STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435066	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA PRINCE OF PEACE	4513 SOUTH PRINCE OF PEACE PLACE , SIOUX FALLS, South Dakota, 57103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/18/25 through 8/21/25. Avera Prince of Peace was found not in compliance with the following requirements: F565, F583, F600, F605, F641, F759, F761, F812, F880.	F0000		
F0565 SS = E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups.	F0565	The Supervisor-Social Work or designee will review the grievance policy with all residents during their next resident council meeting to ensure awareness of the process and know who is the Prince of Peace Grievance Official. They will also review our new resident council process and agenda while offering all residents the opportunity to be heard and understood. The Administrator met with the Supervisor-Social Work and the Social Workers who conduct the resident council meetings in each neighborhood. We revised our current resident council process, agenda form and included guidlines and actions steps to help ensure timely follow-up to all concerns. The Administrator, in collaboration with the Supervisor-Social Work or designee, will monitor resident council meeting minutes and follow-up on cocerns or grievances weekly for 12-weeks to ensure they are being followed-up timely and reported back to the resident council. Results will be brought to QAPI for review and that group will guide further audits 10/04/2025	10/04/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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
Patrick Berry, LNHA	Director-Nursing Home Admin	09/19/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435066	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

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F0565 SS = E	Continued from page 1 §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on resident council meeting, resident council meeting minutes review, and interview, the provider failed to provide resource information and prompt resolution to residents' requests and concerns voiced in resident council meetings that were to the residents' satisfaction. Findings include: 1. A resident council meeting on 8/21/25 at 11:15 a.m. was attended by twelve nursing home residents and revealed: *No residents in attendance were able to name the facility grievance official. *One resident stated she would talk to a nurse if she had a grievance. *Ten of the twelve residents expressed concern and fear of turning on call lights at night due to receiving negative responses from the certified nursing assistants (CNAs). *All residents expressed that it could take a long time for a staff member to respond to a call light and that at times: -The CNAs would turn the resident's call light off and tell the resident they would return, but did not. -Some CNAs will turn the call light off and leave without saying anything at all. -The CNAs would express anger with the residents through their tone of voice, “snapping” at them, complaining that they had turned their call light on again, and used aggressive actions with equipment and doors. -Several residents felt humiliated by needing to ask for help when the CNAs were upset when they responded to the residents' call lights. -A resident stated she had been incontinent because	F0565		

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F0565 SS = E	Continued from page 2 staff had taken so long to respond to her call light. -A resident stated that he suffered pain from needing to use the restroom when he had waited 15 minutes or longer to get assistance from a staff member. -A resident complained of having waited a long time for staff assistance in the morning. If the resident's call light was on at 7:30, the resident worried if he would get assistance and be able to make it to breakfast by 9:00 a.m. 2. Review of the provider's resident council minutes from April 21, 2025, for the second floor neighborhoods revealed: *Four residents were in attendance. *Unresolved concerns from previous months included: -Catheter bins (small tub that holds a urine collection bag) were being left in the middle of residents' rooms. -Some residents wanted to know how often the sheets were washed/changed. Management responded that housekeeping staff were to change the bedding changes beds twice per month. Residents had determined the issue was unresolved. 3. Review of the provider's resident council minutes from May 19, 2025, for the second floor neighborhoods revealed: *Five residents were in attendance. *New business included: -Residents reported extended wait times for their call lights to be answered. -Staff members would turn off the residents' lights, say they would be right back and did not come back, or leave without saying anything at all. *Items listed as unresolved from previous months included: -Residents wanted to know when their sheets were washed. This was noted as "waiting on management response." -Residents would like their windows washed. This was noted as "waiting on management response."	F0565		

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F0565 SS = E	Continued from page 3 -Catheter bins were left in the middle of residents' rooms. -Residents stated beds were not being made. *Management's response to resident council items in the minutes revealed: -"The cath [catheter] bins have been a complaint x [for] 3 months. I have spoken to them … will address this issue again this month. -Will also mention the call light response times." 4. Review of the provider's resident council minutes from June 16, 2025, for the second floor neighborhoods revealed: *Eight residents were in attendance. *Unresolved items from previous months again included: -Catheter bins were being left in the middle of resident rooms. -Residents' beds were not being made. -Call lights were turned off and staff told the residents they will be right back, never come back or they left without saying anything. 5. Review of the provider's resident council minutes from July 21, 2025 revealed: *Four residents were in attendance. *No old, resolved, or unresolved items from previous meetings were noted in the minutes. 6. Interview on 8/21/25 at 12:00 p.m. with Social Services Designee (SWD) F revealed: *She thought the residents knew to come to the social services staff if they needed something. *She had not discussed the grievance process or grievance official at resident council meetings. *She had not invited the area ombudsman (an advocate of residents' overall quality of care and rights) to a resident council meeting. *Grievances were filled out by social services staff and then given to assistant director of nursing (ADON)	F0565		

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F0565 SS = E	Continued from page 4 for resolution. *Resident council issues were given to the head of the department that the issue was related to for response. *She did not know how she could help initiate any resolution to they ongoing issues beyond the department leader response.	F0565		
F0583 SS = E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the	F0583	Unfortunately, we are not able to retroactively change that computers with resident information visible were left unattended. The Avera Health Privacy Officer was notified of the survey findings related to F583 on 9/17/25. They recommended education on safeguarding patient health information (PHI) as a follow-up action. This policy is a system standard policy that is reviewed per Avera Health guidelines and is up to date. Education will be provided to all staff at educational inservices between 9/29/25 and 10/3/25. The education will include the safeguarding PHI policy and specific instructions for how to lock the computer when not attended will be given. The Director of Nursing, or Designee, will audit 5 staff per week for 8 weeks to ensure computers that are logged into the EMR with resident information visible are not left unattended. These results will be brought to the QAPI committee and that group will guide further audits. 10	10/04/2025

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F0583 SS = E	Continued from page 5 provider failed to ensure resident personal and medical records remained secure and confidential in four of six observed resident neighborhoods (Bluegrass Way, Platinum Ridge, Boulder Creek, and Arrowhead Trail). Findings include: 1. Observation on 8/19/25 at 8:11 a.m. in the Boulder Creek hallway outside resident 129's room revealed: *Resident 129's door to her room was closed. *There was a computer on a rolling stand outside resident 129's room. *The computer screen was open with residents' medical information visible on the screen. *The computer screen indicated certified medication aide (CMA) M was logged into the computer. *There were no staff within eyesight of that computer. *CMA M exited resident 129's room and pushed the cart the computer was on down the hallway with the screen still open. 2. Observation on 8/20/25 at 11:08 a.m. in the Arrowhead Trail hallway outside resident 12's room revealed: *There was a computer on a rolling stand in resident 12's room facing the hallway with the computer screen open. *There were no staff within eyesight of that computer. *Residents' medical information was visible on the computer screen. *Which staff member was logged into the computer at that time was not visible. 3. Observation on 8/20/25 at 8:11 a.m. in the Boulder Creek hallway outside of residents 59 and 13's room revealed: *There was a computer on a rolling stand outside of resident 59 and 13's room. *The computer screen was open with residents' medical information visible on the screen.	F0583		

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F0583 SS = E	Continued from page 6 *Which staff member was logged into the computer at that time was not visible. *There were no staff present in the hallway. 4. Observation on 8/20/25 of the Platinum nurses' station revealed: *At 8:45 a.m. certified nursing assistant (CNA) N pushed a rolling computer stand behind the nurses' station with the screen up that showed the resident status board, which contained resident information, and then walked out of the nurse's station. The screen had been visible from the hallway. *At 8:46 a.m., she came back to the computer and left it open at 8:48 a.m. when she again left the nurses' station. The screen had been visible from the hallway. 5. Observation on 08/20/25 9:32 AM in resident 76's room revealed: *There was a computer on a rolling stand inside the residents' room by the medication cupboard. *The computer screen was open with the resident's medical information on it. *Which staff member was logged into the computer at that time was not visible. *There were no staff present inside or near the residents' room. 6. Observation on 8/20/25 at 11:30 a.m. of the nurses' station on the Rehab unit revealed: *There were 2 computer screens open to patient status boards, with visible resident information. *The screens were able to be visualized from the hallway. *Which staff member was logged into the computer at that time was not visible. *There were no staff present near the nurses' station. 7. Observation on 08/20/2025 2:09 p.m. in the Blue Grass Way hallway revealed:	F0583		

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F0583 SS = E	Continued from page 7 *There was a computer screen on a rolling stand near the staff bathroom. *The computer screen was open and displayed resident 4's medications. *Which staff member was logged into the computer at that time was not visible. *There were no staff present in the hallway. 8. Interview on 8/20/25 at 11:55 a.m. with licensed practical nurse (LPN) Z revealed the computer screens should have been closed and locked to protect the residents' private information when staff were not present. 9. Interview on 8/21/25 at 10:50 a.m. with registered nurse (RN) coordinator I revealed: *She expected the screens to be closed when staff were not present. *She indicated she would report to the health insurance portability and accountability act (HIPPA) compliance manager (a person who oversees protecting residents' private health information) if she was made aware that someone gained private resident information that they should not have. 10. Interview on 8/21/25 at 3:38 p.m. with director of nursing (DON) B revealed he expected the residents' private health information to be protected by the staff members. 11. Review of the providers' 1/2023 safeguarding PHI (public health information) policy revealed: *"The purpose of the policy was to provide guidelines to protect PHI and to limit disclosure, intentionally or unintentionally, to unauthorized persons. Also, to ensure the provider entities have appropriate …physical safeguards to protect PHI. *Office Equipment Safeguards for computer access: 1. Only staff members who need to use computers to accomplish work-related tasks shall have access to computer workstations or terminals. 2. All users of computer equipment must have unique login and passwords.	F0583		

