/6/26 at 3:59 p.m. revealed that resident 13 remained in the same position in bed. Observation on 10/6/26 at 5:06 p.m. revealed that resident 13 remained in the same position in bed. Review of resident 13's medical record revealed he had admitted to the facility on 5/9/23. The Brief Interview for Mental Status assessment was not completed with the quarterly Minimum Data Set (MDS; a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) assessment with an assessment reference date (ARD) of 9/28/26 as the resident was "rarely/never understood." He was assessed as "at risk" for developing pressure ulcers and had one unhealed stage III pressure ulcer. Treatments included a pressure-reducing device for his chair and bed, nutrition and hydration interventions to manage his skin problems, pressure ulcer cares, and applying ointments/medications. The "turning/repositioning program" section was not checked, indicating that such a program was not implemented.	F0686	F 0686 Treatment/Svcs to Prevent/Heal Pressure Ulcer Cont. 3.QAPI team reviewed the Notification of Changes and Skin Audits by Nursing policies with no revisions made. 4.QAPI team reviewed and updated the Turn and Reposition Log on 10/30/2026 with this updated form going into effect on 11/1/2026 replacing the current form that had been completed). The Turn and Reposition Log must be completed and prior to each shift leaving, this log must be given to the Charge Nurse to review and initial. 5.Administrator did report to the QAPI team that our Gentell Wound Specialist was contacted on 10/30/2026 concerning the current process of notification, communication, and visitation from her/Gentell. This Administrator did set up a weekly phone call to discuss and review any wound concerns including pressure injuries that are currently being monitored in this facility. This weekly wound call will begin on 11/06/2026 and will include the Gentell Wound Specialist, the Wound RN, and Administrator. 6. Discussion was had with the QAPI team on 10/30/2026 concerning the implementation of a standing order for the treatment of pressure injuries while the facility waits for physician specific orders. Standing order was decided upon by the facility's Medical Director and went into effect on 11/04/2026. 7. Implementation of a separate Wound RN job description was completed and signed by the acting MDS RN/Coordinator/IP/Wound RN on 11/02/2026. It is the goal of this facility to hire a part-time Wound RN to take over these responsibilities. 8. On 11/2/2026 and 11/3/2026, the Administrator and Director of Nursing held a mandatory staff meeting to re-educate the following: Job Duties Documentation of Wound Treatments Use of Support Surfaces Skin Assessments Skin Audits by Nursing Pressure Injury Prevention and Management Pressure Injury Risk Assessment	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0686 SS = SQC-H	Continued from page 2 His diagnoses included normal pressure hydrocephalus (a brain condition characterized by the accumulation of cerebrospinal fluid in the brain, leading to symptoms like cognitive decline, gait disturbances, and urinary incontinence), peripheral neuropathy (damage to nerves outside the brain and spinal cord causing numbness), spondylosis of lumbar spine (wear-and-tear of lower back bones and discs), uncontrolled Type 2 Diabetes (a condition involving disruptions in how the body regulates blood sugar), obesity (overweight), psoriasis (a skin condition causing red, scaly, itchy patches), and generalized weakness. Resident 13's current "NURSE TECH INFORMATION KARDEX" sheet in the care plan (personalized plan that addresses a resident's care needs, goals, and interventions) indicated that he was dependent on the staff for bed mobility, transfers, and he utilized the full-body lift for transfers. He was incontinent (involuntary urine or bowel leakage) of both bladder and bowel. The staff were to perform incontinence checks and change his incontinence briefs every two to three hours and PRN. The "Special Considerations" section included a 6/19/25 handwritten note for "Air pressure pad – easy chair." For skin protection, the staff were to use a barrier cream PRN, reposition him every two to three hours, use a chair cushion, and have a specialty mattress on his bed. His 9/29/26 reviewed care plan indicated that he was dependent on the staff for toileting, personal hygiene, rolling left and right, and transferring to and from surfaces. Resident 13's care plan indicated that he was at risk for impaired skin integrity related to incontinence, diabetes, and psoriasis. On 9/5/26, a problem area was added that read, "Stage 3 [pressure ulcer; open wound with full-thickness skin loss. Fatty tissue may be visible] to [the right] buttock." That problem area was crossed off with a handwritten note of "Healed [on] 10/2/26" next to it. The "Approach" section included interventions like, "Air pressure pad in easy chair 6/19/25," "Weekly skin checks and prn," "Purple cushion in [wheelchair]," "Encourage to lay down daily 6/9/25," "Turn & [and] [reposition] [every two to three hours] & PRN 6/9/25." There were many handwritten interventions that were added and had since been crossed off, and it was difficult to determine which interventions were active, which ones were discontinued, or if there were any active interventions. Resident 13's 8/28/26 Braden Assessment Score (a	F0686	F 0686 Treatment/Svcs to Prevent/Heal Pressure Ulcer Cont. Turning and Repositioning (Includes Updated Form) Pressure Injury Prevention Guidelines Notification of Changes 9. Staff signed a document acknowledging the facility's policies. Continued education will be completed quarterly with all Nursing staff concerning the prevention of pressure injuries. Next scheduled meeting for all Nursing staff will be in February 2027. All staff attended the annual education extravaganza in August of 2026 which reviewed "Resident's With Unqiue Needs Wound Prevention and Treatments". An additional competency for pressure ulcer/injury for CNAs and Nurses will be completed by 11/6/2026. 10. The Director of Nursing will be responsible for completing twice weekly spot checks to ensure the completion of the Turn and Reposition Log. The Director of Nursing will report these findings to the QAPI Committee monthly for 3 months then quarterly until the QAPI Committee advises otherwise. 11. The Director of Nursing will be responsible for completing twice weekly spot checks to ensure the completion of the Weekly Wound Assessment and Summary Form including any new wound documentation. The Director Nursing will report these findings to the QAPI Committee monthly for three months then quarterly until the QAPI Committee advises otherwise. 12. The Director of Nursing will be responsible for completing twice weekly spot checks to ensure the completion of daily wound documentation by the Charge Nurse per shift. The Director of Nursing will report these findings to the QAPI Committee monthly for three months then quarterly until the QAPI Committee advises otherwise.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0686 SS = SQC-H	Continued from page 3 tool used to assess the risk of developing pressure ulcers) was 11, indicating that he was at high risk of developing pressure ulcers. Resident 13's 8/26/26 "Resident Bath/Skin Assessment Tool" revealed that there were no open areas on his buttocks at that time. Resident 13's handwritten "WEEKLY WOUND ASSESSMENT AND SUMMARY," initiated by registered nurse (RN) E, indicated that resident 13 developed a stage III pressure ulcer on his right buttock that was identified on 9/5/26 (which was a Saturday). It measured 5 cm (centimeters) in length by 5 cm in width by 0.2 cm in depth. The "POC" (plan of care) included covering the wound with a honey hydrogel sheet (moist, honey-based dressing that helps wounds heal). The wound was assessed by MDS nurse/infection preventionist (IP)/wound nurse C on 9/12/26 and measured 6 cm in length by 4 cm in width by 0.2 cm in depth. The POC remained the same. The wound was assessed by RN E on 9/17/26 and measured 5.9 cm in length by 4 cm in width by 0.1 cm in depth. The POC remained the same. The wound was assessed by MDS nurse/IP/wound nurse C on 9/24/26 and measured 2.3 cm in length by 6.2 cm in width; there were no depth measurements. The plan on 9/24/26 was to "Continue POC," but there were no further assessments of that wound provided to the survey team. Resident 13's "Fax Communication to Physician" indicated that resident 13's physician was notified of the pressure ulcer on 9/7/26 (a Monday) and wound care orders were received on 9/8/26. The wound treatment orders included placing a honey hydrogel sheet over the wound, which was to be changed daily and as needed. Resident 13's handwritten "DAILY WOUND DOCUMENTATION" indicated that there was missing documentation from 9/10/26, 9/11/26, 9/12/26, 9/17/26, 9/18/26, 9/19/26, 9/22/26, 9/26/26,and 9/29/26 regarding resident 13's pressure ulcer. On 9/23/26, the handwritten note read, "Wound bed dark pink – no open areas. Surrounding [skin is] dry/flaky. No drainage. No c/o [complaints of] pain." On 9/24/26, the handwritten note read, "Dressing [changed] – no open areas, dark pink, [treatment] still applied [and] covered." On 9/25/26, the handwritten note read, "Dressing [changed]. Area is pink in color. No open areas seen." On 9/27/26, the handwritten note read, "Wound bed darker pink, surrounding skin lighter pink. Some flaking skin. No drainage. Treatment per MAR [medication	F0686	F 0686 Treatments/Svcs to Prevent/Heal Pressure Ulcer Addendum 11/10/2026 13. The Director of Nursing will visually observe the Wound Nurse who completes the Weekly Wound Summary, the Charge Nurses who completes the twice daily wound documentation, and the CNAs who complete the Turn and Reposition to ensure that what is being documented is in compliance. This will be done for one of the the twice weekly spot checks per area. 14. The following interventions are in place to identify residents who are at risk of developing pressure injuries: * Charge Nurse completion of the Braden Scale at least monthly *If the Braden Scale reveals a Moderate, Severe, or High Risk then the Charge Nurse will complete a "Stop and Watch" form and foward this to the Wound RN for review to ensure proper interventions are in place to prevent a wound injury. *Monthly the Administrator, Wound RN, Director of Nursing, and Dietician will review any residents who have received a Braden Scale score of Moderate, Severe, or High Risk and review interventions in place. The Wound RN will present this documentation to the group as well as present any resident who is on the turn and reposition list and any resident who is currently being monitored for an open pressure injury. *CNAs continue to notify the Charge Nurse of any open areas or areas of concern following any cares and/or bathing	11/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0686 SS = SQC-H	Continued from page 4 administration record].” On 9/30/26, the handwritten note read, “Brownish wound bed [with] pink skin around area.” There was no pressure ulcer documentation for resident 13 provided to the survey team after 9/30/26. Resident 13’s “Nurse’s Notes” indicated that a 9/7/26 note read, “…Resident has a new stage 3 pressure injury to the right buttock; fax sent to PCP [primary care provider] requesting treatment orders.” Another