STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A136	A. BUILDING _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME	2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 4/29/25 through 5/1/25. Michael J Fitzmaurice South Dakota Veterans Home was found not in compliance with the following requirements: F657, F686, F689, F880, and F909. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 4/29/25 through 5/1/25. The area surveyed was resident neglect after a resident had become sick and staff did not initiate standing orders for an upset stomach. Michael J Fitzmaurice South Dakota Veterans Home was found to have past non-compliance at F600.	F 000	Statement of Compliance: The following represents the plan of correction for the alleged deficiencies cited during the survey that was conducted on 4/29/25 through 5/1/25. Please accept this plan of correction as Michael J Fitzmaurice South Dakota Veterans Home's credible allegation of compliance with the completion date of 6/27/25.	
F 600 SS= G	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:	F 600		

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

DEP SECRETARY | 6 JUNE 2025

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F 600	Continued From page 1 Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), observation, record review, and interview, the provider failed to protect the resident's right to be free from neglect by one of one licensed practical nurse (LPN) (U) who failed to initiate standing orders for an upset stomach for one of one sampled resident (210) after he became sick in the dining room at supper time and later that night aspirated on his emesis and passed away. This citation is considered past non-compliance based on a review of the corrective actions the provider implemented immediately following the incident. Findings included: 1. Review of the provider's SD DOH FRI submitted on 2/14/25 at 10:35 a.m. revealed: *Nurse manager P had been completing a chart audit for an Ombudsman report regarding resident 210 and had concerns regarding some missing documentation the day before he passed away. *Nurse manager P had completed a camera review and discovered resident 210 had an episode of emesis (vomiting) in the dining room on 1/24/25 at 5:45 p.m. before the evening meal. -Staff had taken resident 210 to his room to clean him up and then brought him back to the dining room. -Staff had placed a full meal in front of him when he returned from his room after he had been cleaned up. --Resident 210 had eaten 100% of his supper. *Later during the evening shift, resident 210 was found to have aspirated on his emesis and passed away in his room. *Nurse manager P reviewed resident 210's daytime documentation in his electronic medical record (EMR) and it had shown:	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 2 -On 1/24/25 LPN U did not document that he had an emesis during the evening meal. The documentation stated he had no complaints of pain. -There was no documentation that LPN U initiated the standing orders for an upset stomach, made any changes to his diet such as from a regular diet to clear liquids, no assessments of the residents condition were completed, and no vital signs were taken. *Homemaker X had reported to LPN U that resident 210 was not feeling well and that he had stomach pains. *LPN U was placed on administrative leave effective 2/12/25. *An investigation was initiated by staff interviews. *Education was provided to all staff that included understanding of the documentation processes, assessments, vital sign assessments, the importance of comprehensive change of shift reporting, and a change of a resident's condition. 2. Review of resident 210's EMR revealed: *He was admitted on 4/8/21 and his diagnoses included dementia, chronic obstructive pulmonary disease (COPD), atrial fibrillation (irregular, rapid heart rate), diabetes, chronic kidney disease, post-traumatic stress disorder (PTSD), Parkinson's disease, and hypertension (high blood pressure). *His Brief Interview for Mental Status (BIMS) assessment score was 1, which indicated he was severely cognitively impaired. On 5/1/25 at 11:46 a.m. LPN U's personal file was requested from DON A, but it had been closed and sent to the Human Resources Department. 3. Interview on 5/1/25 at 1:46 p.m. with director of	F 600		

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F 600	Continued From page 3	F 600		

nursing (DON) A regarding resident 210 revealed she:
*Had watched the 1/24/25 camera footage and had seen LPN U put her hand on resident 210's head but LPN U did not listen to his stomach or do any vitals after his emesis.
*Stated LPN U did not initiate the standing order for an upset stomach.
*Stated the staff gave resident 210 a regular diet that evening instead of thin liquids for his upset stomach.
*Stated LPN U reported to the night nurse that he had an emesis once but was fine.

4. Homemaker X was unavailable for an interview at the time the survey was conducted.

5. Phone interview on 5/1/25 at 3:07 p.m. with agency certified nursing assistant (CNA) V regarding resident 210 revealed:
*She was working the evening shift on 1/24/25 and had heard that resident 210 had an emesis earlier that day.
*She had heard a loud sound coming from resident 210's room after supper.
-He was sitting on the side of his bed, and his walker had fallen over.
*He had told her he wanted to lie down and rest.
*She stated she raised the head of the bed 45 to 60 degrees due to him having emesis earlier that day.
*She stated she checked on him until 10:00 p.m., then she left due to being assigned to another resident area. It wasn't until later when the nurse in that neighborhood got a call from a CNA that resident 210 had aspirated and needed assistance.