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F0583 SS = E	Continued from page 8 3. Access to computer-based PHI shall be limited to staff members who need the information for treatment…. 4. Facility staff members shall log off or lock their workstation when leaving the work area. 5. Computer monitors shall be positioned so that unauthorized persons cannot easily view information on the screen. …7. Employees will immediately report any violations of this policy to their supervisor, administrator, or the Privacy Office, or designee….”	F0583		
F0600 SS = E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on resident council meeting response, subsequent individual interviews, resident complaint/grievance reports, and policy review the provider failed to ensure residents were kept free from neglect as it related to ten of twelve residents who attended resident council on 8/21/25, in addition to 11 of 11 sampled residents (2, 44, 51, 61, 66, 73, 77, 79, 91, 108, and 126) who communicated complaints of long staff response times to call lights, which left the residents feeling humiliated, fearful, and in pain. Findings include: 1. A resident council meeting on 8/21/25 at 11:15 a.m. with twelve nursing home residents from long term care revealed:	F0600	Each specific incident noted was addressed timely with the resident prior to the Department of Health Survey. Social Services will have a follow-up conversation with each resident noted and, if the resident wishes, will resubmit a complaint into the facilities complaint/ grievance system. The IDT team has begun meeting each business day to discuss open complaints and track the investigation. This results in complete documentation of the investigation and resolution of that complaint. Trends noted in the complaints will be reported to the facility's QAPI committee for further review. Nursing staff will be re-educated on the abuse and neglect policies. Education will also include the importance of answering call lights promptly and following up on resident concerns. Education will take place at educational inservice meetings between 9/29/25 and 10/3/25. Average call light response times will be reviewed for each area on a weekly basis by the Director of Nursing, or designee. Average call light response time data will be reported to the QAPI committee, as well, at their monthly meeting. Director of Nursing, or designee, will round with 3 residents each week to inquire about their care and any complaints they may have. The rounds will be documented and any trends will be reported at the monthly QAPI meeting. The Director of Nursing, or designee, will audit 3 complaints per week for 8 weeks to ensure complete documentation of investigation and complaint resolution	10/04/2025

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F0600 SS = E	Continued from page 9 *Ten of twelve residents in attendance expressed concern and fear of turning on call lights at night due to receiving negative response from the certified nursing assistants CNAs. *All residents expressed that it could take a long time to get a response to a call light: -A long time was described by them as 30 minutes or longer. -They stated that the CNAs would turn off the call light and tell the resident they will return but do not. -Some CNAs would turn off the call light and leave, but did not say anything at all. -The CNAs would be angry with them for turning on the call light, and expressed that through their tone of voice, “snapping” at them, and by using aggressive actions with equipment and doors. -Several residents expressed that they felt humiliated by needing to ask for help when they knew the CNAs were busy. -A resident stated they had been incontinent due to the wait for call light response. -A resident expressed that he suffered pain from needing to use the restroom when he had to wait 15 minutes or longer to get assistance. -A resident stated that they had to wait a long time in the morning, and that if they put their call light on at 7:30, they still had to worry if they would get assistance and be able to get out for breakfast by 9. 2. Review of provider's resident council minutes from May 19, 2025 for the second floor neighborhoods revealed: *Five residents were in attendance. *New business included: -Residents reported extended wait times for someone to answer their call light. -Staff told the residents they would be right back and never come back, or they just left and didn’t say	F0600		

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F0600 SS = E	Continued from page 10 anything at all. *Items listed as unresolved from previous months: -Residents were waiting a long time for someone to answer their call light. -Staff told residents they would be right back and don't return, or they would turn and leave and not say anything at all. *Leadership response to resident council items in the minutes revealed: -"Will mention the call light response times." 3. Review of provider's resident council minutes from June 16, 2025 for the second floor neighborhoods revealed: *Unresolved items from previous months: -Call lights: Staff tell residents they would be right back and never come back or they just left and didn't say anything. 4. Interview on 8/21/25 at 12:00 p.m. with Social Worker Designee (SWD) F revealed: *Resident council issues were sent to the head of the responsible department for response. *She did not know how she could help initiate any resolution to ongoing issues beyond the department leader response. 5. Interview on 8/21/25 at 11:10 a.m. with Director of Nursing (DON) B revealed he expected the staff to answer call lights ideally within 5 minutes, but he felt 10 minutes would be understandable due to staff duties. 6. Interview on 8/21/25 at 1:13 p.m. with DON B and Assistant Director of Nursing (ADON) C regarding resident concerns documented in the resident council meeting minutes and voiced during the 8/21/25 resident council revealed: *ADON C stated that the residents should never be afraid to turn on their call lights or ask for	F0600		

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F0600 SS = E	Continued from page 11 assistance in any way as that is what the staff are there for. *DON B stated that CNAs may have to tell a resident that they know they need assistance but the CNA may have to help with another task first, and then the CNA was expected to return to assist the resident. *In response to whether they have enough staff, both DON B and ADON C stated that there are busier times, especially in the morning, and they had been trying different activities such as delegating particular duties during the night staff/day staff overlap from 6:00 a.m. to 6:30 a.m. *DON B expressed that she would never want the residents to be afraid to use their call light or to feel bad about it, and residents should be treated with respect. 7. Interview on 8/21/25 at 1:20 p.m. with Administrator A revealed that he would expect call light answer times to average 10 minutes. He would not want residents to be hesitant or afraid to use their call lights. 8. Interview with resident 91 on 8/19/25 at 8:14 a.m. and on 8/21/25 at 2:02 p.m. revealed: *He felt some staff did not treat him with respect. *There were two CNAs he felt were rough with him. He was unsure of their names. *He identified CNA CC as always being in a hurry and rough with him at times. *He reported his complaints to a nurse, he was unsure of her name, and he was told she would look into it. *He felt that the staff took too long to answer his call light at times, and the call light wait times were typically longer in the morning. *It hurt him when staff were rough with him. He stated that made him feel sad and upset. *He filed a complaint on 4/17/25, resident 91 reported to SWD F during his care conference that he received rushed care from a CNA during his shower, that the CNA kept looking at her watch. -The specific staff member was not clearly identified	F0600		

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F0600 SS = E	Continued from page 12 in the report. -ADON C followed up with the CNA about not making the residents feel rushed during assisting with their care needs. *The call light audit from 8/14/25-8/21/25 for resident 91 revealed he had waited for staff to respond to his call light for over 10 minutes: -On 8/16/25 at 3:01 p.m. his call light was on for 11 minutes and 37 seconds -On 8/18/25 at 6:07 a.m. his call light was on for 11 minutes and 3 seconds -On 8/18/25 at 3:30 p.m. his call light was on for 13 minutes and 29 seconds -On 8/19/25 at 7:31 a.m. his call light was on for 13 minutes and 55 seconds -On 8/19/25 at 7:13 p.m. his call light was on for 12 minutes and 35 seconds. 9. Interviews with resident 126 on 8/19/25 9:19 a.m. and on 8/21/25 at 2:06 p.m. revealed: *He felt some staff did not treat him with respect. *He felt staff took too long to answer his call light at times. *Last week, he had to hold his bowels while waiting for staff assistance. When a CNA came to help him to the bathroom, he was not able to have a bowel movement. -A while later he turned his call light on again to use the bathroom and the CNA “screamed” at him and said she was not going to take him in there anymore since he did not go to the bathroom earlier. -He relied on staff to help him to the bathroom as he was physically unable to do that independently. -His eyes teared up when he described that incident. *When he had to wait for long periods for staff assistance to the bathroom, he was incontinent of his bladder at times. *He felt the staff did not keep him dry from urine.	F0600		

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F0600 SS = E	Continued from page 13 -He had a rash in his groin due to his incontinence. -He had an open sore on his buttocks, which had healed, and he stated he wanted to stay dry to keep it healed. -He felt the CNAs did not clean his skin after he was incontinent. *He reported he told both registered nurse (RN) I and social worker designee (SWD) F about the CNA yelling at him. He was unable to identify the CNA. *He felt that sometimes his complaints were ignored. *He had acquired bruising to his hands from bumping the doorway when certain CNAs brought him to the bathroom while using the stand aid lift (a mechanical lift used to assist from a seated to a standing position) *He had been “stewing” over and thinking about the incident where he was yelled at, often. *He liked to be positive and kind and wished he would be treated that way. *He would not turn his call light on sometimes when certain staff are working. *He filed complaints: -On 7/21/25 he reported to SWD F during a resident council meeting that he had bruises to his hands from hitting his hands on the frame of his bathroom when he was brought to the bathroom using a stand aid lift. Bruising was noted on his hands and arms. When ADON C asked the CNAs, they reported the stand aid lift was difficult to maneuver, and a maintenance report had been filed by ADON C, but the CNAs reported it had not been fixed. -Specific staff were not identified in the report. -ADON C made a note that she would provide staff education and follow up with maintenance. -On 8/18/25 he reported two concerns to SWD F. -The first concern was regarding that his hands had continued to be bumped on the frame to his bathroom when being transferred while using the stand aid lift. -Staff were not identified in the report -ADON C documented that she would educate staff	F0600		