note from 9/8/26 read, “Resident has an open area noted to his coccyx [tailbone]. Orders given for Honey hydrogel & dressing daily & PRN [as needed].” Resident 13’s physician’s orders indicated that there was a 9/8/26 order for “Buttock Dressing” scheduled PRN. The instructions were not fully printed on the page, with partial instructions able to be read, “hydrogel sheet & cover w.” Interview on 10/7/26 at 10:46 a.m. with licensed practical nurse (LPN) F revealed that she thought resident 13’s wound on his buttock “just got healed last week” and that his wound treatment order was changed to PRN (as needed). Observation on 10/7/26 at 10:52 a.m. in a common area revealed that resident 13 was seated upright in his wheelchair. He was sitting on a cushion. Interview on 10/7/26 at 11:10 a.m. with CNA P revealed that resident care plans were in the care plan binder in the medical chart room. The CNAs also had binders to chart different resident care activities, like turning and repositioning. They were supposed to mark down whenever they turned or repositioned a resident in those binders. Observation on 10/7/26 at 11:38 a.m. in a common area revealed that resident 13 was seated upright on the cushion in his wheelchair. Observation on 10/7/26 at 12:48 p.m. in a common area revealed that resident 13 was seated upright on the cushion in his wheelchair. Interview on 10/7/26 at 12:54 p.m. with CNA P revealed that resident 13 was unable to turn or reposition himself. Staff had to manually assist him with turning, repositioning, and offloading pressure. Observation on 10/7/26 at 1:04 p.m. in resident 13’s room revealed that resident 13 was lying on his back in his bed. The air mattress overlay was turned on.	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0686 SS = SQC-H	Continued from page 5 Observation on 10/7/26 at 2:08 p.m. in resident 13's room revealed that resident 13 was lying slightly on his right side (the side that his pressure ulcer was on) as there were two pillows propped under the left side of his back and buttock. Observation on 10/7/26 at 3:39 p.m. in resident 13's room revealed that resident 13 was on his back in bed. It appeared that he had slid off the positioning pillows. Observation on 10/8/26 at 11:42 a.m. revealed that resident 13 was sitting in his wheelchair. The wheelchair was reclined back. He was sitting on a pressure-reducing cushion. Review of resident 13's Turning and Repositioning Log for September and October 2026 revealed that the letters "B," "L," "R," "C," and "WC" were used to indicate the resident's position throughout the day. There was no legend to indicate what each letter meant. There was missing documentation from about 3:00 p.m. to 8:00 p.m. from 9/1/26 to 9/7/26. He was documented as being in the "B" position from about 8:00 p.m. to about 6:00 a.m. on 9/1/26, 9/4/26, 9/5/26, 9/9/26, 9/10/26, 9/12/26, 9/13/26, 9/14/26, 9/15/26, 9/18/26, 9/19/26, 9/20/26, 9/21/26, 9/23/26, 9/24/26, 9/25/26, 9/26/26, 9/27/26, 9/28/26, 9/30/26, 10/1/26, 10/2/26, 10/3/26, 10/4/26, 10/5/26, and 10/6/26. There was no documentation that resident 13 was repositioned between about 3:00 p.m. to about 7:00 p.m. on 9/1/26, 9/2/26, 9/3/26, 9/4/26, 9/5/26, 9/6/26, and 9/7/26, and between about 2:00 p.m. to about midnight on 9/15/26 and 9/16/26. Interview and review of the CNAs turning and repositioning log on 10/8/26 at 11:44 a.m. with CNA I revealed that they tried to lay resident 13 down in his bed after breakfast and after lunch to reduce the pressure on his bottom. They used to help him to sit in the recliner after meals, but they noticed that the pressure ulcer on his bottom would worsen if he was sitting in the recliner. They used to have an air mattress overlay made for the recliner, but she did not know where that went. She did not know if his care plan included instructions to move the pressure-reducing cushion from his wheelchair to the recliner if the resident was sitting in the recliner. She confirmed that they "probably should have" moved the cushion from his wheelchair to the recliner. When resident 13 was lying in bed, the CNAs were supposed to use pillows to prop him up and turn	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0686 SS = SQC-H	Continued from page 6 him every two hours. She confirmed that resident 13 was unable to reposition himself. She indicated that he did have an air mattress to help redistribute the pressure but confirmed that the air mattress did not replace the need for turning and repositioning. She thought that his current pressure ulcer was on his right buttock but was not positive of its location. The pressure ulcer was a chronic issue. She explained that the aides were supposed to document in a binder whenever they turned or repositioned a resident, and what position they helped the resident get into. When looking at the turning/repositioning log sheet, she indicated that the “B” meant “bed,” but explained that some people will put “B” to indicate the resident was on their “back.” “C” meant “chair,” and “WC” meant “wheelchair.” 2. Interview on 10/6/26 at 4:24 p.m. with resident 11 revealed that he acknowledged he had skin wounds on his bottom for the past couple of months. He was able to shift his weight in his wheelchair and while in bed. He sometimes needed help from the staff to turn and reposition in bed. He confirmed he was sitting on a pressure-reducing cushion. The staff tried to educate him before about pressure ulcer risks and when to reposition. He usually preferred to stay in his wheelchair for most of the day. He was aware that increased his risk of developing a pressure ulcer and understood the importance of offloading pressure by switching from his wheelchair to the recliner or to his bed throughout the day. Interview on 10/7/26 at 10:47 AM with LPN F revealed that resident 11’s wound treatment was scheduled in the morning and at bedtime. She explained that he liked to stay in his wheelchair for most of the day. Interview on 10/7/26 at 12:54 p.m. with CNA P revealed that resident 11 was able to reposition himself in bed. Review of resident 11’s medical record revealed a 1/13/26 Braden Assessment Score of 17, which indicated that he was at mild risk of developing pressure ulcers. No recent Braden assessment scores were provided to the survey team after that date. Resident 11’s quarterly MDS assessment with an ARD of 7/13/26 revealed that he was at risk for developing pressure ulcers. He had an unhealed stage II (2; open wound or blister with	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0686 SS = SQC-H	Continued from page 7 partial-thickness skin loss) pressure ulcer and an unhealed stage III pressure ulcer. Treatments included a pressure-reducing device for his chair and bed, nutrition and hydration interventions to manage his skin problems, and pressure ulcer cares to be provided by the staff. His 7/14/26 last reviewed care plan indicated that two staff members were to assist him with bed mobility and transfers, he used a full body lift, needed the assistance of one staff member for peri (perineum, the skin between the genitals and anus) cares, he used a urinary catheter (flexible tubing placed in the bladder to drain urine), he used a chair cushion and specialty mattress, the staff were to reposition him every two to three hours, and that the staff were to perform incontinence checks and help him change his incontinence brief during their "nightly rounds prn." His care plan included that he had a pressure area to his right buttock that was added on 4/11/26, and to his left buttock that was added on 6/25/26. Interventions included "weekly skin checks and prn," "Peri care [twice daily] and prn," "Frequent position changes," and "Lay down [every day] and offload." Resident 11's "WEEKLY WOUND ASSESSMENT AND SUMMARY" indicated that he had two pressure ulcers: a stage II pressure ulcer on his right buttock that was identified on 4/11/26, and a stage III pressure ulcer on his left buttock that was identified on 6/25/26. The pressure ulcer on his right buttock that was identified on 4/11/26 started out as a stage I (1; unopened non-blanchable skin redness, meaning the area remains red when pressed, caused by pressure) pressure ulcer. It was first assessed on 4/11/26. It was then assessed on 4/24/26. That pressure ulcer area measured 0.3 cm in length by 0.2 cm in width by 0.1 cm in depth. That pressure ulcer was assessed on 4/30/26 with two areas identified: the "top" area was measured as 1.6 cm in length by 0.6 cm in width, and the "bottom" area was measured as 1 cm in length by 0.4 cm in width. That pressure ulcer on his right buttock was assessed on 5/13/26, with only one measurement provided of 1.5 cm in length by 1 cm in width by (the depth was marked as "scab" rather than a measurement). The pressure ulcer was assessed weekly on 5/21/26, 5/29/26, 6/4/26, and 6/11/26.	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0686 SS = SQC-H	Continued from page 8 On 6/20/26, his right buttock pressure ulcer was assessed and categorized as a stage II pressure ulcer. It measured 1.5 cm in length by 0.4 cm in width by 0.1 cm in depth. That pressure ulcer was assessed on 6/25/26 and measured 3.1 cm in length by 2.5 cm in width and “superficial” depth. On 7/3/26, there were two measurements listed: the “upper line” measured 2.5 cm in length by “0.5.0 cm” in width by 0.1 cm in depth, and the “lower spot” measured 1.1 cm in length by 0.3 cm in width by 0.1 cm in depth. New treatment orders were obtained of “hydrogel + [plus] collagen pellets, dressing to cover.” That wound was next assessed on 7/11/26 and measured 0.8 cm in length by 1.1 cm in width by 0.1 cm in depth. His right buttock pressure ulcer was next assessed on 7/30/26 and measured 4 cm in length by 3cm in width. The area was described as “bumpy-white & pink tissue, surrounding tissue pink/reddish…” The survey team was not provided with documentation to support that MDS nurse/IP/wound nurse C or the resident’s physician was notified of the worsening pressure ulcer between 7/11/26 and 7/30/26. His right buttock pressure ulcer was assessed weekly on 8/7/26, 8/14/26, 8/20/26, 8/27/26, and 9/3/26. The pressure ulcer measured 5 cm in length by 2.3 cm in width on 9/3/26. On 9/12/26, the pressure ulcer was assessed and measured 5 cm in length by 4.5 cm in width. New orders were requested and obtained from his physician on 9/11/26 to address the worsening wounds. His right buttock pressure ulcer was assessed on 9/17/26 and measured 4.5 cm in length by 4 cm in width and the “widest open area” was 0.9 cm. The pressure ulcer was assessed on 10/2/26 and measured 4 cm in length by 3.5 cm in width. Resident 11’s “DAILY WOUND DOCUMENTATION” for the pressure ulcer on his right buttock indicated there was missing daily documentation from 4/16/26 to 4/21/26, 4/23/26 to 4/25/26, 4/27/26, 5/1/26 to 5/7/26, 5/9/26 to 5/12/26, 5/14/26 to 5/17/26, 5/19/26 to 5/21/26, 5/23/26 to 6/8/26, 6/10/26 to 6/18/26, 6/20/26 to 6/21/26, 6/23/26 to 6/25/26, 6/27/26 to 7/1/26, 7/3/26, 7/5/26, 7/11/26 to 7/13/26, 7/15/26, 7/20/26 to 7/21/26, 7/23/26 to 7/27/26, 7/30/26 to 8/2/26, 8/5/26 to 8/6/26, 8/8/26 to 8/12/26, 8/14/26 to 8/16/26, 8/18/26 to 8/19/26, 8/21/26 to 8/22/26, 8/24/26 to 8/30/26, 9/1/26 to 9/3/26, 9/5/26 to 9/11/26, 9/13/26 to 9/16/26, 9/18/26 to 9/25/26, and 9/27/26 to 10/5/26.	