6. Phone interview on 5/1/25 at 3:11 p.m. with

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F 600	Continued From page 4	F 600		

agency licensed practice nurse (LPN) W regarding resident 210 revealed:
*She was working the evening shift on 1/24/25 and had heard he had an emesis earlier that day and later that evening, she got a call from a CNA that resident 210 had aspirated and needed assistance.
*She stated that when she had gotten to his room, he was "air hungry"; and he had an advanced directive of a do-not-resuscitate.
-She stated the head of the bed was elevated 45 to 60 degrees.
*She had called his power of attorney (POA), and the POA said to make him comfortable, and when she returned to resident 210's room, he had passed away within one to two minutes.
*She said he had emesis all over his clothes and while she cleaned him up and turned him over to his side, more of the emesis had come out of his mouth.

7. Interview on 5/1/25 at 4:27 p.m. with DON A regarding LPN U revealed:
*LPN U had multiple coaching sessions with a nurse educator.
*The nurse educator would often be with LPN U on the floor, ensuring LPN U completed her nursing duties as required.
*She stated LPN U's performance had improved for a while.
*Some of the issues they had with LPN U included her lack of safety measures, which included not locking the medication cart, not using appropriate hand hygiene, failure to accurately chart on residents, failure to properly assess residents conditions, and medication administration errors.
*They continued to investigate LPN U's competency as a nurse, and had moved forward

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F 600	Continued From page 5 with termination. The provider implemented actions to ensure the deficient practice does not recur was confirmed after record review revealed the facility had followed their quality assurance process, education was provided to all staff regarding understanding of documentation processes, assessments, vital sign assessments, the importance of comprehensive change of shift reporting, and a change of a resident's condition. Audits were being continued for completion of nursing assessments after an incident and discussed in QAPI. Interviews and observations indicated staff understood the education provided. Based on the above information, non-compliance at F600 was determined to have occurred on 1/24/25, and the provider's implemented 3/23/25 corrective actions for the deficient practice confirmed on 5/1/25; the non-compliance is considered past non-compliance.	F 600		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 657	1. Upon identification from surveyors that the care plan did not reflect the current necessary needs for resident 47, the Resident Care Coordinator (RCC) took immediate steps to review his/her orders and update them as appropriate; the Assistant Director of Nursing (ADON) corrected the care plan to reflect these orders. Immediate verbal education was provided to nursing staff regarding the importance of maintaining updated care plans. 2. All residents in the facility have the potential to be affected in a similar manner.	06/27/25

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F 657	Continued From page 6 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to ensure the care plan was reviewed and revised to reflect the current necessary care needs for one of one sampled resident (47). Findings include: 1. Observation on 4/29/25 at 11:35 a.m. of resident 47 in his room revealed: *He was seated in a recliner with the footrest halfway up. -He had on a pair of gripper socks on his feet. Observation on 4/30/25 at 1:48 p.m. of resident 47 in his room revealed: *He was seated in a recliner with the footrest up, and he was covered with a blanket. *A wheelchair was across the room, against the wall, with a pair of protective boots on the seat. Observation on 4/30/25 at 2:59 p.m. and again at 3:07 p.m. of resident 47 revealed he was lying on his bed, his eyes were closed, and a bed cradle	F 657	To ensure no other residents were affected by these deficient practices, a review of each resident's orders and care plans was conducted to confirm accuracy and cohesiveness. 3. The current "Using the Care Plan" policy will be updated to "Care Planning" policy to include the directions on when the care plan must be reviewed and updated. This policy will be uploaded into Relias and assigned to all nursing staff with a due date of 6/15/25. A review of the current nursing staff orientation process and checklist will be completed to ensure necessary education is provided regarding the care planning process. 4. The MDS Coordinator or designee will complete audits of resident orders and care plans to ensure accuracy and cohesiveness; five (5) random audits will occur weekly for four (4) weeks, bi-weekly for four (4) weeks, then monthly for one (1) month. Audits will begin on 6/2/25 with the potential to end on 9/2/25 pending 100% compliance and as determined by the QAPI team.	

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F 657	Continued From page 7	F 657		

device (suspends bedsheets and blankets off a person's legs and feet) was holding the blankets off his feet.