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F0600 SS = E	Continued from page 14 regarding the use of the stand aid lift and she would follow up with maintenance. -The second concern was regarding that he had waited 15 minutes to use the bathroom and when he could not go a staff member yelled at him and told him she would never bring him to the bathroom again. He reported she was rude and he felt ashamed. -Staff were not identified in the report. -ADON C documented that she had educated the staff member about treating residents with dignity and respect. She talked to the resident about it and thought he was okay with the resolution. *The call light audit from 8/14/25-8/21/25 revealed he had waited for staff to respond to his call light for over 10 minutes: -On 8/14/25 at 6:12 p.m. his call light was on for 23 minutes and 54 seconds. -On 8/15/25 at 7:58 a.m. his call light was on for 18 minutes and 2 seconds. -On 8/16/25 at 6:39 a.m. his call light was on for 12 minutes and 19 seconds. -On 8/19/25 at 6:21 p.m. his call light was on for 12 minutes and 40 seconds. -On 8/20/25 at 8:59 a.m. his call light was on for 12 minutes and 8 seconds. -On 8/20/25 at 12:16 p.m. his call light was on for 2 minutes and 23 seconds. 10. Interview on 8/19/25 at 4:30 p.m. and on 8/21/25 at 2:24 p.m. with resident 61 revealed: *She had a CNA take care of her, who she felt was very rude to her. *She had to wait for long periods of time for the staff to answer her call light. *A staff member had told her that staff had 20 minutes after she put her call light on to help her. *When she had to wait for help to use the bathroom, she sometimes wet her pants.	F0600		

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F0600 SS = E	Continued from page 15 *If she had to wait a long time for assistance, she sometimes transferred herself to her recliner because her legs hurt when sitting in her wheelchair, and elevating them in her recliner helped to relieve the pain. She had transferred herself to the toilet so she would not wet her pants, even though she knew she was supposed to wait for help because she fell and broke her leg in the past. *She felt bad that she needed to turn her call light on for help when the facility was short-staffed. *She stated it hurt her feelings when the CNA was rude to her, because she thought if she was treated that way, other residents must have been treated that way. *She had filed a complaint : -On 4/17/25, the resident reported to SWD F during her care conference that she received care that was rough and rude from a CNA and the CNA pushed her up to the wall, told her to “stand up” and asked her why she couldn’t pull her own pants up. -Staff were not clearly identified in the report. -ADON C documented that she followed up with the staff member about the expectation of professionalism and coached her on communication with residents. -On 5/19/25 the resident reported to SWD F that she was left in her recliner for 12 hours and had been soaked in urine. She said the staff were not kind to her and did not want to take care of her. -Staff were not identified in the report. -ADON C documented that she talked with the resident, and the complaint was resolved. -The report did not include any other information about the investigation. *The call light audit from 8/14/25-8/21/25 revealed she had waited for staff to respond to her call light for over 10 minutes: -On 8/17/25 at 5:08 a.m. her call light was on for 11 minutes and 44 seconds. -On 8/17/25 at 6:58 a.m. her call light was on for 30 minutes and 45 seconds. -On 8/17/25 at 8:47 a.m. her call light was on for 20	F0600		

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F0600 SS = E	Continued from page 16 minutes and 37 seconds. -On 8/18/25 at 6:28 a.m. her call light was on for 24 minutes and 1 second. -On 8/19/25 at 7:59 a.m. her call light was on for 19 minutes and 27 seconds. -On 8/19/25 at 8:54 a.m. her call light was on for 15 minutes and 27 seconds. -On 8/19/25 at 1:50 p.m. her call light was on for 21minutes and 46 seconds. 11. Review of the provider's Complaints and Grievances received related to call light times and reports of staff being rude and/or rough from 3/7/2025 through 8/18/2025, excluding the above residents, revealed: *On 3/7/25, a staff member reported to SWD F that resident 108 and a CNA were arguing about the cares the resident wanted. Another CNA went and yelled at resident 108 to listen and be nice to the other CNA. The staff member also reported that another CNA said that when she saw that resident's call light go off, she purposely ignored it. -Staff were not clearly identified in the report. -DON B documented that the corrective action taken had included coaching and counseling of staff by ADON C. *On 3/7/25 resident 44 reported to SWD F and a nursing coordinator, who was not identified in the report, that some CNAs were talking badly about a CNA who was leaving the facility. A CNA asked resident 44 if she was going to cry about it in a rude tone. The report indicated that resident 44 was upset and started crying. -Staff were not clearly identified in the report. -DON B documented that the social worker (SW) had followed up with the resident and the complaint was resolved. *On 3/24/25 resident 2 reported to ADON AA that a CNA was rude to her about various things that included warming up her burger, adding cheese, and asking for fresh ice water. -CNA slammed the resident's door and told her “no” she would not get her fresh ice water.	F0600		

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F0600 SS = E	Continued from page 17 -Staff were not clearly identified in the report. -ADON AA and the RN coordinator, who was not identified on the report, talked with resident 2 about the event, and the resident was tearful during that conversation. -ADON AA documented that education was provided to the CNA involved. *On 4/4/25, an activity assistant reported to SWD F that a CNA told resident 51 “You shush, or I'll take you back to your room.” -Staff were not clearly identified in the report. -ADON C documented that she had followed up with the staff member and coached the staff member. *On 4/21/25, a complaint was made to social work supervisor BB from a staff member that resident 73 was unable to participate in activities without her hearing aids, and when she requested staff to bring them, they did not. When she brought the resident back to her room after the activity, the resident had been incontinent of bowel. She told the staff, and they walked away. She turned the residents' call light on and left the unit. When she returned to the unit after an undisclosed amount of time, she noticed the call light was still on. -Staff were not clearly identified in the report. -ADON C documented she had educated the staff about encouraging resident 73 to wear her hearing aids. *On 5/5/25, a complaint was made to SWD F from resident 77’s family about numerous skin tears she had received, long call light times, rough care from a CNA, even after the resident’s physician had given an order for staff to be slow and gentle, and the family requested another staff member to care for her mother. -Staff were not clearly identified in the report. -ADON C documented that she provided education to all staff on all shifts and called and talked with the family about their concerns. *On 5/13/25 a complaint was made by resident 79’s family member to administrator A and ADON C regarding concerns of staff being rough while providing resident care, rude staff, and delaying assistance to use the bathroom, which resulted in the resident being	F0600		

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F0600 SS = E	Continued from page 18 incontinent. Another incident in that report stated resident 79 had spilled water, and a staff member had told her she would need to wait for more water until staff refilled water pitchers at the scheduled pass time. -Staff were not clearly identified in the report. -ADON C documented that she talked with the resident and the possible staff member who was working with her, but that was unclear if she was the staff member involved. ADON C educated staff on all shifts regarding expectations of resident care and how each person will be treated with dignity and respect. *On 7/11/25 a complaint was received from a staff member to SWD F that a CNA was heard yelling at resident 66, while the staff member was sitting at the nurses' station. The SWD F talked with the resident to find out what had happened. Resident 66 reported to SWD F that it was about dressing, and she did not pay attention to why because she did not appreciate being talked to in that way. The resident also reported that she asked the same CNA at lunch for help to use the bathroom and was told she could try it herself. The resident needed staff assistance with using the bathroom. -Staff were not clearly identified in the report. -ADON C documented that she interviewed all other staff who were working with that CNA that shift, and no one reported hearing any yelling, but the staff reported that the CNA had been rough with resident 66. ADON C followed up with the CNA and "stressed" the importance of helping residents and to be mindful of how she talked with residents, as it was sometimes perceived as harsh. 12. Interview with RN coordinator I on 8/21/25 at 1050 a.m. revealed: *When a resident had complaints about staff members, those complaints would go to SWD F, and an investigation would be completed. *She was aware of one resident with complaints of staff being rough when assisting the resident with transfers, and SWD F was looking into it. *She did not have a process for monitoring concerns of residents who resided on her assigned units.	F0600		

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F0600 SS = E	Continued from page 19 13. Interview on 8/21/25 at 11:42 a.m. with SWD F revealed: *When she received a complaint, she would fill out a report, and then ADON C would complete the follow-up for the complaint. *Education was last provided to all staff on residents' rights and abuse, dignity, and respect around May 15, 2025. 14. Interview on 8/21/25 at 2:14 p.m. with ADON C revealed: *Facility incident reports, which included grievances, were filled out electronically by staff, and she reviewed them. *If the incident involved a staff member and a resident, she would talk to both involved. *If the resident had complained about a staff member being rude or rough, she would visit with the resident to get a picture of what happened, if the resident could recall the incident. *If the staff member could be identified, she would talk to them about the incident or complaint. *She had received complaints about a staff member being rude and rough to residents. She explained she told the staff member to be mindful of what they say and how they say it. She thought it was due to a cultural difference. *She stated if there was evidence of verbal abuse, then she would involve DON B and the human resources (HR) department. *She reported some corrective action scenarios in the past related to rude and rough staff. *She stated she tried to be clear with staff that they were expected to treat the residents with dignity and respect, regardless of what type of day they were having themselves. *Education was completed annually regarding resident rights, dignity, and abuse. The last education was completed in May 2025. *She reported she documented on the complaints and	F0600		

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F0600 SS = E	Continued from page 20 grievances report the outcomes of the investigations. *Regarding the 8/18/25 report about resident 126 having been yelled at by a staff member, ADON C identified certified medication aide (CMA) DD as being that staff member. -ADON C reported she told CMA DD she expected the staff to bring residents to the bathroom when they requested. She talked to CMA DD about her interaction with resident 126. ADON C stated she thought CMA DD's accent could sound rude. ADON C educated her CMA DD about treating residents with dignity and respect. She talked to resident 126 about the incident and thought he had been okay with the resolution. *Regarding the 5/19/25 filed incident report of resident 61's complaint, ADON C stated she investigated that complaint and was not able to substantiate that the resident had been left in her recliner for 12 hours. She verified she did not document that investigation in the report. *Regarding having 14 grievances in 6 months of residents being treated poorly, she stated that she looks for trends. *She stated she completed rounding (checking on residents' status and assistance needs) on the units daily and asked residents if there was anything she should know about. She stated she did not document this. *The resident council minutes were given to department coordinators, and she expected them to come up with solutions to the complaints and to update SWD F. *She stated she thought RN coordinator I was watching her assigned unit for some of the reported issues. Review of the provider's LTC abuse, neglect, mistreatment and misappropriation of resident property policy revised on 2/2025 revealed: *The term "abuse" included deprivation of goods and services and neglect. *The policy definition of abuse stated "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish". *Deprivation of goods and services definition was "the	F0600		