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0686 SS = SQC-H	Continued from page 9 The treatments to resident 11's pressure ulcer on his right buttock included applying his PRN Calmoseptine and/or Calazinc (both skin barrier ointments) and encouraging the resident to offload pressure from 4/11/26 to 7/1/26. His 7/2/26 physician's orders were to apply a collagen powder and a hydrogel sheet and cover with a dressing to each area [by then, resident 11 had another pressure ulcer to his left buttock, see below] every day and PRN. On 8/13/26, the physician discontinued the previous treatment orders and instructed the staff to apply Aquaphor ointment to the areas twice a day. On 9/11/26, the physician updated the treatment orders to add collagen pellets to the Aquaphor and apply to the areas twice daily and as needed. Resident 11's "WEEKLY WOUND ASSESSMENT AND SUMMARY" documentation for the pressure ulcer on his left buttock indicated it was identified on 6/25/26 as a stage III pressure ulcer and measured 2 cm in length by 2 cm in width. The physician notification documentation indicated that his physician was notified of the pressure ulcer on 7/1/26 and provided wound treatment orders on 7/2/26. On 7/3/26, the handwritten wound note for resident 11's left buttock pressure ulcer read, "[Left] wound bed is open; dark pink, white edges around wound bed/very superficial, dark pink surrounding [tissue.] No complaints of pain, no drainage." The pressure ulcer measured 1.5 cm in length by 0.8 cm in width by 0.1 cm in depth. His left buttock pressure ulcer was assessed on 7/11/26 and measured 1.1 cm in length by 1 cm in width by 0.1 cm in depth. The treatment orders remained the same. The pressure ulcer was assessed on 7/30/26 and measured 2 cm in length by 2.5 cm in width. The survey team was not provided with documentation to show that resident 11's physician was notified of the worsening pressure ulcer on his left buttock. His left buttock pressure ulcer was assessed on 8/7/26, 8/14/26 (new orders were obtained), 8/20/26 (new orders were obtained), 8/27/26, and 9/3/26. It measured 2 cm in length by 2 cm in width on 9/3/26. His left buttock pressure ulcer was assessed on 9/12/26 and measured 4 cm in length by 3 cm in width. The "follow-up" section indicated that the plan of care was continued. The survey team was not provided with documentation that the resident's physician was notified that the wound had increased in size.	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0686 SS = SQC-H	Continued from page 10 On 9/17/26, the left buttock pressure ulcer was assessed and measured 6 cm in length by 3 cm in width. The plan of care was continued, and no open areas were noted. On 10/2/26, the left buttock pressure ulcer was assessed and measured 1 cm in length by 1.6 cm in width. It was noted as, “open.” The plan of care was continued. Resident 11’s “DAILY WOUND DOCUMENTATION” for the pressure ulcer on his left buttock indicated there was missing daily documentation from 6/27/26 to 6/28/26, 7/1/26, 7/3/26, 7/5/26, 7/12/26 to 7/13/26, 7/15/26, 7/20/26 to 7/21/26, 7/23/26 to 7/27/26, 7/30/26 to 8/2/26, 8/5/26 to 8/6/26, 8/8/26 to 8/12/26, 8/14/26 to 8/16/26, 8/18/26 to 8/22/26, 8/24/26 to 8/30/26, 8/31/26 to 9/3/26, 9/5/26 to 9/11/26, 9/13/26 to 9/16/26, 9/18/26 to 9/25/26, and 9/27/26 to 10/5/26. Resident 11’s 7/2/26 physician’s treatment order for the pressure ulcer on his left buttock was to cover with a hydrogel sheet plus collagen pellets and cover with a dressing. His 8/13/26 physician’s order discontinued the previous treatment order and instructed the staff to apply Aquaphor to the pressure ulcers on his right and left buttocks twice daily. On 9/11/26, the physician updated the treatment orders to add collagen pellets to the Aquaphor and apply to the pressure ulcers on his right and left buttocks twice daily and as needed. 3. Observation on 10/6/26 at 10:28 a.m. of resident 15 in her room revealed she was lying in bed on her left side with her knees tucked in front of her and pillows between her knees and behind her back. There was a cushion in her wheelchair and an air mattress on her bed. She did not respond when spoken to. Review of resident 15’s medical record revealed she admitted to the facility on 2/23/17. Her 9/7/26 Minimum Data Set (MDS) assessment indicated she was rarely understood or able to understand others and severely cognitively impaired. Resident 15’s Braden Scale for predicting pressure ulcers score risk was 13 on 6/9/26 and 9/9/26, which indicated moderate risk for the development of a pressure ulcer. A pressure ulcer to her coccyx was identified on 8/14/26. MDS nurse/IP/wound nurse C documented the measurements as 1.1 cm in length by 0.6 cm in width and described the wound bed as white slough.	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0686 SS = SQC-H	Continued from page 11 MDS nurse/IP C notified resident 15's physician that she had an "open area" on her coccyx but did not describe the wound bed. There was no documentation that resident 15's representative was notified of her pressure ulcer or the physician's order for treatment. On 9/12/26, resident 15's pressure ulcer measured 0.8 cm in length by 0.4 cm in width by 0.1 cm in depth, with the wound bed described as dull pink with lighter edges. On 9/17/26, resident 15's pressure ulcer measured 1.8 cm in length by 1.2 cm in width by 0.2 cm in depth, and the wound bed was described as dark pink with lighter pink edges and the surrounding skin was "darker/bruised in appearance." There was no documentation that resident 15's physician or representative was notified that her pressure had increased in size, or the surrounding skin had changed color. The next documented weekly wound assessment was on 10/2/26, and the pressure ulcer measured 1.1 cm in length by 0.8 cm in width by 0.2 cm in depth. The wound bed was described as "sloughy" with the edges of the wound "reddened." She had a 9/1/26 physician's order to apply a honey hydrogel pad to her pressure ulcer on her coccyx and cover it with a dressing daily and as needed. Resident 15's 10/7/26 care plan indicated that on 10/8/23 she was identified as being at risk for impaired skin integrity due to incontinence and impaired mobility and was to be turned and repositioned every two to three hours and as needed. On 1/13/24 she developed a stage I (1; unopened non-blanchable skin redness, meaning the area remains red when pressed, caused by pressure) pressure ulcer to her coccyx. On 8/15/26 she had a stage III pressure ulcer on her coccyx. Observation and interview on 10/7/26 at 10:23 a.m. of LPN F and CNA I changing resident 15's dressing on her pressure ulcer revealed resident 15 was positioned on her left side with a pillow behind her back. CNA turned resident 15 further onto her left side. LPN F unfastened resident 15's incontinence brief, and exposed resident 15's pressure ulcer on her coccyx. There was no dressing covering the pressure ulcer. CNA I stated resident 15 had a bath that morning at about 7:00 a.m. LPN F stated that she was not told that resident 15 had a bath and needed to have a dressing put on her pressure	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0686 SS = SQC-H	Continued from page 12 ulcer. LPN F stated that resident 15 usually had her pressure ulcer dressing changed at bedtime so she expected to be notified that a dressing needed to be put on resident 15's pressure ulcer after her bath. LPN F did not measure the pressure ulcer but stated it was about 3 cm in length by 2 cm in width, by 0.2 cm in depth, and the wound bed was about 75 percent slough. The slough was surrounded by a red area with the skin edges rolled back about 0.5 cm from the slough. After LPN F applied the dressing over resident 15's pressure ulcer, and reapplied a brief, CNA I positioned resident 15 back on her left side with a pillow behind her back. Interview on 10/7/26 at 1:40 p.m. with director of nursing (DON) B revealed she was unable to find documentation that resident 15's representative was notified that she had developed a pressure ulcer. Interview on 10/8/26 at 7:41 a.m. with registered nurse (RN) E revealed that she worked the night shift and changed the dressing on resident 15 because it was scheduled to be changed at bedtime. Resident 15 was unable to reposition herself, so the staff repositioned her every two hours. The nurse who identified a new pressure ulcer was responsible for assessing the pressure ulcer, measuring the pressure ulcer, and starting the wound documentation assessment forms. The nurse faxed the provider to notify him of the new pressure ulcer and to obtain a physician's order for treatment. MDS nurse/IP/wound nurse C was to be notified, and when the physician's treatment orders for the pressure ulcer were received, they would be given to the wound nurse. MDS nurse/IP/wound nurse C would notify the resident's representative of the new pressure ulcer and the physician's ordered treatment. If a pressure ulcer's condition worsened or it increased in size, MDS nurse/IP/wound nurse C was to be notified. If MDS nurse/IP/wound nurse C was not available, the nurse would notify the physician of the change in condition. RN E stated that she had observed resident 15's pressure ulcer when she changed the dressing on 10/7/26. She stated the bed of the pressure ulcer was 75 percent slough, 25 percent red tissue with loosened edges and macerated skin (skin that has been exposed to moisture) surrounding the pressure ulcer. The pressure ulcer had increased in size since she had	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0686 SS = SQC-H	Continued from page 13 last observed it on 9/29/26. She did not notify MDS nurse/IP/wound nurse C of the increased size. She said MDS nurse/IP/wound nurse C would read her documentation. RN E looked at resident 15's pressure every night she worked whenever she changed the dressing. She was scheduled to work three nights in a row, and she would document the pressure ulcer's condition on her first night and third night. Interview and review of resident 15's October Turning and Repositioning log on 10/8/26 at 9:09 a.m. with CNA G revealed that the CNAs repositioned the residents who were unable to reposition themselves every two hours and documented the repositioning on the Turning and Repositioning log. Resident 15's Turning and Repositioning log indicated there was a box to document every hour for each day of the month. Documented on the Log were, "L," which CNA G stated meant the resident was positioned on her left side, "R," which indicated the resident was positioned on her right side, "WC," which indicated the resident was in her wheelchair, "C," which indicated the resident was in her recliner, and "B," which CNA G stated she charted when the resident was in her bed, but stated others used "B," to indicated she was on her back. CNA G acknowledged that if she was charting "B" for bed the documentation did not indicate that resident 15 was being repositioned while she was in bed. Before resident 15 developed her pressure ulcer, she had an air mattress on her bed and a cushion in her wheelchair. When she developed redness on her buttocks area, the CNAs began using a moisture barrier cream. CNA G stated resident 15 had a previous pressure ulcer because she was very thin, contracted (the loss of joint and soft tissue mobility caused by the shortening and hardening of muscles, tendons, and ligaments), and had multiple bony areas. Review of resident 15's Turning and Repositioning Log for August, September, and October 2026 revealed that she was documented as lying on her left side from 12:00 a.m. until 6:00 a.m. on 8/2/26, 8/3/26, 8/4/26, 8/5/26, 8/6/26, 8/7/26, 8/9/26, 8/10/26, 8/11/26, 8/12/26, 8/13/26, 8/16/26, 8/17/26, 8/22/26, 8/25/26, 8/26/26, 8/27/26, 8/30/26, 8/31/26, 9/11/26, 9/12/26, 9/13/26, 9/14/26, 9/15/26, 9/17/26, 9/18/26, 9/19/26,	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0686 SS = SQC-H	Continued from page 14 9/20/26, 9/23/26, 9/24/26, 9/25/26, 9/29/26, 9/30/26, 10/1/26, 10/2/26, 10/3/26, 10/4/26, 10/5/26, and 10/6/26. She was documented as being positioned “B” from 7:00 p.m. until 12:00 a.m. on 8/1/26, 8/2/26, 8/3/26, 8/4/26, 8/5/26, 8/6/26, 8/7/26, 8/9/26, 8/10/26, 8/11/26, 8/12/26, 8/13/26, 8/14/26, 8/15/26, 8/16/26, 8/17/26, 8/18/26, 8/22/26, 8/23/26, 8/24/26, 8/25/26, 8/27/26, 8/28/26, 8/29/26, 8/30/26, 8/31/26, 9/2/26, 9/3/26, 9/6/26, 9/8/26, 9/9/26, 9/10/26, 9/14/26, 9/16/26, 9/18/26, 9/24/26, 10/2/26, 10/3/26, and 10/6/26. There was no documentation that resident 15 was repositioned between 4:00 a.m. and 2:00 p.m. on 8/2/26, between 2:00 p.m. and 12:00 a.m. on 8/8/26, 8/22/26, 9/5/25, 9/7/26, and 10/7/26 and between 2:00 p.m. and 7:00 p.m. on 8/26/26, 8/27/27, and 9/15/26. 