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F0600 SS = E	Continued from page 21 deprivation by staff of goods and services that are necessary to attain or maintain physical, mental, and psychosocial wellbeing." *Neglect was defined as "the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical pain harm, pain, mental anguish, or emotional distress." *"Residents will be protected from abuse, neglect, and harm while they are residing at the facility."	F0600		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints	F0605	A request for Gradual Dose Reduction (GDR), or clinical information for why one should not be completed, will be sent to Resident 129's primary care physician on or before 9/24/25. Consultant Pharmacist will request GDR per their usual process for all medications in a psychotropic class, regardless of indication for use. Education will be provided to nursing staff regarding gradual dose reductions for psychotropic medications at educational inservices held between 9/29/25 and 10/3/25. Director of Nursing, or designee, will audit 3 residents who take psychotropic medications per week for 8 weeks to ensure they had a GDR completed per regulation. Results will be reported to the facility QAPI committee and they will inform on further audits.	10/04/2025

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F0605 SS = D	Continued from page 22 imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an	F0605		

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F0605 SS = D	Continued from page 23 effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (129) who received psychotropic medications (any medication that affects brain activities associated with mental processes and behavior) had an attempted gradual dose reduction (systemic dose reduction over time to determine if the condition could be managed with a lower dose or discontinuation of the medication) (GDR) or a documented rationale to support that a GDR for those medications was clinically contraindicated (not appropriate based on the resident's condition, potential risks, or adverse effects) according to the provider's policy. Findings include: 1. Observation on 8/18/25 at 2:31 p.m. of resident 129 from the hallway revealed: *The lights in her room were off. *She was lying in bed on her left side with her eyes closed. *She had a urinary catheter (flexible tubing placed in the bladder to drain urine) bag hanging on the side of	F0605		

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F0605 SS = D	Continued from page 24 her bed. 2. Observation and interview on 8/18/25 at 4:18 p.m. with resident 129 in her room revealed she: *Was trying to read the newspaper but stated she could not because she did not have her glasses. *Stated the staff and the food were, “pretty good”. *Had no concerns. 3. Interview on 8/19/25 at 8:11 a.m. with certified medication aide (CMA) M about resident 129 revealed: * Resident 129 received hospice services. *She slept “a lot”. *CMA M stated resident 129 often slept for a couple days at a time and then would have a normal sleep cycle for a couple of days. *That morning, she was awake and wanted to get out of bed for breakfast. 4. Review of resident 129’s electronic medical record (EMR) revealed: *She was admitted on 1/26/24. *Her 8/11/25 Minimum Data Set (MDS) indicated she was rarely understood or able to understand others and was severely cognitively impaired. *She was receiving hospice services. *She had diagnoses of Alzheimer’s (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), vascular dementia (a group of symptoms affecting memory, thinking, and social abilities), a history of strokes, and depression. *She had a history of falls. *She had a 7/8/22 physician’s order for “DULoxetine 60 MG [milligram] capsule [Cymbalta] 60 MG PO [by mouth] DAILY”. -Duloxetine’s indication for use was depression. *Resident 129’s 8/21/25 care plan included:	F0605		

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F0605 SS = D	Continued from page 25 -A care area of psychotropic drug use. -The “Mood State” problem area indicated she had a diagnosis of depression with an intervention of, “I would like to be reminded of daily activities, even though sometimes she prefers to sleep.” -The “Medication Side Effects” problem area indicated resident 129 used, “antidepressant medications daily for depression” with an intervention of, “Nurses to monitor for any adverse drug reactions and report any [reactions] noted to her hospice nurses so she can contact her provider. Medications are to be reviewed at least every 6 months and prn [as needed] per physician/pharmacy review to ensure lowest effective therapeutic dosage possible.” *A 5/15/25 physician’s visit note indicated, “She has had some issues with depression. It is hard to assess her for that. She seems to be up and down a little bit with her mood. We will continue duloxetine as it helps her facial dysesthesias [an abnormal physical touch sensation without an outside cause].” *There was no documentation that indicated a GDR was recommended from the consultant pharmacist or documentation from the physician to support that a GDR was clinically contraindicated within the past year. 5. Interview on 8/21/25 at 10:28 a.m. with director of nursing (DON) B, consultant pharmacist X, and consultant pharmacy director Y revealed: *The consultant pharmacy’s process for residents who were on a psychotropic medication was to address the resident’s GDR of the psychotropic medication two times in the first year after the resident’s admission or after starting a psychotropic medication and then yearly after that. *If the physician did not provide documentation of the reasoning for not having decreased a psychotropic medication, the consultant pharmacist would produce a document for the physician to complete which would include whether a GDR was to be attempted, and if it was not to be attempted, why it was not being attempted. *Consultant pharmacist X and consultant pharmacy director Y stated a GDR for resident 129’s duloxetine was not addressed with her physician in the past year because in 2022 he had documented that a GDR on the duloxetine was contraindicated because it was helpful for resident 129’s facial pain related to her stroke.	F0605		

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F0605 SS = D	Continued from page 26 *After the 2022 GDR documentation by the physician the consultant pharmacist no longer considered duloxetine as an antidepressant or psychotropic medication because it was being used to treat “nerve pain”. *DON B confirmed that the indication for use of the duloxetine in resident 129’s physician’s orders was depression, not nerve or facial pain. *Consultant pharmacy director Y stated he thought because resident 129’s duloxetine was being used for facial nerve pain it no longer met the criteria for the required GDR of a psychotropic medication. Review of the provider’s September 2023 Long Term Care Psychotropic Medication Use policy revealed: *“’All medications included in the psychotropic medication definition may affect brain activities associated with mental processes and behavior…Risks associated with psychotropic medications still exist regardless of the indication for their use (e.g., nausea, insomnia, itching), therefore the requirements pertaining to psychotropic medications in 483.45(e) apply to the four categories of drugs (anti-psychotic, anti-depressant, anti-anxiety, and hypnotic) listed in 483.45(c)(3) without exception.’” *“Residents who receive psychotropic medications will receive gradual dose reductions and behavioral interventions unless clinically contraindicated with the intention to decrease or discontinue the use of the psychotropic medication whenever safe and possible.” *“The objective of this policy is to monitor and ensure that the resident’s drug regimen is managed to promote or maintain the resident’s highest practicable mental, physical and psychosocial well-being. The goal is to monitor the resident’s use of psychotropic drugs in an effort to assist with stabilizing or improving the resident’s outcome, quality of life and functional capacity, while using psychotropic medications only when needed to treat a specific condition that is diagnosed and documented.” *“The purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident. The time frame and duration of attempts to taper any medication must be consistent with accepted standards of practice and depend on factors including the coexisting medication regimen, the underlying causes of symptoms, individual risk factors, and pharmacological	F0605		

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F0605 SS = D	Continued from page 27 characteristics of the medications." *"Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated." *A "GDR may be considered clinically contraindicated for reasons that include, but are not limited to: -1. The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility. -2. The physician has documented the clinical rationale for why any additional attempted dose reduction at that time would likely impair the resident's function or increase distressed behavior."	F0605		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a	F0641	The MDS assessment that was miscoded has been modified and submitted. Social Workers attended a South Dakota training for new guidelines regarding PASRR completion on September 16th and September 17th, 2025 on a new screen to be completed with all significant changes, new diagnosis, and medicaton changes. Social Workers, or designee, will review current resident MDS and ensure that the current PASRR matches what is coded in the MDS before 9/26/25. Social Workers, or designee, will review each resident's MDS and PASRR on a quarterly basis and ensure that no changes are needed and that the MDS is coded correctly. Director of Nursing, or designee, will audit 3 resident MDS per week for 8 weeks to ensure accurate documentation of the resident's PASRR on the MDS. Results of the audits will be reported to the facility QAPI committee who will inform on any future audits.	10/04/2025

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F0641 SS = D	Continued from page 28 resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and policy review the provider failed to ensure one of one residents (15) preadmission screening and resident review (PASRR) assessment level II (in-depth evaluation of a resident's needs, recommended services, and determination of what type of setting was appropriate for her care) was coded accurately on the Minimum Data Set (MDS) assessment (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs). Findings include: 1. Review of resident 15's electronic medical record (EMR) revealed: * She was admitted to the facility on 8/15/23. *She had diagnoses of post-traumatic stress disorder (PTSD) and bipolar 2 disorder. *She took duloxetine (a medication to treat depression and pain) 30 mg daily and clonidine (a sedating medication) 0.1mg/24-hour patch. *Her care plan indicated she had a PASRR level II assessment completed and listed the recommendation for care. 2. Interview with social worker designee (SWD) F on 8/21/25 at 11:42 a.m. revealed: *Resident 15 had a PASRR level II assessment completed on 11/20/23. *She completed the PASRR level II assessment for residents who resided on her assigned unit but did not document those in the MDS assessments. *Registered nurse (RN) coordinator EE would document	F0641		