4. Interview on 10/8/26 at 9:40 a.m. with RN D revealed that she expected the residents to be repositioned at least every two hours. The CNAs were to document the repositioning on their “sheets”. The CNAs documentation was given to DON B for her to review. RN D acknowledged that if a resident was unable to reposition themselves and they were not repositioned routinely, they would be at increased risk for the development of a pressure ulcer, or if they had a pressure ulcer, it could delay the healing of that pressure ulcer. If a new pressure ulcer was identified, the nurse who was taking care of that resident would measure the size of the pressure ulcer and document the measurements on the wound assessment sheet. The nurse would notify MDS nurse/IP/wound nurse C, and the resident’s physician. When the physician’s treatment order was received, the resident’s representative would be notified of the wound because the resident’s treatment had changed. MDS nurse/IP/wound nurse C, usually obtained the treatment order and notified the resident’s representative. She expected the family notification to be documented in the progress notes in the resident’s medical record. The nurse who completed a resident’s daily dressing change for their pressure ulcer was responsible for documenting the pressure ulcer daily on the daily wound documentation. MDS nurse/IP/ wound nurse C documented the resident’s pressure	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0686 SS = SQC-H	Continued from page 15 ulcers weekly on the weekly wound assessment. 5. Interview and record review on 10/8/26 at 1:26 p.m. with DON B revealed that she expected the staff to move a resident's pressure-reducing cushion from their wheelchair to the recliner. Staff were to use pillows to help reposition the residents while in bed and in the recliner. If a CNA identified a concerning skin area on a resident, they were to notify the nurse. She expected the nurse to assess and measure the wound and notify MDS nurse/IP/ wound nurse C as she was the the facility's designated wound nurse. If the pressure ulcer was identified on a weekend or after normal working hours, she expected the nurse to notify the resident's physician via fax machine, but the physician might not get back to them with orders until the following day. She expected the resident's physician to be notified of pressure ulcers "sooner than later." The nurse would also notify the residents' families, but only if there were new treatment orders. She expected MDS nurse/IP/wound nurse C to assess the resident's wounds at least weekly, and the staff nurses charted on the wounds daily with the wound treatments. Someone was at least looking at the wounds daily. She was aware of the residents that had pressure ulcers. There were monthly skin/wound meetings that were held after their monthly Quality Assurance and Performance Improvement (QAPI) meetings. When reviewing the CNA charting binder for the turning/repositioning sheets, she indicated that she thought that the "B" meant "bed," but acknowledged how it could be interpreted as "back." She confirmed there was no legend on the charting sheet to know what each letter on the chart meant. She acknowledged that the CNA's turning/repositioning chart book showed that the residents were not being turned or repositioned every two hours. If a pressure ulcer increased in size, she expected the staff nurses to notify the resident's physician. She confirmed that MDS nurse/IP/wound nurse C was not gone from work during 9/17/26 to 10/3/26 when there was missing documentation in the weekly wound assessments. 6. Interview and record review on 10/8/26 at 1:15	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0686 SS = SQC-H	Continued from page 16 p.m. with MDS nurse/IP/wound nurse C revealed that she was the facility's designated wound nurse. She did weekly wound assessments on the residents with wounds. She expected the nurses who changed the resident's dressing to document daily, the color of the wound, any drainage, if the wound appeared infected, if the wound had an odor, and if the wound looked better or worse. She expected the nurse to notify her if the wound looked worse or was larger in size. She was not notified on 10/7/26 that resident 15's pressure ulcer was larger than her documented assessment on 10/2/26. She confirmed there was a delay in treatment to resident 11's pressure ulcer on his left buttock as it was identified on 6/25/26. His physician was notified on 7/1/26, and treatments were started on 7/2/26. She expected the staff to reposition the residents every two to three hours and as needed whether they were in bed, in a chair, or in a wheelchair. The staff were to document their repositioning on the resident's turning and repositioning log. If the repositioning was not documented on that log she could not verify if that resident was repositioned. She acknowledged that "B" documented on the turning and repositioning log could refer to the resident being in bed or on their back because there was no direction on what to use when the staff documented. For resident 13, she "did not necessarily" expect the staff to place the pressure-reducing cushion in the recliner because she expected the staff to turn and reposition him. She acknowledged the documentation on residents 11, 13, and 15 did not support that they were repositioned every two to three hours. She acknowledged that not being repositioned routinely could increase the risk for a resident to develop a pressure ulcer and could slow the healing of a current pressure ulcer. She had taken time off from work and asked one of the nurses to complete and document the residents' wound assessments. She did not recall who she had asked to complete and document the assessments. She stated she did not take time off between 9/17/26 and 10/2/26 and did not know why there was no weekly wound documentation between those dates. When a pressure ulcer was identified, she expected	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0686 SS = SQC-H	Continued from page 17 the nurse who found the pressure ulcer to measure the wound, document the measurements and the pressure ulcer characteristics on the weekly wound assessment, initiate the treatment for the pressure ulcer, and notify the resident's physician, herself, and the resident's family of the pressure ulcer. She expected the CNAs to notify the scheduled nurse if the dressing over the pressure ulcer came off or if the resident had a bath, so the nurse knew to put a new dressing on the pressure ulcer. She verified resident 15 had slough in the pressure ulcer bed, and with that slough, she could not verify how deep or what stage the pressure ulcer was. She stated it was a stage III previously, so she continued documenting that it was a stage III but acknowledged it was an unstageable pressure ulcer. 7. Review of the provider's 2/13/26 Pressure Injury Preventions and Management policy revealed that, "This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries." "This facility will establish and utilize and [a] systematic approach for pressure ulcer prevent [prevention] and management, including prompt assessment and treatment, intervening to stabilize, reduce or remove underlying risk factors, monitoring the impact of the interventions and modifying the interventions as appropriate." "The pressure injury risk assessment (Braden Scale) will be used in conjunction with other risk factors not captured by the risk assessment tool. Examples of risk factors include, but are not limited to: Impaired/decreased mobility and decreased functional ability. Co-morbid conditions, such as end stage renal [kidney] disease, thyroid disease, or diabetes mellitus…Cognitive impairment. Exposure of skin to urinary and fecal incontinence. Under nutrition, malnutrition, and hydration deficits. The presence of a previously healed pressure injury." "The MDS coordinator/Wound nurse will review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing and compliance at least weekly and document a summary of findings in the wound record." "The attending physician will be notified of a new pressure injury upon identification, progression towards healing or lack of healing of any pressure injuries, and any complications as needed."	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0686 SS = SQC-H	Continued from page 18 8. Review of the provider's 10/16/25 Notification of Changes policy revealed, that "The purpose of this policy is to ensure the [facility name] promptly informs the resident, consults the resident's physician, and notifies, consistent with his/her authority, the resident's representative when there is a change requiring notification." "Circumstances requiring notification include: …Significant change in [a] resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status."	F0686		
F0636 SS = E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status.	F0636	F 0636 Comprehensive Assessments & Timing Since it is the responsibility of the facility to conduct initially and periodically comprehensive, accurate, and standardized reproducible assessments of each resident's functional capacity within the required timetime, the following has been completed to ensure compliance. 1. On 10/29/2026, the Administrator and MDS RN/Coordinator met and reviewed the MDS Completion policy. No changes made to this policy during this review. 2. On 10/29/2026, the MDS RN/Coordinator provided the Administrator with documentation of a copy of the census sheet and a copy of the upcoming MDS calendar. MDS RN/Coordinator is aware of her responsibilities to ensure that assessments are completed within the required time frame. MDS RN/Coordinator will give the Administrator a copy of the completed validation sheet showing proof of submission following every MDS submission. 3. Administrator will be responsible for completing 1 weekly spot check to ensure that the MDS RN/Coordinator completes the MDS submissions in the required time frame and reports these findings to the QAPI Committee monthly for 3 months then quarterly until the QAPI advises otherwise.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0636 SS = E	Continued from page 19 (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, Long-Term Care (LTC) Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 October 2025 review, and job description review, the provider failed to ensure that the residents' comprehensive Minimum Data Set (MDS; a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) assessments were: Transmitted within 14 days of the documented MDS care plan completion date (V0200C2) for two of two sampled residents (21 and 27) whose comprehensive MDS assessments were transmitted more than 14 days after their MDS V0200C2 dates.	F0636	F 0636 Comprehensive Assessments & Timing Addendum 11/10/2026 4. Administrator spoke with MDS RN/ Coordinator concerning the late comprehensive assessment submissions. MDS RN/Coordinator stated it was "staff error" versus our contracted MDS submission company. Unable to correct the late submissions. MDS RN/ Coordinator has put the following in place to ensure timely submissions going forward: * submissions are completed weekly *change to her process of tracking submission due dates to ensure timeliness	11/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0636 SS = E	Continued from page 20 Completed within the required timeframe for one of one sampled resident (10) whose comprehensive MDS assessment was completed more than 366 days after the resident's previous comprehensive assessment. Findings include: 1. Review of resident 21's MDS assessments revealed that the resident's most recently completed comprehensive MDS assessment had an assessment reference date (ARD; refers to the specific endpoint for the observation, or "look-back" periods in the MDS assessment process) of 7/13/26. The assessment had a consistency warning that read, "Error ID: -3810c. Record Submitted Late: The submission date is more than 14 days after V0200C2 [the care plan completion date] on this new (A0050 equals 1) comprehensive assessment (A0310A equals 01, 03, 04, or 05)." Section V0200C2, titled "Signature of Person Completing Care Plan Decision and Date Signed," was dated 7/25/26. That assessment had a submission timestamp of 8/25/26, which was 31 days after the V0200C2 date. 2. Review of resident 27's MDS assessments revealed that the resident's most recently completed comprehensive MDS assessment had an ARD of 8/17/26. The assessment had a consistency warning that read, "Error ID: -3810c. Record Submitted Late: The submission date is more than 14 days after V0200C2 on this new (A0050 equals 1) comprehensive assessment (A0310A equals 01, 03, 04, or 05)." The date in section V0200C2 was 8/29/26. That assessment had a submission timestamp of 9/28/26, which was 30 days after the V0200C2 date. 3. Review of resident 10's MDS assessments revealed the resident's most recent comprehensive assessment had an ARD of 8/24/26, which was 441 days after the resident's previous comprehensive assessment with an ARD of 6/9/25. There were four individual quarterly MDS assessments completed between those comprehensive assessments, instead of three quarterly assessments then a comprehensive assessment. 4. Interview and record review on 10/8/26 at 3:18 p.m. with MDS nurse/infection preventionist (IP)/wound nurse C revealed that she was responsible for gathering the resident's MDS assessment data. A contracted company reviewed the MDS assessment submissions prior to encoding (entering the resident's MDS assessment data into	F0636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0636 SS = E	Continued from page 21 the computer software) and transmitting (submitting the completed MDS assessment to the Centers for Medicare and Medicaid Services (CMS)) the assessment. They recently switched contracted companies to encode and transmit the MDS assessments, and she had trouble selecting the correct dates (section V0200C2) to ensure the assessments were not late. She thought she had fixed the late submission issues, so she was not aware that the MDS assessments for residents 21 and 27 were late. She did not realize that resident 10 had a fourth quarterly assessment completed, instead of a comprehensive assessment. 5. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, version 1.20.1, published October 2025, revealed, "The ARD of an assessment drives the due date of the next assessment. The next comprehensive assessment is due within 366 days after the ARD of the most recent comprehensive assessment." "For the other comprehensive MDS assessments, Significant Change in Status Assessment and Significant Correction to Prior Comprehensive Assessment, the CAA [Care Area Assessment; reflect common conditions, symptoms, or concerns found in nursing home residents that are often identified by the MDS] Completion Date (V0200B2) must be no later than 14 days from the ARD (A2300) and no later than 14 days from the determination date of the significant change in status or the significant error, respectively." …"For a comprehensive assessment (Admission, Annual, Significant Change in Status, and Significant Correction to Prior Comprehensive), encoding must occur within 7 days after the Care Plan Completion Date (V0200C2 + 7 days)." …"Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 + 14 days). All other MDS assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days)."	F0636		
F0638 SS = E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is NOT MET as evidenced by:	F0638	F 0638 Qrtly Assessment at Least Every 3 Months It is the responsibility of the facility to assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months, the following has been completed to ensure compliance. 1. On 10/29/2026, the Administrator and MDS RN/ Coordinator met and reviewed the MDS Completion policy. No changes made to this policy at the time of this review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0638 SS = E	Continued from page 22 Based on record review, interview, and Long-Term Care (LTC) Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 October 2025 review, the provider failed to ensure timely completion of the resident's quarterly Minimum Data Set (MDS; a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) assessments for four of six sampled residents (10, 16, 21, and 27) whose quarterly assessments were not signed as completed in section Z0500B within 14 days of the MDS assessment reference date (ARD; section A2300). Findings include: 1. Review of resident 10's quarterly MDS assessment with an ARD (refers to the specific endpoint for the observation, or "look-back" periods in the MDS assessment process) of 12/1/25 in section A2300, revealed it had a documented completion date of 1/8/26 in section Z0500B, which was 38 days after the MDS's ARD. 2. Review of resident 16's quarterly MDS assessment with an ARD of 11/24/25 in section A2300, revealed it had a documented completion date of 12/26/25 in section Z0500B, which was 32 days after the MDS's ARD. 3. Review of resident 21's quarterly MDS assessment with an ARD of 10/13/25 in section A2300, revealed it had a documented completion date of 12/24/25 in section Z0500B, which was 72 days after the MDS's ARD. 4. Review of resident 27's quarterly MDS assessment with an ARD of 11/17/25 in section A2300, revealed it had a documented completion date of 12/16/25 in section Z0500B, which was 29 after the MDS's ARD. 5. Interview and record review on 10/8/26 at 3:18 p.m. with MDS nurse/infection preventionist (IP)/wound nurse C revealed that she was responsible for gathering the resident's MDS assessment data. A contracted company reviewed the MDS assessment submissions prior to encoding (entering the resident's MDS assessment data into the computer software) and transmitting (submitting the completed MDS assessment to CMS) the assessment. The facility recently switched contracted companies to encode and transmit the MDS assessments, and she had trouble selecting the correct dates to ensure the assessments were not late. She thought she had fixed the MDS completion	F0638	F 0638 Qrtly Assessment at Least Every 3 Months Cont. 2. On 10/29/2026, the MDS RN/Coordinator provided the Administrator with documentation of a copy of the census sheet and a copy of the upcoming MDS calendar. MDS RN/Coordinator is aware of her responsibilities to ensure that assessments are completed within the required time-frame. MDS RN/Coordinator will give the Administrator a copy of the completed validation sheet showing proof of submission following every MDS submission. 3. The Administrator will be responsible for completing 1 weekly spot check to ensure that the MDS RN/Coordinator completes the MDS submissions in the required time-frame and reports these findings to the QAPI Committee monthly for 3 months then quarterly until the QAPI Committee advises otherwise. Addendum 11/10/2026 4. Administrator spoke with MDS RN/Coordinator concerning the late quarterly submissions as cited. Unable to correct these late submissions. The cause of the late submissions was due to the contracted MDS submission company building a program for our facility to utilize for MDS submissions due to the loss of IQIES.	11/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0638 SS = E	Continued from page 23 issues, so she was not aware that the quarterly MDS assessments for residents 10, 16, 21, and 27 were late. 6. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, version 1.20.1, October 2025, section 5.2 Timeliness Criteria, "For all non-Admission OBRA [Omnibus Budget Reconciliation Act] and PPS [Prospective Payment System] assessments, the MDS Completion Date (Z0500B) must be no later than 14 days after the Assessment Reference Date (ARD) (A2300)."	F0638	F 0761 Label/Store Drugs and Biologicals It is the responsibility of the facility to ensure that drugs and biologicals used in the facility are labeled and stored in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. The following was implemented to ensure compliance. Medication Storage 1. On 10/08/2026, the Director of Nursing inspected all resident rooms to ensure no further presence of medications/biologicals were left in these areas. 2. On 10/28/2026, the Administrator and Director of Nursing reviewed the Medication Storage policy and the Storing Medication in Rooms policy. No changes made to these policies as these policies state that all drugs will be stored in locked compartments and during a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication store area/cart, and no medications will be stored in resident's room. 3. On 11/2/2026 and 113/2026, the Administrator and Director of Nursing held a mandatory staff meeting to review the facility's Medication Storage and Storing Medication in Rooms policies. All RNs/LPNs, Medication Aides, and CNAs were re-educated in the proper/required storage of medications. Expiration Dates 1. On 10/6/2026, the Director of Nursing wasted the expired TB solution. Let it be noted that the last time the TB solution was used was on 8/31/2026 which was the open date of the solution. 2. On 10/28/2026, the Administrator and Director of Nursing reviewed the Labeling of Medications in Bulk Containers and Multi-dose Pens/Vials policy. No revisions made to policy as policy states in a multi-use pen/vial is accessed, the vial should be dated and discarded within 28 days unless the manufacturer specifies a different date for that specific multi-dose pen/vial.	