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F0641 SS = D	Continued from page 29 those in the MDS assessments. 3. Interview with RN coordinator EE on 8/21/25 at 1:10 p.m. revealed: *She documented resident 15's PASRR level IIs in the MDS assessments. *She verified the current comprehensive MDS assessment, signed on 8/13/25, was inaccurate. *She reported resident 15's quarterly MDS assessment, signed on 2/15/25, had been incorrectly marked as well. *She verified resident 15 had a documented diagnosis that would require a PASRR level II assessment. 4. Interview with DON B on 8/21/25 at 3:38 p.m. revealed he expected the MDS data to be documented accurately. 5. Review of the provider's 1/2025 LTC Resident-Assessment-Instrument (RAI)- System Standard Policy revealed: * "…5. All persons who have completed any portion of the MDS Resident Assessment Form must sign the document attesting to its accuracy. 6. An RN must sign the MDS Resident Assessment Form and thereby certify the assessment is complete. 7. The Assessment Coordinator is responsible for electronically transmitting encoded, accurate, and complete MDS data to the CMS [Centers for Medicare and Medicaid Services] system…. 8. The Assessment Coordinator is responsible for the completion of correction and/or inactivation of assessment as follows the MDS Correction Policy…." 6. Review of the provider's 10/21/24 LTC PASRR-South Dakota-System Standard Policy revealed: *" It is the policy to screen all potential admissions on an individualized basis. As part of the preadmission process, the facility participates in the Preadmission Screening and Resident Review (PASRR) screening process (pre-screening and Level I screen) for all new and readmissions per requirement to determine if the individual meets the criterion for mental disorder (SMI/SMD), intellectual disability (ID) or related condition. Based upon the Level I screen, the facility will not admit an individual with a mental disorder or	F0641		

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F0641 SS = D	Continued from page 30 allow for a nursing facility admission and the facility's ability to provide the specialized services determined in the Level II screen…. *The objective of the PASRR policy is to ensure that individuals with mental illness and intellectual disabilities receive the care and services that they need in the most appropriate setting."	F0641		
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the provider failed to ensure a medication error rate below 5%. Two of twenty-seven observed medications administered by certified medication aide (CMA) K and FF were completed with an error, which resulted in a 7.41% medication error rate. Findings include: 1. Observation and interview on 8/20/25 at 7:55 a.m. with certified medication aide (CMA) K while administering medications for resident 58 revealed: *He was to receive two tablets of carbidopa 25mg/levodopa 100mg (medication to manage motor symptoms such as shaking and stiffness) at 6:30 a.m., but it was administered at 7:55 a.m. *CMA K, who is working the day shift, reported that the night shift usually administered that medication. *That medication was ordered to be given three times per day. 2. Observation and interview on 8/20/25 at 1:53 p.m. with CMA FF while administering medications for resident 20 revealed: *He was to receive 10 milliliters (mL) of Guaifenesin/DM SF 100-10 mg/5mL (milligrams per mL) (cough medication) three times per day.	F0759	CMA K and CMA FF will be provided with one to one education that includes the 6 rights of medication administration and liquid medication best practices. The medication administration policy will be reviewed and/or revised by the IDT team, including feedback from the medical director, by 9/26/25. All staff that administer medications will be educated on the medication administration policy, including 6 rights of medication administration and liquid mediation best practices, at educational inservices held between 9/29/25 and 10/3/25. Director of Nursing, or designee, will audit 3 staff during medication administration per week for 8 weeks to ensure administration follows the policy. The results of the audit will be reported to the facility QAPI committee who will inform on any further audits.	10/04/2025

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F0759 SS = D	Continued from page 31 *She poured the medication into a medication cup to fill to approximately 8 mL (just above the 7.5mL mark on the med cup). *She verified the amount again and stated it was the correct dose. *She administered approximately 8 mL of the medication, the incorrect dose. 4. On 8/21/25 at 3:48 p.m., DON B acknowledged the medication error rate. 3. Review of provider's 1/2025 Medication Administration policy revealed: *"…B. Medications may be administered by a registered nurse, licensed practical nurse, certified medication aide…. -Medications with very specific time requirements will be considered specialty medications and will be given at the specific ordered time plus or minus 1 hour. *All medications are to be given following the 6 "R"s: Right resident, right medication, right dose, right route, right time, and right documentation…. *E. Medication Errors. The following situations are considered a medication error: Failure to administer, correct dosage…, incorrect time…."	F0759	RN G, LPN HH, RN Coordinator I, and LPN Z will be provided with individual education prior to 9/26/25. Education will include labeling of open medications and self-administration of medications. Keys will be removed from computer carts and will instead be provided to CMAs and nurses working the shift with a check in/check out process. A reference guide will be provided on the units to guide expiration dates for opened insulin pens. All staff that administer medications will received education on labeling of open medications, checking in and out medication keys, and selfadministration of medications. Director of nursing, or designee, will audit 3 insulin pens per week for 8 weeks to ensure appropriate labeling. Director of nursing, or designee, will audit 1 neighborhood (unit) weekly for 8 weeks to ensure other open items that require dating, such as tube feeding, are dated appropriately. They will also audit to ensure no staff have access to medications that should not on the same frequency. Director of nursing, or designee, will audit 3 residents per week for 8 weeks that have nebulizers to ensure the self-administration policy is followed. All audits will be reported to the facility QAPI committee and they will inform on future audits.	10/04/2025
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.	F0761		

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F0761 SS = E	Continued from page 32 §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: *Insulins with shortened expiration dates were dated properly for five of five random residents (27, 44, 60, 75, 76). *Medical supplies, such as glucose testing strips, sterile water, distilled water, and formula, were dated properly for seven of seven residents (4, 9, 27, 44, 63, 75, 119) in two of five observed units. *Medications were not accessible by unnecessary persons throughout the Rehab, Arrowhead Trail, Boulder Creek, Bluegrass Way, and Platinum Ridge units. *Proper medication administration for two of two residents (63 and 119) without a self-administration physician's order or safety assessment completed. Findings include: 1. Observation and interview on 8/20/25 at 9:41 a.m., with RN G in resident 76's medication cupboard revealed he had a Novolog pen that was not dated with an expiration date and a Lantus pen that had been dated with an incorrect expiration date, as it was dated to expire on 9/18. It had approximately 100 units of the medication used from it, and it did not have a date on which it was opened on it. -RN G verified she did not open those insulin pens today (8/20/25), and they were incorrectly dated and undated. -According to the insulin expiration chart, if the Lantus pen had been opened today, it would have expired on 9/17/25. -RN G indicated she was unsure when they expired without the dates they were opened or the correct	F0761		

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F0761 SS = E	Continued from page 33 expiration dates written on them. -RN G put the insulin pens back into the resident's medication cupboard. *Observation on 8/20/25 at 9:46 a.m., with RN G in resident 44's medication cupboard revealed resident 44's Novolog pen did not have a legible expiration date written on it, which was verified by RN G. *Observation on 8/20/25 at 10:41 a.m. with licensed practical nurse (LPN) HH in resident 75's medication cupboard revealed resident 75 had a Novolog pen in her medication cupboard that did not have an opened date written on it. -LPN HH verified the Novolog pen was not dated when opened. -LPN HH stated she was unsure when the medication would have expired, without it having been dated when opened. *Interview on 8/20/25 at 10:55 a.m. with RN coordinator I revealed she expected the insulin pens to be dated with the expiration date once opened, and she was not aware of a reference sheet available to staff to know when the medications would expire after opening. *Observation on 8/20/25 at 11:39 a.m. with LPN Z in resident 60's medication cupboard revealed resident 60 had a Fiasp insulin pen that was not dated with the expiration date once opened. -LPN Z verified it was undated. *Observation on 8/20/25 at 11:40 a.m. with LPN Z of resident 27's medication cupboard revealed he had a Lantus pen that was not dated with the expiration date once opened. -LPN Z verified it was undated. *Interview on 8/21/25 at 3:38 p.m. with director of nursing (DON) B revealed he expected the staff would have followed the policy, and to have dated the insulin pens with the opened and/or expiration dates. -He verified that the Lantus that was missing approximately 100 units with the expiration date of 9/18, was incorrectly dated. *Review of the facility's 1/2025 medication administration policy revealed, "All multi dose vials shall be initialed and dated when the first seal is	F0761		

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F0761 SS = E	Continued from page 34 broken…" *Review of the 12/17/24 Avera long-term care pharmacy insulin expiration chart listed how many days each type of insulin was good for after opening. 2. Observation on 8/18/25 at 3:45 p.m. of the Bluegrass Way nurse's station revealed: -A glucometer (device for testing blood sugar levels) box in the cupboard contained: -A bottle of control level 1 and a bottle of control level 3 (used to ensure the glucometer was properly functioning) that were open and not dated with an open date or expiration date. -Two bottles of glucose test strips that were not dated with an open date or expiration date. -There was a sign in the cupboard that stated how many days the controls and test strips were good for after being opened. 3. Observation on 8/19/25 at 8:41 a.m., of resident 119's room revealed an undated jug of distilled water on his nightstand by his continuous positive airway pressure (CPAP) machine (a medical device used to deliver a constant steady air pressure to help a person breathe while they sleep). *Observation on 8/18/25 at 3:10 p.m., of resident 9's room revealed an undated jug of distilled water by her CPAP machine. *Observation on 8/18/25 at 4:29 p.m., of resident 4's room revealed an undated sterile water container on his nightstand, and a bag of formula and a bag of clear fluid were hanging on a pole on his wheelchair that were not dated. *Observation 8/20/25 9:46 a.m., of resident 44's medication cabinet revealed there were undated glucose test strips stored in her medication cabinet. -RN G verified that observation and she stated she thought the test strips were good for one month after opening. *Observation on 8/20/25 at 10:25 a.m., of resident 63's medication cabinet revealed there were undated glucose test strips stored in his medication cabinet. *Observation on 8/20/25 at 10:41 a.m., of resident 75's	F0761		