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure medications and biologicals were labeled, securely stored, kept within the manufacturer's safe temperature range, not expired, and accessible only to authorized personnel regarding: Two of two sampled residents' (11 and 25) topical	F0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0761 SS = E	Continued from page 24 medications that were stored in their rooms. One of one unauthorized individual (maintenance director J) who was unsupervised in one of one medication room where medications were not securely stored. Medications with shortened expiration dates stored in one of one medication refrigerator that were not discarded after their expiration dates. One of one observed Lantus insulin (a long acting insulin used to lower blood sugar levels in the blood) pen and one of one observed Novolog (short-acting insulin) insulin pen that did not have pharmacy labels to indicate whose medications they were, directions for use, and the prescriber's name, for one of one sampled resident (2) with unlabeled insulin pens stored in a plastic bag. Findings include: 1. Observation on 10/6/26 at 8:23 a.m. in resident 11's room revealed there was a clear plastic tub on his bedside dresser with a white lid screwed on top. The handwritten label read, "Aquaphor + [plus] Collagen pellets [topical ointment]" and was dated 9/12/26. Interview on 10/6/26 at 4:26 p.m. with resident 11 revealed that he did not use the Aquaphor plus collagen pellets topical ointment on himself. The staff used the ointment on his bottom. He could not reach to put the ointment on himself. Review of resident 11's medical record revealed that he had an 8/12/26 physician's order for "Aquaphor with collagen pellet Ointment to Buttocks" with directions to "Apply BID [twice a day] to buttocks." 2. Observation on 10/6/26 at 10:14 a.m. in resident 25's room revealed that there was a bottle of Nystop powder (a topical anti-fungal medicated powder) on her bedside table. The bottle had a handwritten date of 7/1/26 on it. There was about 25 percent of powder remaining in the bottle. Interview on 10/7/26 at 2:18 p.m. with resident 25 revealed she did not use the Nystop powder on herself. The staff helped her apply the topical powder, but she had not used it in a long time. Review of resident 25's medical record revealed she had a 7/2/26 physician's order for "Nystatin powder 1 application Topical PRN [as needed] BID [twice daily] apply under breasts." According to the	F0761	F 0761 Label/Store Drugs and Biologicals Cont. 3. On 11/2/2026 and 11/3/2026 the Administrator and Director of Nursing held a mandatory staff meeting to review the facility's Labeling of Medications in Bulk Containers and Multi-dose Pens/Vials policy. All RNs/LPNs and Medication Aides were re-educated on dating all multi-dose pens/vials with the date it was first accessed, date that the multi-dose pen/vial out dates, and discarding the multi-dose pen/vial within 28 days. Medications Accessible Only to Authorized Personnel 1. On 10/28/2026, the Administrator and the Director of Nursing reviewed the Medication Storage Policy, policy states that only authorized personnel will have access to the keys to locked compartments. The Charge Nurse and Director of Nursing are the only staff who have keys to the medication room and medication carts. Policy was changed to reflect the following: If the Charge Nurse and/or Director of Nursing allows access to a staff member (who is not a RN/LPN/Medication Aide)/contracted entity performing maintenance, repair, and/or cleaning, the Charge Nurse and/or Director of Nursing MUST stay with that individual while the maintenance, repair, and/or cleaning is being completed. 2. On 11/2/2026 and 11/3/2026, the Administrator and Director of Nursing held a mandatory staff meeting to review the facility's policy on Medication Storage. All RNs/LPNs and Medication Aides were re-educated on the proper procedure when allowing any staff who is not a RN/LPN/Medication Aide access into the medication room. Proper Labeling 1.On 10/8/2026, the Administrator and Director of Nursing contacted the facility's contracted pharmacy concerning obtaining labels for insulin multidose pens once removed from the original packaging.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0761 SS = E	Continued from page 25 medication administration record (MAR), the Nystop powder was last used on 8/6/26. 3. Interview and record review on 10/7/26 at 3:56 p.m. with licensed practical nurse (LPN) F revealed that she thought resident 11's Aquaphor plus collagen pellets topical ointment was okay to store in the resident's room. She said that ointment was usually stored in the resident's medicine cabinet in their bathroom rather than on the bedside dresser. She was not aware that resident 25's Nystop powder was in her room. She confirmed that medicated powder was not supposed to be stored in the resident's room. She said that with some of the PRN medications, like the topical powders and ointments, the nurses would sometimes forget to mark that it was used in the residents' MAR. According to resident 25's MAR, the Nystop powder was marked as last used in August, but she explained that it could have been used more recently and not marked on the resident's MAR. 4. Review of the provider's 8/3/25 Storing Medications in Rooms policy revealed, "Prescription medications will not be stored in a resident's room. Over the counter creams such as Calazinc/Vaseline will be stored in rooms as they may be used on a PRN basis and can be administered by a nursing assistant." 5. Observation on 10/6/26 at 11:37 a.m. of the medication room revealed maintenance director J was inside the medication room. There were no nursing staff within sight of the medication room. The medication room contained medications that were not locked and could have been accessed by maintenance director J. Interview on 10/6/26 at 4:24 p.m. with LPN F revealed that the maintenance staff, the nurses, and director of nursing (DON) B had keys to get into the medication room. She verified that the maintenance staff had the ability to enter the medication room without supervision from a nurse. Interview on 10/8/26 at 10:57 a.m. with maintenance director J revealed that he did not have a key to enter the medication room, and that he asked a nurse to open the door to the medication room when he needed to be in there. He verified he was not a nurse and did not have specialized training to administer medications. He was left unsupervised in the medication room at times. He stated on 10/6/26 he asked a nurse to let	F0761	F 0761 Label/Store Drugs and Biologicals Cont. 2. On 10/17/2026, contracted pharmacy provided labels for multidose insulin pens. All multidose insulin pens have a pharmacy generated prescription label on the cap of the multidose insulin pen with the resident's initials and expiration date written on the multidose vial portion. Temperature 1. On 10/6/2026, the Administrator met with the Director of Nursing and reviewed the Medication Storage policy. Policy states that the Medication Room should be maintained between 68-77 degrees Fahrenheit. 2. On 10/6/2026, implementation of daily documentation of the temperature of the Medication Room was implemented. Since implementing the daily documentation/ monitoring of the temperature of the Medication Room, the temperature has been in the required range of 68-77 degrees Fahrenheit. The Director of Nursing will be responsible for completing weekly spot checks to ensure compliance with medications being properly stored, medications being discarded following the expiration date, access to only the authorized personnel into the medication room/ monitoring those who are not authorized to be in the Medication Room without RN/LPN/ Medication Aide monitoring, proper labeling of multi-dose insulin pens/caps, and monitoring temperature in the medication room. The Director of Nursing will report these findings to the QAPI Committee monthly for 3 months then quarterly until the QAPI Committee advises otherwise.	11/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0761 SS = E	Continued from page 26 him in the medication room to fix a light. The nurse let him in the medication room, and she did not remain in the room with him but said she would be “in the area.” He acknowledged that he had access to medications while he was in the medication room. 6. Observation and interview on 10/6/26 at 4:19 p.m. of the medication room with LPN F revealed there was a vial of tuberculin (TB) solution (test liquid made from tuberculosis bacteria proteins to check infection) that was dated as opened on 8/31/26. LPN F verified the TB solution was expired because it was dated as being opened more than 28 days ago. There was a thermometer on the wall of the medication room that indicated it was 78 degrees Fahrenheit (F) in the medication room. LPN F stated the temperature of the medication room was not monitored and documented. The boxes of nebulizer solutions (a liquid medication that is converted into an inhalable mist), inhalers, and some topical creams indicated there was a manufacturer’s recommended medication storage temperature range of 68 to 77 degrees F. LPN F verified the boxes of nebulizer solutions, inhalers, and some topical creams indicated they were to be stored between 68 and 77 degrees F and the temperature of the medication room was 78 degrees F. She stated she was not aware those medications had a manufacturer’s medication storage temperature range. 7. Observation and interview on 10/7/26 at 8:20 a.m. of LPN F administering insulin to resident 2 revealed that LPN F removed a plastic bag with resident 2’s Lantus insulin pen and Novolog insulin pen from a container in the medication room with other plastic bags that contained injectable pens. The plastic bag had resident 2’s name handwritten on it. She removed the Lantus and Novolog insulin pens from the plastic bag. There were no pharmacy labels on the Lantus or Novolog insulin pens. Resident 2’s name was handwritten on the cap of the Novolog and Lantus insulin pens with the date that those pens were opened. LPN F removed the caps from the Novolog and Lantus insulin pens, placed the caps on the counter in the medication room, cleaned the top of the Novolog insulin pen with an alcohol wipe from the counter in the medication room, put the needle on the pen, dialed two units of Novolog, and primed the Novolog pen. She cleaned the top of the Lantus pen with an alcohol wipe from the counter in the medication room, put the needle on the pen, dialed	F0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0761 SS = E	Continued from page 27 two units of Lantus, and primed the Lantus pen. LPN F carried the two insulin pens to the west medication cart by the nurses' station, reviewed resident 2's medication administration record (MAR), and dialed the Novolog insulin pen to five units. She reviewed resident 2's MAR and dialed the Lantus insulin pen to 32 units. LPN F wheeled resident 2 into the medication room and administered the Novolog insulin and the Lantus insulin. LPN F verified there was no pharmacy label on resident 2's Novolog or Lantus insulin pens. She stated none of the residents' injectable pens were labeled with pharmacy labels. The pharmacy labels were on the box of pens in the medication refrigerator. She acknowledged there was the potential for the insulin pens to be administered to the wrong resident if the handwritten name wore off the cap of the insulin or if the insulin caps were switched between pens. When the cap was removed from the insulin pens, there was no resident identifier on the insulin pen. She acknowledged that without a pharmacy label with the resident's name and administration instructions, the rights of medication administration (verification steps that help the staff give medicine safely) could not be completed by checking the pharmacy label against the resident's MAR. 8. Interview on 10/8/26 at 1:38 a.m. with DON B revealed the provider was having difficulty with the air conditioning in the medication room, and it was warmer than normal in that room. The room temperature was not monitored or documented. She was aware that there were medications in the medication room that the manufacturer recommended the storage of those medications to be within a specified temperature range. She acknowledged that she could not verify those medications were stored within their recommended storage temperatures because the temperature in the medication room was not monitored or documented. The scheduled night shift nurse was responsible for checking for expired medications in the medication room. DON B stated she was not aware that the TB solution had a shortened expiration date after it was opened. She acknowledged there was the potential for the insulin pens to be used on the wrong resident when the insulin pens were not labeled with a pharmacy label, and the nurses were unable to complete the five rights of medication administration when there was no pharmacy label to perform those checks.	F0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0761 SS = E	Continued from page 28 The maintenance staff was to request access to be in the medication room from a nurse. She expected a nurse to supervise maintenance director J while he was in the medication room. She acknowledged that maintenance director J was not authorized to be in the medication room unsupervised and he had access to medications while he was unsupervised in the medication room. 9. Review of the provider's 10/28/25 Medication Storage policy revealed, "It is the policy of the [facility's name] to ensure all medications housed on our premises will be stored in the medication room(s) according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security." "All drugs will be stored in locked compartments (such as medication carts, cabinets, drawers, medication rooms, etc.) under proper temperature controls. 'Room Temperature' refers to temperature maintained between 68-77 degrees F." "Only authorized personnel will have access to the keys to locked compartments." "The medication room is routinely inspected every three months by the DON for discontinued, outdated, defective, or deteriorated medications. The night Charge Nurse completes the following monthly tasks: 1st Saturday of the month ~ Check expiration dates of all meds [medications] in the med room. 10. Review of the provider's 8/3/25 Labeling of Medications in bulk containers and multidose pens/vials revealed, "Multidose pens/vials shall be dated, the date it was first accessed. If a multidose pen/vial is accessed the vial should be dated and discarded within 28 days unless the manufacture [manufacturer] specifies a different (shorter or long) date for that specific multidose pen/vial." 11. Review of the provider's 2/16/16 Medication Administration Process policy revealed, "Compare the medication label on the card, bottle, vial, etc. with the MAR. Make sure the orders on the MAR match the medication label."	F0761		
F0909 SS = E	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of	F0909	F 0909 Resident Bed It is the responsibility of the facility to conduct regular inspection of all bed frames, mattresses, and bed rails and to use only those bed rails that are compatible with the bed frames according to the bed frame manufacturer owner's manual instructions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469

(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
F0909 SS = E	Continued from page 29 possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to conduct regular inspections of bed frames, mattresses, and side rails as part of a regular maintenance program for four of four sampled residents (11, 13, 19, and 20) with side rails attached to their beds that were not compatible with the bed frames according to the bed frame manufacturer owner's manual instructions. The resident census was 30. Findings include: 1. Observation on 10/6/26 at 8:23 a.m. revealed that resident 11 had "M-type" (meaning they were shaped like the letter M) side rails on both sides of his bed. The side rails were strapped to the bedframe rather than bolted. 2. Observation on 10/6/26 at 2:25 p.m. revealed that resident 13 had "M-type" side rails on both sides of his bed. The side rails were strapped to the bedframe rather than bolted. 3. Interview on 10/7/26 at 5:07 p.m. with administrator A revealed that there was no documentation that supported the facility had a resident bed maintenance program. The maintenance department thought the housekeeping department was responsible for the program, and the housekeeping department thought the maintenance department was responsible for maintaining the program. 4. Interview on 10/8/26 at 10:46 a.m. with maintenance director J revealed that he installed side rails on residents' beds when he was instructed to do so by Minimum Data Set (MDS) nurse/infection preventionist (IP) C. He did not check any measurements after the side rails were installed to ensure the residents' risk of entrapment was minimized. He was not aware of the potential entrapment risks the residents' beds or side rails could pose. He did not know about the requirement to conduct regular inspections of the residents' bedframes, mattresses, and side rails as part of a regular maintenance program to identify areas of potential entrapment. He did not keep track of which residents had side rails or the different types of side rails used on the residents' beds. He was aware that	F0909	F 0909 Resident Bed Cont. 1. On 10/14/2026, Resident 13's "M-rail" was discontinued and removed by the Maintenance Director. 2. On 10/29/2026, the Maintenance Director discontinued and removed all "M-rails" that were being used. Only assist rails that are compatible with the specific model/manufacture will be used. 3. On 10/29/2026, the Director of Nursing met with the Maintenance Director and a resident list to include the type of bed, type of mattress, and type of rail was used if applicable. 4. On 10/29/2026, the Maintenance Director and and Maintenance Assistant completed monthly bed frame/electronic components/electrical cords and assist rail checks to ensure good working order to lessen the risk for entrapment. 5. On 10/29/2026, the Administrator and Maintenance Director reviewed the Bed Maintenance and Inspections and Proper Use of M-Rails policies. Change made to the Bed Maintenance and Inspection policy as follows: Only assist rials that are compatible with the specific model/manufacturer will be used. Changes made to the Proper Use of M-Rails policy as follows: removal of M-rails for use, addition of the use of assist rails can pose a potential risk for injury and/or death if not used or maintained properly and only assist rails that are compatible with the specific model/manufacturer will be used. 6. On 10/30/2026, the Housekeeping Director and Housekeeping Assistant completed monthly mattress checks to ensure good working order. 7. On 10/30/2026, the Administrator met with all Maintenance and Housekeeping staff to review the changes to the above listed policies. 8. The Activity Director will complete monthly spot checks to ensure the completion of monthly inspections of all bed frames, mattresses, and assist rails with proper follow-up if required and report these findings to the QAPI Committee monthly for 3 months then quarterly until the QAPI Committee advises otherwise.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0909 SS = E	Continued from page 30 some of the side rails attached to residents' beds were strapped to the bedframe rather than bolted to the bedframe, but he did not know which beds had side rails attached to them like that. He performed monthly "room checks" to see if any regular maintenance needed to be performed, but he did not specifically inspect the bed, mattress, bedframe, or side rails as part of a preventative maintenance program. 5. Observations throughout the facility on 10/8/26 at 11:05 a.m. revealed that there were at least three residents (13, 19, and 20) with "M-shaped" side rails that were strapped to the resident's bedframe rather than bolted to the bedframe. The excess straps were wrapped around the base of the side rails. 6. Interview on 10/8/26 at 2:28 p.m. with administrator A revealed that they did not have the manufacturer's instructions for the "M-rails" to allow them to determine if they were compatible to use with the brand of bedframes they were attached to. 7. Review of the provider's revised 10/7/26 Bed Maintenance and Inspections policy revealed that, "It is the policy of the Eastern Star Home of South Dakota, Inc. to conduct regular inspections of all bed frames, mattresses, and any bed rails that may be in use, as part of a regular maintenance program to identify and avoid areas of possible entrapment." The procedures included: "1. The Maintenance Director and Housekeeping/Laundry Supervisor are responsible for keeping records of bed inspections and maintenance." "2. A list of bed frames, mattresses, and bed rails will be maintained, including the manufacturer for each. The Maintenance Director shall be notified of any new equipment brought into the facility." "3. The Maintenance Director shall review each manufacturer's recommendations and requirements for maintenance and bed inspections and shall establish a maintenance and inspection schedule accordingly with the assistance from the Housekeeping/Laundry Supervisor." "4. Bed rails shall be securely and properly installed." "5. When bed rails and mattresses are used and purchased separately from the bed frame, the facility will ensure that the bed rails, mattress, and bed frame are compatible." "6. Bed frame, mattress, and bed rail inspections will be conducted upon each item entering the facility and then placed on a regularly scheduled inspection and maintenance cycle." 8. Review of the provider's owner's manual for the	F0909	F 0909 Resident Bed Cont Addendum 11/10/2026: 9. On 11/2/2026 and 11/3/2026, the Administrator and Director of Nursing held a mandatory staff meeting to discuss the reason for the discontinuation of M-rails and re-educated the risk for entrapment when assist rails are in use, reason for use or discontinuation of an assist rail, and notification process if assist rail is desired or needs to be discontinued.	11/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0909 SS = E	Continued from page 31 Direct Supply Panacea 1750 & 2000 Adjustable-Height Low Bed revealed that the warnings included, “WARNING: Possible Injury or Death. Use a properly sized mattress in order to minimize the gap between the side of mattress and assist device. The gap must be small enough to prevent resident/patient from getting his/her head or neck caught in this location. Make sure that raising or lowering bed or contouring the sleep surface does not create any hazardous gaps. Excessive gaps may result in injury or death.” “WARNING: Possible Injury or Death. Do not use Panacea assist device until you verify it is designed specifically for [your] Panacea bed and it is locked in place. Failure to lock assist devices may result in injury or death.” “WARNING: Possible Injury or Death. If using accessories not manufactured, marketed or provided by Direct Supply Panacea for Direct Supply Panacea beds, consult with the manufacturer for compatibility and limitations prior to use. Failure to do so may result in injury or death.” 9. Review of the provider’s owner’s manual for Siderails and Assist Devices for Direct Supply Panacea 1000 Adjustable-Height Low Beds revealed that the warnings included, “WARNING: Risk of Serious Injury or Death. These products are intended only for use with the Direct Supply Panacea 1000 Adjustable-Height Low Bed. Never use these products on any other bed; the use of this product with any other bed could result in an unproven or unsafe configuration, potentially resulting in serious injury or death.”	F0909		
F0637 SS = D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is NOT MET as evidenced by:	F0637	F 0637 Comprehensive Assessment After Significant Chg It is the responsibility of the facility to complete and submit a Comprehensive Assessment within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition (decline or improvement), the following has been completed to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0637 SS = D	Continued from page 32 Based on record review, interview, Long-Term Care (LTC) Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 October 2025, and version 1.20.11 October 2026, the provider failed to complete a Significant Change in Status Assessment (SCSA) for one of one of sampled residents (13) who experienced a significant change in status related to an overall health decline, weight loss and developing a pressure ulcer (skin and/or underlying tissue injury from prolonged pressure). Findings include: 1. Review of resident 13's medical record revealed an 8/27/26 nurse's note indicating, "Resident has had overall decline in condition with decreased oral intake and refusing to take scheduled [medications]." A 9/2/26 nurse's note indicated, "This RN [registered nurse] and [resident's primary care physician (PCP)] met with resident's [family members] in regards to [the resident's overall] decline in condition. …The [family's] main request is that [the] resident remain comfortable and at this time both the family and [resident's PCP] are in agreement that resident does not exhibit any pain. In the future, [the] family also does not wish to have resident transferred to the hospital for end of life care…" On 9/5/26, the staff identified resident 13 had a stage III (3; open wound with full-thickness skin loss and fatty tissue may be visible) pressure ulcer on his right buttock. A 9/16/26 nurse's note indicated, "…Prior to seeing resident this RN verbalized that resident continues to decline along with his weight. Resident has a wound on his toe and now his buttocks…" A 9/30/26 dietary care plan (personalized plan that addresses a resident's care needs, goals, and interventions) item note indicated resident 13 had a 10-pound weight loss, which was a 5.3% (percent) loss within the past month. His physician was notified of his significant weight loss and decline in status. The note included nutrition interventions to address his weight loss and skin wounds. His completed Minimum Data Set (MDS; a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) assessments included a comprehensive assessment with an assessment reference date (ARD) of 4/6/26, a quarterly assessment with an ARD of 7/6/26, a discharge record with an ARD of	F0637	F 0637 Comprehensive Assessment After Significant Chg Cont. 1.On 10/29/2026, the Administrator met with MDS RN/Coordinator and reviewed the MDS Completion policy. Updated the policy to include: Notification MUST be given to the MDS RN/Coordinator via facility's "Stop and Watch" forms when the following occurs: implementation of catheter, noted weight loss or gain, increase or decrease in assistance with ADLs, end of life status, charting the verbiage "decline in status/function or improvement in status/function", and new/ change/completion of any wound statuses." 