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F0761 SS = E	Continued from page 35 medication cabinet with LPN HH revealed there were undated glucose test strips stored in her medication cabinet. *Interview with RN coordinator I on 8/20/25 at 10:55 a.m. revealed she expected glucose test strips, sterile water, distilled water, and formula to be dated once opened. * Observation on 8/20/25 at 11:39 a.m., of resident 27's medication cupboard with LPN Z revealed there were undated glucose test strips. *Observation on 8/20/25 at 11:40 a.m., of the Rehab unit's nurse's station revealed: - A bottle of glucose test strips that was opened and undated. - A bottle of control 1 that was open and undated. -LPN Z verified that glucose test strips and controls were to be dated once opened. *Interview with Infection Prevention and Control RNs II and JJ revealed that fluids were to be dated when opened. *Interview on 8/21/25 at 3:38 p.m. with DON B revealed he expected staff to follow the policy and to date fluids, glucose test strips, and controls after being opened. *Review of the facilities test strip bottle and daily quality control (QC) requirement reference sheet revealed: -Glucose test strips "must immediately be labeled with an open date and a 180 day expiration date." -QC bottles are sent to your unit with a 90 day (3 month) expiration date already written on them. -DO NOT use any controls past the written expiration date…." 4. Observation on 8/20/25 at 8:11 a.m., in the hallway outside of residents 39 and 7's rooms, revealed there was a wheeled computer cart with a key attached to it, and no staff were present. *Observation on 8/20/25 at 9:32 a.m., inside of resident 76's room, revealed there was a wheeled computer cart with a key attached to it, and no staff	F0761		

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F0761 SS = E	Continued from page 36 were present. *Interview with RN coordinator I on 8/20/25 at 10:01 a.m. revealed: -The keys on the wheeled computer carts opened the medication cupboards in all of the residents' rooms. -She verified that anyone could have accessed the medication cupboards in the residents' rooms. -The keys had been attached to the wheeled computer carts because the medication aids had been taking the keys home. *Observation on 8/20/25 at 10:05 a.m. of three of three wheeled computer carts on the Platinum Ridge unit revealed they each had a key attached to them. *Observation on 8/20/25 at 10:06 a.m. of three of three wheeled computer carts on the Bluegrass Way unit revealed they each had a key attached to them. *Interview on 8/20/25 at 10:07 a.m. with CMA K revealed: - A few CNAs that were not medication aides would use the wheeled computer carts to document. - They had six wheeled computer carts on that floor, three for each unit, and all the medication computer carts had a key attached to them. -The wheeled computer carts were stored in an unlocked conference room on the units when not in use an anyone could have accessed them, even the residents. *Observation on 8/20/25 at 10:09 a.m. of the conference room in the Bluegrass Way unit revealed there was a wheeled computer cart that had a key attached to it. *Observation on 8/20/25 at 11:30 a.m., revealed both nurses' stations on the Rehab unit had wheeled computer carts with keys attached to them, and five of the five observed carts had a key attached to them. *Observation on 8/20/25 at 2:09 p.m. in the hallway by resident 4's door, revealed there was a wheeled computer cart with a key attached to it, and no staff were present. *Interview on 8/21/25 3:38 p.m. with DON B revealed: -The keys attached to the wheeled computer carts	F0761		

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F0761 SS = E	Continued from page 37 unlocked the medication cupboards for all of the residents' rooms. -He verified an unauthorized person could have accessed all resident medications with those keys. *5. Observation on 8/19/25 at 8:41 a.m. of CMA GG while administering medications to resident 119 revealed: -Resident 119 was in the bathroom in his room. -CMA GG left his morning medications in a medication cup sitting on his bedside table, told him they were there, and left the room. -Interview with LPN HH on 8/20/2025 at 10:46 a.m. indicated that no residents on the Bluegrass Way unit could self-administer medications. *Observation on 8/20/25 at 10:16 a.m. of LPN HH while administering medication through a nebulizer (a device that converts liquid medication into an inhalable mist) to resident 63 revealed LPN HH left the room while the resident was inhaling the medication. -Interview on 8/20/25 at 10:49 a.m. with CMA N indicated that no residents on the Platinum Ridge unit could self-administer medications and that only nurses were able to administer nebulized medications. *Interview with RN coordinator I on 8/20/25 at 10:55 a.m. revealed that no residents on the Platinum Ridge or Bluegrass Way units were able to self-administer medications. -For a resident to self-administer medications, the resident would need an to be assessed to ensure he or she was safe to do so. -They would need a doctor's order to self-administer medications. -She expected the nurse to stay in the room for the full time a medication was being administered through a nebulizer, and agreed that leaving the resident with the medication running through the nebulizer was considered self-administration of the medication. * Interview on 8/21/25 at 3:38 p.m. with DON B revealed: -No residents were allowed to self-administer medications at that time, and an assessment needed to be completed first to determine the resident's ability	F0761		

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F0761 SS = E	Continued from page 38 to safely self-administer medications. -It was considered self-administration for the resident to complete his nebulized medication without the nurse in the room. -He expected the staff to stay and monitor the residents while taking the medications. *Review of the provider' 1/2025 medication administration policy revealed: -"Residents may self-administer prescribed medications under the supervision of a licensed nurse. -A physician's order is required. -The resident must be able to demonstrate administration of the medication and must be able to verbalize the drug name and strength and directions for use including the dose, route and time to be taken. -An evaluation and education will be documented every 90 days or upon any significant change regarding the resident's wish to self administer from bedside or self administer after setup will be documented."	F0761		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve	F0812	Staff identified during survey will receive reeducation on proper hand hygiene and glove use by 9/26/25. All staff that contribute to meal service will receive education on proper hand hygiene and glove use at educational inservices held between 9/29/25 and 10/3/25. Dietary Services Manager, or designee, will audit 2 meal services per week for 8 weeks for proper glove usage and hand hygiene. Results of the audits will be reported to the facility QAPI committee who will inform on future audits.	10/04/2025

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F0812 SS = E	Continued from page 39 food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to follow standard food safety practices by not having ensured proper glove use and hand hygiene was performed during two of two observed resident meal services in two of three neighborhood dining rooms by three of three servers (O, S, and U), and five of five certified medication aides (P, Q, R, V, and W). Findings include: 1. Observation on 8/18/25 at 4:57 p.m. of the kitchenette in the Boulder Creek and Arrowhead Trail dining area revealed: *Server O removed the covers from the steam table. *She transferred the metal containers that were covered with foil from an insulated cart and placed them into the steam table. *Server O used a metal tong to puncture and open the foil on each of the containers of food. *She placed those tongs she used to open the foil covered containers into the container of bacon. *There was an uncovered tray of bread on the serving counter near the walkway between the kitchenette and the dining area. *Certified medication aide (CMA) P and CMA Q were not wearing hairnets and walk beside that uncovered tray of bread. 2. Observation on 8/18/25 beginning at 5:05 p.m. of the Boulder Creek and Arrowhead Trail dinner service revealed: *At 5:05 CMA R served drinks to a resident seated at a table, moved her hair from her shoulder, went behind the kitchenette, and prepared more drinks for residents without performing hand hygiene (handwashing). *At 5:34 CMA R pushed a resident in a wheelchair to her table and picked the resident's purse up off the floor. CMA R then moved her hair off her shoulder, adjusted her uniform, went into the kitchenette, poured a cup of	F0812		

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F0812 SS = E	Continued from page 40 coffee, walked down the resident hallway with the cup of coffee, and did not perform hand hygiene between any of those tasks. 3. Observation on 8/19/25 beginning at 8:55 a.m. of the Boulder Creek and Arrowhead Trail breakfast service revealed: *At 8:55 server S used a gloved hand to cut a banana on a serving tray, removed her gloves, did not perform hand hygiene, picked up a frosted long john roll with her bare hand, placed the long john on a resident's plate, used tongs to pick up another item for the resident's plate, wrote on a piece of paper with a pen, applied a glove to her right hand, and picked up a food item from the freezer, removed the glove on her right hand, and then gathered items from the cupboard in the kitchenette. No hand hygiene was performed during those tasks. *There was a tray of frosted long john rolls sitting on the edge of the serving counter between the kitchenette and the dining room. *At 9:08 a.m. resident 38 self-propelled her wheelchair into the dining room, touched multiple long johns with her bare hands, grabbed one of the long johns and began to eat it. *Server T picked up the tray of long john rolls and placed them on top of the plastic cover over the prepared food, out of resident 38's reach. *After resident 38 had touched multiple frosted long johns, two more long john rolls from that same tray were served to residents during the breakfast food service. 4. Observation in the Bluegrass Way and the Platinum dining room on 8/18/25 at 5:21 p.m. revealed: *Server U, without performing hand hygiene, applied gloves, grabbed a package of bread, then removed slices of bread out of the package to make sandwiches with those same gloved hands. She removed those gloves, and no hand hygiene was performed. *She did the same process again of touching the bread package and then the bread slices with the same gloves. She made more sandwiches and used the same gloves to put the lettuce and bacon on the sandwiches. She removed those gloves, and no hand hygiene was	F0812		

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F0812 SS = E	Continued from page 41 performed. *CMA W touched areas around her mouth, her shirt, grabbed a clean tray, then took clean silverware from a bin, grabbed the resident's plated meal, and then served it to the resident without performing hand hygiene. 5. On 8/18/25 at 5:36 p.m. CMA V was observed touching her nose with her hand and then fed a resident with that same hand without performing hand hygiene. There was no hand hygiene completed by CMAs W and V between serving meal trays to the residents. 6. Interview with CMA W on 8/18/25 at 5:45 p.m. revealed she: *Should have washed her hands before and after serving resident trays. *Would clean her hands if they were dirty before serving the next resident. *Confirmed she should have washed her hands after touching her face and shirt. 7. Interview with server U on 8/18/25 at 5:55 p.m. revealed that she should have washed her hands before touching food, and she was not aware that touching the outer bread package and then the bread slice was considered non-sanitary. 8. Review of the provider's November 2024 Hand Hygiene policy revealed: *"Hand hygiene (HH) continues to be the primary means of preventing the transmission of infection." -"To cleanse hands to prevent the spread of infection." -"To provide a clean and healthy environment for residents, staff, and visitors." *"HH, either with soap and water or with alcohol based hand rub (ABHR):" -"Before a clean procedure..." -"After removing gloves."	F0812		

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F0812 SS = E	Continued from page 42 Review of the provider's January 2025 Food Handling and Hygiene policy revealed: *"Purpose: To provide safe food for the residents." *"Procedure: All Dietary personnel shall wear hairnets or bonnets which completely cover the hair while in the kitchen." -"Gloves will be utilized when handling ready-to-eat (RTE) foods." -"Do not cough, sneeze, or clear the mouth and/or nose near food or dishes... and wash hands immediately after..." -"Keep hands and fingers out of food..." -"Disposable gloves/utensils must be worn when direct contact with a food item is made."	F0812		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F0880	Education will be provided to staff that care for the identified residents that includes enhanced barrier precautions, glove use, hand hygiene, standard precautions - notably when inducing coughing, transfering soiled linens, urinary catheter irrigation process, and tube feeding storage. Transmission based precautions, cleaning an occupied resident room, terminal cleaning, catheter (retention) irrigation, LTC food safety and sanitation - system standard policy, avera standard precuations, clean & soiled linens, and Avera LTC - Hand Hygiene policies will be reviewed and/or updated by 9/26/25. All staff will receive education on the same topics at educational inservices held between 9/29/25 and 10/3/25. Director of Nursing, or designee, will audit 1 neighborhood per week for 8 weeks. The audit will include 5 instances of hand hygiene, 1 instance of bladder irrigation, 5 instances and enhanced barrier precautions and/or standard precautions, and 1 instance of transportation of clean and dirty linens. Results of the audit will be reported to the facility QAPI committee who will inform on future audits 10	10/04/2025

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F0880 SS = E	Continued from page 43 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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, record review, interview, and policy review, the provider failed to ensure the staff had followed standard infection control practices to	F0880		

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F0880 SS = E	Continued from page 44 decrease the risk of infection to other residents, staff, and visitors for ten of ten sampled residents (4, 9, 20, 33, 49, 75, 76, 119,126, and 129) on enhanced barrier precautions by eight of eight observed staff members (certified medication aides (CMAs) M, FF, GG,NN licensed practical nurse (LPN)s HH, LL, MM, and registered nurse (RN) G) according to the provider's policy. Findings include: 1. Observation on 8/18/25 at 2:31 p.m. of resident 129's room from the hallway revealed: *She had a magnet on her door frame at the entrance to her room which indicated she was on enhanced barrier precautions (EBP) (glove and gown use when providing contact care). *She had a urinary catheter (flexible tubing inserted into the bladder to drain urine) bag hanging on the side of her bed. *There was no personal protective equipment (PPE) (gown and gloves) visible from the hallway. 2. Observation on 8/19/25 at 8:11 a.m. of certified medication aide (CMA) M in resident 129's room revealed: *CMA M was not wearing gloves or a gown. *CMA M performed a sit-to-stand (a mechanical lift used to assist from a seated to a standing position) assisted transfer of resident 129 from her bed to her wheelchair. *CMA M positioned resident 129 in her chair, brushed her hair, and adjusted resident 129's clothing. *There were gowns available in a cupboard with the linen, in the resident 129's room. 3. Review of resident 129's electronic medical record revealed: *She was admitted on 1/26/24. *She required the assistance of one staff member for all of her care needs, including transfers with a sit-to-stand mechanical lift.	F0880		

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F0880 SS = E	Continued from page 45 *Her care plan indicated she had a urinary catheter. 4. Observation and interview on 8/19/25 at 8:39 a.m. of CMA GG in resident 119's room revealed: *A magnet on the door frame and a sign in the resident's room indicated the resident was on EBP. *It was observed that she showered the resident in his room and did not wear a gown. *She picked up dirty linens from his bathroom and did not wear a gown. *Resident 119 stated he had a wound on his foot. 5. Observation on 8/19/25 at 9:15 a.m. of housekeeper KK cleaning resident 126's room revealed she was cleaning it without wearing a gown. *A magnet on the door frame and a sign in the resident's room indicated the resident was on EBP. 6. Observation on 8/19/25 at 9:51 a.m. of housekeeper KK cleaning resident 9's room revealed she was cleaning it without wearing a gown. *A magnet on the door frame and a sign in the resident's room indicated the resident was on EBP. 7. Observation and interview on 8/19/25 at 3:13 p.m. with LPN LL in resident 9's room and bathroom revealed: *Resident had a magnet on the door frame, and a sign in the resident's room indicated the resident was on EBP. *LPN LL reported and observed that resident 9 had a stage III or IV pressure ulcer on her coccyx (tailbone) that was covered with a foam dressing. *LPN LL assisted her to the bathroom using a sit-to-stand lift. *She wore a gown and gloves. *She removed her gloves, did not perform hand hygiene, and answered her portable work phone. *She did not perform hand hygiene and put on a new pair of gloves. *After wiping the resident's bottom, she removed her gloves and pulled the resident's incontinence product	F0880		

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F0880 SS = E	Continued from page 46 and pants up. Then she transferred the resident to her wheelchair and then removed her gown. *She then made the resident's bed without wearing gloves or a gown 8. Observation on 8/19/25 at 10:17 a.m. in resident 4's room of LPN MM and CMA NN revealed: *A magnet on the door frame and a sign in the resident's room indicated the resident was on EBP. *LPN MM used the same pair of gloves to change the dressing on his feeding tube site and his dressing on his suprapubic urinary catheter (a flexible tubing surgically placed through the abdomen into the bladder to drain urine) site. *She touched a clean roll of tape without changing her gloves. *LPN MM removed those gloves, did not perform hand hygiene, and left the room. *She returned with the sit-to-stand lift and put on a gown and gloves without performing hand hygiene. *LPN MM and CMA NN transferred resident 4 to his wheelchair. *LPN MM then removed her gloves and, with her bare hands went to the resident's bedside, grabbed a graduated container, used for measuring sterile water to flush his feeding tube, brought it over to the clean pull-out table located in the resident's medication cupboard, set the container on a clean paper towel, and added sterile water to the container. *She put on a pair of gloves and administered a medication into his feeding tube. *She came back to the medication cupboard and, with those same gloved hands, grabbed a medication cup out of the clean bin in the medication cupboard. *When she finished administering his medications, she removed her gloves and did not perform hand hygiene. *She removed the resident's sterile oral suctioning supplies from his bedside drawer without performing hand hygiene. *She washed her hands, put on gloves, and set up the resident's suctioning supplies.	F0880		

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F0880 SS = E	Continued from page 47 *She used a sterile suction catheter and completed a deep suctioning of the resident's mouth. She did not wear eye shields or a mask. The resident was coughing deeply during this procedure. *CMA NN put on gloves, went to the resident's bed, and touched his bedding. Then, with those same gloved hands, she obtained cleaning wipes and cleaned the lift. *A staff member brought CMA NN a package of white pads into the resident's room. With those same gloved hands, CMA NN removed one pad from the package and then placed the rest of the package in the clean cupboard with the resident's feeding tube supplies. *Without gloves on, LPN MM grabbed the resident's graduated cylinder for his feeding tube flush and rinsed it out in the resident's bathroom sink. *She put on gloves without performing hand hygiene and then hooked up the resident's formula tubing to his feeding tube. *She removed her gloves and gown, touched the graduated cylinder with her bare hands, touched his call light, touched her left ear, touched her medication computer cart, and then left the room without performing hand hygiene. *LPN MM verified the resident was on EBP. She was not sure why he was on precautions. *She stated staff were to wear gowns and gloves when working with him. *She stated she should have changed her gloves between providing his care and the dressing changes. *She stated staff were to perform hand hygiene before administering his medications, before putting gloves on, before and after helping residents to the bathroom, and before performing a sterile procedure. -She stated deep suctioning of a resident's mouth was considered a sterile procedure. 9. Observation and interview in resident 75's room on 8/18/25 at 4:02 p.m. revealed: *She had a magnet on her door frame and a sign in her room that indicated she was on EBP.	F0880		

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F0880 SS = E	Continued from page 48 *She stated that the staff used to wear gowns, but now they usually did not. 10. Observation and interview on 8/20/25 at 9:18 a.m. with RN G and CMA M in resident 49's room revealed: *They did not wear gowns or gloves to transfer the resident with the sit-to-stand aid. *After transferring the resident, RN G left the room with the sit-to-stand aid and did not perform hand hygiene. She put the sit-stand-aid in its designated location, walked to the nurses' station, obtained gloves, put them on without performing hand hygiene, and then cleaned the sit-to-stand aid with sanitary wipes. *CMA M stated the resident was on "somewhat EBP but not full-blown." *She stated she was to wear a gown and gloves while assisting the resident with bathing and changing the resident's linens. -After reading the EBP sign, she verified she was to wear a gown and gloves for transferring the resident. *She was not sure why the resident was on EBP. *RN G stated she was not sure if resident 49 was on EBP. *She stated when working with residents on EBP she needed to: perform hand hygiene, wear gloves, and gowns when providing resident hygiene care. *She stated she was not sure why the resident was on EBP as she did not have a multi-resistant drug organism (MDRO). 11. Observation and interview on 8/20/25 at 8:21 a.m. of CMA MM walking in the hallway revealed: *She had a resident gown in her bare hand, that was not in a bag, and carried it to the dirty linen room. *Interview with CMA MM revealed she was to have worn gloves and had the gown in a bag. *She verified that she had been in resident 33's room, who had an EBP magnet on his door frame. *She was unsure why resident 33 was on EPB.	F0880		