2.On 11/2/2026 and 11/3/2026, the Administrator and Director of Nursing met with all RNs/LPNs, Medication Aides, and CNAs and reviewed the updated MDS Completion policy. 3.The Director of Nursing will be responsible for completing 1 weekly spot check to ensure that the MDS RN/Coordinator completes the MDS submissions required for a significant change if indicated and will report these findings to the QAPI Committee monthly for 3 months then quarterly until the QAPI Committee advises otherwise. Addendum 11/10/2026 4. MDS RN/Coordinator will be using her assessments, weekly verbal conversations with charge nurses, and received "Stop and Watch" forms to identify other potential residents who are experiencing a significant change. Since 11/06/2026, one other resident has been identified and a significant change MDS submission is in process.	11/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0637 SS = D	Continued from page 33 7/27/26, an entry tracking record with an entry date of 7/31/26, and a quarterly assessment with an ARD of 9/28/26. There were no SCSAs completed for resident 13 within the past 12 months. 2. Interview on 10/7/26 at 12:54 p.m. with certified nursing assistant (CNA) P revealed that resident 13 had a significant decline in his health lately. He was not eating as much anymore and experienced some weight loss. He was completely dependent on the staff for all activities of daily living (ADLs; basic self-care tasks like eating, dressing, bathing, and moving around), he was becoming nonverbal, and he had skin wounds. 3. Interview on 10/8/26 at 3:18 p.m. with MDS nurse/infection preventionist (IP)/wound nurse C revealed that she was responsible for completing the resident's MDS assessments. For SCSAs, the resident must have a decline in at least two areas, such as weight changes, cognition, and wounds. She acknowledged that resident 13 had a significant decline in his overall health status and agreed that a SCSA should have been completed for that resident. She did not know why she did not identify that the resident experienced a significant change in condition and met the criteria to initiate a SCSA for resident 13. 4. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, version 1.20.1, October 2025, revealed that, "A 'significant change' is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered 'self-limiting'; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan." "An SCSA is appropriate when: -There is a determination that a significant change (either improvement or decline) in a resident's condition from their baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and -The resident's condition is not expected to return to baseline within two weeks…" 5. Review of the updated Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, version 1.20.11, October 2026 revealed the same SCSA criteria.	F0637		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0637 SS = D	Continued from page 34 6. Review of the provider's undated MINIMUM DATA SET (MDS) COORDINATOR~JOB DESCRIPTION revealed, "The purpose of this position is to coordinate and oversee all functions of the MDS and resident care assessment process to assure compliance with federal and state regulations and to certify timely completion of MDS assessments." Responsibilities included, "Assume accountability and responsibility for accuracy of MDS assessment information," and "Comply with all federal and state regulations when completing the MDS assessment."	F0637		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F0880	F 0880 Infection Prevention & Control It is the responsibility of the facility to ensure the staff follow infection prevention and control practices regarding hand hygiene and proper glove use to prevent the development and transmission of communicable diseases and infections. The following was implemented to ensure compliance. 1. On 10/30/2026, the Administrator met with the Director of Nursing and reviewed the Hand Hygiene, Clean Dressing Change, and Gastrostomy Site Care policies. No revisions made to these policies. 2. On 11/2/2026 and 11/3/2026, the Administrator and Director of Nursing held a mandatory all staff meeting to review the facility's Hand Hygiene, Clean Dressing Change, and Gastrostomy Site Care policies. All staff were re-educated on hand hygiene and proper glove use to prevent the development and transmission of communicable diseases and infections. 3. The MDS RN/Coordinator will be responsible for completing twice weekly spot checks to ensure compliance with hand hygiene and proper glove use. The MDS RN/Coordinator will report these findings to the QAPI Committee monthly for 3 months then quarterly until the QAPI Committee advises otherwise.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0880 SS = D	Continued from page 35 (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. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure the staff followed infection prevention and control practices regarding hand hygiene (handwashing or hand sanitizer use), and glove use for one of one sampled resident's (15) observed wound and personal cares and one of one sampled resident's (27) observed percutaneous endoscopic gastrostomy (PEG) tube (a tube surgically placed through the abdomen into the stomach to administer liquid nutrition, fluids, and medications) care and medication administration completed by one of one licensed practical nurse (LPN) F.	F0880	F 0880 Infection Prevention & Control Addendum 11/10/2026 4. Please note that these spot checks to ensure compliance with hand hygiene and proper glove use will be completed visually by the MDS RN/Coordinator and spot checks will be completed randomly ensuring compliance with all three scheduled shifts.	11/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0880 SS = D	Continued from page 36 Findings include: 1. Observation on 10/7/26 at 10:23 a.m. of LPN F and certified nursing assistant (CNA) I revealed that LPN F and CNA I performed hand hygiene, entered resident 15's room, and both put on a gown and a pair of gloves. Resident 15 was lying in bed. CNA I rolled resident 15 onto her left side while LPN F placed a tissue paper from the bedside stand onto the head of the bed. She opened a package of gauze and set it on the tissue paper. She then opened a package that contained a square film and a wound dressing with an adhesive border and placed them on the tissue paper. LPN F unfastened resident 15's incontinence (involuntary urine or bowel leakage) brief, and exposed resident 15's pressure ulcer (skin and/or underlying tissue injury from prolonged pressure) on her coccyx (tailbone). There was no dressing covering the pressure ulcer. LPN F stated that resident 15 had a bowel movement and her brief needed to be changed. LPN F went into the resident's bathroom and returned to the bedside with disposable wipes. LPN provided personal cares for resident 15 with those disposable wipes, removed the soiled brief, and placed the brief in the trash can. With those same gloved hands, LPN F opened resident 15's closet, took a clean brief from the closet, unfolded the brief, and placed the brief on the bed behind resident 15. LPN F removed her soiled gloves, disposed of them in the trash can, did not perform hand hygiene, and put on a clean pair of gloves. LPN F picked up a bottle of wound cleanser from resident 15's bedside table and cleaned the wound with the cleanser and a piece of gauze that was on the tissue on the head of the bed. With those same gloved hands, she picked up the square film that was on the tissue paper and placed it on resident 15's pressure ulcer. She picked up the dressing with the adhesive border that was on the tissue paper and covered the square film with it. LPN F and CNA I rolled resident 15 onto her back, fastened the brief, positioned resident 15 on her left side with a pillow placed behind her back, and covered her with blankets. LPN F and CNA I removed their gowns and gloves, placed them in the trash can, and performed hand hygiene. 2. Observation on 10/7/26 at 2:14 p.m. of LPN F administering medications through resident 27's PEG tube revealed that LPN F entered resident 27's room with the medications she had prepared at the	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0880 SS = D	Continued from page 37 medication cart and placed it on a rolling bedside table that she rolled into resident 27's room. She performed hand hygiene and put on a gown and a pair of gloves. Using the bed controls, she raised the bed to waist height. LPN F lowered resident 27's blankets and lifted the resident's shirt to expose her PEG tube. LPN F removed the gauze from around the PEG tube and placed that in the trash can. With those same gloved hands, she took a tube of cream from the bedside table drawer, squeezed some cream onto her gloved fingertips, and wiped the cream on resident 27's skin around her PEG tube site. With those same gloved hands, she picked up a package of gauze from the rolling bedside table, opened the package, and placed the clean gauze around resident 27's PEG tube site. LPN F removed a roll of tape from the bedside table and taped the gauze together around the PEG tube. LPN F removed her gloves and placed them in the trash can, put the roll of tape in resident 27's closet, and without performing hand hygiene, put on a clean pair of gloves. She attached a syringe to resident 27's PEG tube and pushed air into the PEG tube while listening over resident 27's stomach. With the same syringe, LPN F withdrew a light tan liquid from the PEG tube and pushed it back into the PEG tube. She removed the syringe from the PEG tube, took the plunger out of the syringe, and reattached the syringe to the PEG tube. She picked up a glass of water from the rolling bedside table and poured water into the syringe. After the water emptied from the syringe, she picked up the glass of medications that were dissolved in water and poured them into the syringe. After the medications emptied from the syringe, she poured more water from the glass into the syringe. She picked up a glass of Diet Coke (soda) that was on the rolling bedside table and poured it into resident 27's PEG tube. After the Diet Coke emptied from the syringe, she detached the syringe from the PEG tube, capped the end of the PEG tube, lowered resident 27's shirt, and covered her with blankets. LPN F removed her gown and gloves and placed them in the trash can, did not perform hand hygiene, and used the bed controls to lower the bed to the low position. With her bare hands, she took the trash bag out from the trash can, replaced the trash liner, and exited the room. She disposed of the trash bag in a trash can in the soiled utility room and performed hand hygiene.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE POST OFFICE BOX 150, REDFIELD, South Dakota, 57469**

(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
F0880 SS = D	Continued from page 38 3. Interview on 10/7/26 at 2:35 p.m. with LPN F revealed that she was supposed to remove her gloves, discard them, perform hand hygiene, and put on a new pair of gloves after she completed a care task that required glove use and before she began another similar task. She acknowledged she went into the closer, got a clean brief, and placed it under resident 15 without following those steps. She cleansed resident 15's wound and did not follow those steps before she applied the clean dressing. She acknowledged she missed hand hygiene opportunities after she removed her soiled gloves and before she put on a clean pair of gloves. She acknowledged that she removed resident 27's PEG tube dressing, applied cream around the PEG tube, and put on a clean dressing without changing her gloves or performing hand hygiene. She did not think of the gauze around resident 27's PEG tube as a dressing change, so she did not change her gloves, but acknowledged that she should have. 4. Interview on 10/8/26 at 1:04 p.m. with Minimum Data Set (MDS) nurse/infection preventionist (IP)/wound nurse C revealed that she expected the staff to wear gloves while changing a resident's dressing and to perform hand hygiene when they entered a resident's room, before exiting the room, after removing their gloves, and before putting on a new pair of gloves. 5. Interview on 10/8/26 at 1:38 p.m. with director of nursing (DON) B revealed that she expected the staff to remove their gloves, discard them, and perform hand hygiene before putting on a new pair of gloves. 6. Review of the provider's 1/7/26 Hand Hygiene policy revealed, "All staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors." "The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning [putting on] gloves and immediately after removing gloves." 7. Review of the provider's 1/7/26 Personal Protective Equipment policy revealed, "Change gloves and perform hand hygiene between clean and dirty tasks, when moving from one body part to another, when heavily contaminated or when torn."	F0880		