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F0880 SS = E	Continued from page 49 12. Observation on 8/20/25 at 9:41 a.m. in resident 76's room revealed RN G administered the resident's insulin, removed her gloves, did not perform hand hygiene, and then left the resident's room. 13. Observation on 8/20/25 at 1:58 p.m. of CMA FF in resident 20's room revealed she did not perform hand hygiene before or after administering the resident's medications. 14. Observation on 8/20/25 at 2:21 p.m. of LPN HH in resident 4's room revealed: *LPN HH put on gloves and exposed the resident's feeding tube from under his shirt. *With those same gloved hands, she grabbed her keys and opened the medication cupboard. Then she stated she was going to flush his catheter first. *Without changing her gloves, she exposed the urinary catheter port. *She touched the sterilized water container, which was stored in the clean medication cabinet, with those same gloved hands, poured the water into a clean plastic cup, and flushed the resident's urinary catheter. She did not wear a gown. * She removed her gloves, washed her hands in the residents' bathroom, turned the faucet off with her hand, and then grabbed a paper towel to dry her hands. * She then put on a gown and gloves, prepared and administered his medications. *She removed her gloves and put on new gloves, and without performing hand hygiene, flushed his feeding tube. *She then removed her gown and gloves, grabbed the garbage bag out of the garbage can, then locked the medication door without performing hand hygiene. *She buckled the resident's seat belt without wearing gloves. *Interview with LPN HH about urinary catheter flush revealed she thought it was a clean procedure, not sterile. *She stated the resident was on EBP due to the feeding tube and urinary catheter, so she should have worn a gown when flushing the catheter.	F0880		

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F0880 SS = E	Continued from page 50 15. Observation on 8/20/25 at 3:06 p.m. of the medication room behind the Bluegrass Way nurses' station revealed there were five boxes of Peptamen nutritional formula for administration through a feeding tube stacked on the floor. 16. Observation on 8/20/25 at 4:05 p.m. of LPN HH flushing resident 75's urinary catheter revealed she put the sterile flushing solution in a clean cup, and not in a sterile container. 17. Interview on 8/21/25 at 10:00 a.m. with facility services manager E revealed: *He expected dirty linen to be transported in a sealed bag, especially for residents who were on EBP. *He expected the housekeeper to wear gowns when cleaning a room for a resident on EBP. 18. Interview, record review, and policy review on 8/21/25 at 10:50 a.m. with RN coordinator I revealed: *She expected urinary catheter flushing to be a clean technique and staff to use a sterile syringe and solution, but the sterile solution did not need to be in a sterile container. *She stated resident 75 had a UTI on 6/27/25. -This was verified with residents' urine lab results. -Her culture indicated she had a Proteus and Staphylococcus aureus-MRSA (type of bacterium) infection. *She stated resident 4 had a UTI on 6/7/25 and 2/23/2025. -This was verified with residents' urine lab results. -His culture indicated he had a Proteus (type of bacterium) infection. *After review of the provider's bladder irrigation or urinary catheter flushing policy, she verified it was supposed to be a sterile technique, and they were to use a sterile container for the sterile solution. *She verified that not following sterile technique created a risk for an infection. *She expected the boxes of the nutritional formula not	F0880		

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F0880 SS = E	Continued from page 51 to be stored on the floor. 19. Interview with on 8/21/25 at 12:15 p.m. with Infection Prevention and Control RN II and Quality and Infection Prevention RN Supervisor JJ revealed: *They had current performance improvement projects regarding hand hygiene. *They expected staff to follow the five movements of hand hygiene (a reference for healthcare workers to follow for when to complete hand hygiene) and know when to use soap and water vs alcohol-based hand rub sanitizer (ABHR). *They stated they educated staff to let them know if soap or ABHR were not available. -Housekeeping had been making sure all of the alcohol dispensers were full and working. *They expected staff to wear gowns and gloves when completing high-contact activities with residents on EBP, such as: -transferring, dressing, bathing, linen changes, hygiene, device management, and administering medications through a feeding tube. *They completed hand hygiene and personal protective equipment (PPE) audits. *Staff were provided yearly education about different focuses on EBP during CNA and nurse meetings and one-on-one meetings. *Residents on EBP have a sign on the gown holders in their rooms and have an EBP magnet on their door. *Nurses were to follow sterile technique when flushing a urinary catheter and were to use a sterile solution and a sterile container. *They verified that putting a sterile solution into a clean cup to flush a resident's urinary catheter could risk a urinary tract infection. 20. Interview with the director of nursing (DON) B on 8/21/25 at 3:38 p.m. revealed: *He expected staff to wear gowns and gloves per the policy for residents who were on EBP.	F0880		

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F0880 SS = E	Continued from page 52 *He expected the staff to follow the hand hygiene policy. -He indicated they had started a performance improvement project regarding hand hygiene. 21. Review of the provider's 3/2025 Cleaning an Occupied Resident Room policy revealed: *Housekeepers were to: "…4. Apply personal protective equipment (PPE) per standard and transmission based precautions and clean per recommendations in the Avera LTC-Transmission Based Precautions and Enhanced Barrier Precautions." *Review of the provider's 11/2024 Hand Hygiene policy revealed: *The purpose of hand hygiene (HH) was to: " …prevent the transmission of infection." -to cleanse hand to prevent the spread of infection. -to provide a clean and healthy environment for residents, staff, and visitors." *HH should be done: "either with soap and water or with alcohol based hand rub (ABHR): 1. immediately before touching a resident 2. before a clean procedure or handling an invasive medical device 3. after contact with potential for body fluid or contaminated surfaces 4. after touching a resident or the resident's immediate environment 5. after removing gloves…." Review of the provider's 11/13/2024 Transmission Based Precautions and Enhanced Barrier Precautions policy revealed: *The purpose was to: "provide infection prevention and control recommendations for long-term-care…" -"…2. Enhanced Barrier Precautions are used during high contact resident care activities for the following residents and should be implemented as facilities are able:	F0880		

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F0880 SS = E	Continued from page 53 a. Infection or colonization with an MDRO status b. Wound requiring a dressing, regardless of MDRO status c. indwelling medical device, regardless of MDRO status…. d. If a, b, or c apply, gown and gloves must be used during high contact resident care activities including (but not limited to) i. dressing ii. bathing or showering iii. transferring iv. providing hygiene v. changing linen vi. changing briefs or assisting with toileting vii. device care use…. viii. wound care…. B. Respiratory hygiene/Cough Etiquette will be followed as per Avera LTC Standard Precautions. -III. Isolation Room Procedure: Isolation supplies kept in a designated area can be kept on the units as long as they are properly stocked and cleaned. Place of the proper color-coded isolation sign for the type of precaution(s) on the resident's door or designated area. H. Equipment: 1. Any equipment brought into the resident's room must be cleaned …prior to using on another resident…. K. Use of PPE: …2. In addition to what is posted on isolation signage, follow Standard Precautions by type of exposure anticipated with additional tasks: Work from 'clean to dirty'	F0880		

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F0880 SS = E	Continued from page 54 Limit opportunities for 'touch contamination'-protect yourself, others, and the environment. If contamination occurs, remove PPE, complete hand hygiene and don [put on] clean PPE Do not touch your face or adjust PPE with contaminated gloves Do not touch environmental surfaces (including privacy curtains) except as necessary during resident care 3. Remove PPE appropriately and complete hand hygiene before leaving the room N. Resident Supplies: 1. Clean, disposable, wrapped supplies stored in an enclosed space a. Only clean, ungloved hands should enter supply drawers and cupboards b. Whenever you need to remove something from a drawer or cupboard, gloves are taken off, hand hygiene performed, and the item removed; hands are re-gloved and proceed with your task…. d. If gloved hands enter a supply drawer while in an isolation room, any disposables that are touched are considered contaminated and are to be used for that resident or discarded.... T. When a nurse phone is taken into an isolation room, clean the phone upon leaving the room U. When the key to the medication locked box is used in an isolation room, it is cleaned with facility approved disinfectant…." Review of the provider's sign hanging in the resident's room, indicating the resident required EBP revealed it indicated: *"EVERYONE MUST: Clean their hands, including before entering and when leaving the room." *"PROVIDERS AND STAFF MUST ALSO: -Wear gloves and a gown for the following High-Contact Resident Care Activities. - Dressing - Bathing/Showering	F0880		

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F0880 SS = E	Continued from page 55 - Transferring - Changing Linens - Providing Hygiene - Device care or use: central line, urinary catheter, feeding tube, tracheostomy - Wound Care: any skin opening requiring a dressing….” Review of the provider’s 4/2025 Clean and Soiled Linens policy revealed: *The purpose was to “…B. Minimize the possibility of cross-contamination between patients and/or employees. *…Soiled Linen: -All soiled linen is considered contaminated and proper personal protective equipment (PPE) will be utilized when handling per standard precautions…. - Soiled linens and resident personal clothing will be bagged at the point of care prior to transport to the soiled utility room….” Review of the provider's 4/2025 Cather (Retention) Irrigation policy revealed: *…A. Equipment: 1. Sterile irrigating set…. 4. Sterile solution as ordered…. B. Method: … 3. Perform hand hygiene 4. Maintain sterile technique….”	F0880		