Review of resident 47's electronic medical record (EMR) revealed:
*His admission date was 1/16/24.
*His Brief Interview of Mental Status assessment score was a 3, indicating he was severely cognitively impaired.
*His diagnoses included: Parkinson's, dementia, chronic pain, post-traumatic stress disorder, disorders of bone density and structure, paralysis of 7th and 11th cranial nerves, pain, neurostimulator for low back pain, urgency of urination, anxiety disorder, insomnia, osteoarthritis of the hip, and hallucinations.

Review of resident 47's 4/30/25 care plan revealed he was:
*To wear compression stockings on his feet and legs.
*To wear foam boots when he was in bed.
-It did not specify if he was to wear the boots when in his recliner.
*Unable to walk independently and needed staff members to assist him to "walk around" and "I need to be reminded to take big sets [steps] when walking."
*Unable to walk.
*To be transferred with the use of a Hoyer [a mechanical lift and sling that lifts a person's full body) lift or a ceiling lift.
*Had a pressure "pressure injury noted to my left second toe."
-There was no diagnosis in his EMR for this pressure injury.

Review of resident 47's 4/16/25 baseline care

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F 657	Continued From page 8	F 657		

plan, provided to certified homemakers who cared for him, revealed:
*His mobility included: "Hoyer lift or ceiling lift".
*Supportive aides included "Ceiling lift for transfers".

Interview on 5/1/25 at 1:25 p.m. with certified homemaker N regarding resident 47 revealed:
*She would refer to the resident's baseline care plan when she provided care to resident 47.
*She knew there was a care plan in the resident's EMR, but she did not use that one.
*He was no longer able to walk.
*Could self-propel himself in a wheelchair for short periods.
*He did not wear compression stockings as his wife did not want him to wear them.
*He used protective boots "periodically" when in his recliner.
*He was not to wear socks as they rubbed on his toes.

Interview and EMR review on 5/1/25 at 1:31 p.m. with licensed practical nurse (LPN) E regarding resident 47's toe pressure wound revealed:
*She thought he only wore protective boots on his feet when he was in bed.
*She verified he had physician's orders to use a bed cradle for blankets and to have protective boots on in the a.m., p.m., and nighttime, for pressure relief.

Interview on 5/1/25 at 1:44 p.m. with registered nurse (RN) M and RN L regarding resident 47's care plan revealed:
*RN L stated that the Minimum Data Set (MDS) assessment nurse coordinator updated the residents' care plans
*She stated the MDS coordinator was out of the

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F 657	Continued From page 9 building and unavailable for an interview. Interview on 5/1/24 at 2:55 p.m. with assistant director of nursing (ADON) B revealed: *Resident 47 no longer wore compression stockings on his legs. *He had pressure wounds to his toes, and was unable to walk. *The MDS Coordinator was responsible for updating the resident's care plan. -The care plan in the EMR should have been updated with new orders or when there were changes in a resident's condition or their care needs. *Resident 47's EMR care plan should have included: -He was not to wear compression stockings on his feet and legs. -He was to wear foam boots when he was in bed. -He was to wear foam boots when in his recliner. -Identify if he was able walk or if he was unable to walk. Review of the provider's 6/12/23 Using the Care Plan policy revealed: *"The nurse supervisor uses the care plan to complete CNAs daily/weekly work assignment sheet and/or flow sheets." *"The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident." *"CNAs are responsible for reporting to the nurse supervisor any change in the resident's condition and care plan goals and objectives that have not been met or expected outcomes that have not been achieved." *"Other facility staff noting a change in the resident's condition must also report those	F 657		

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F 657	Continued From page 10 changes to the nurse supervisor and/or MDS Coordinator." *"Changes in resident condition should also be reported to the ADON or DON, whomever is on call, immediately." *"Changes in the resident's condition must be reported to the MDS Coordinator so that a review of the resident's assessment and care plan can be made." *"Documentation must be consistent with the resident's care plan." Review of the provider's 2/27/24 Pressure Ulcer Prevention and Treatment policy revealed: *"Care plan will reflect current wound status and treatment and be updated as needed."	F 657		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure ordered treatments for a current pressure ulcer	F 686	1. Upon identification that resident 47 did not have his ordered foam boots on, the ADON provided immediate verbal education to the nursing staff regarding the importance of following provider orders, treatments, and care plans; she assisted nursing staff by putting on the resident's foam boots. Further, the RCC updated the foam boot order to state "continuous." 2. All residents in the facility have the potential to be affected in a similar manner. To ensure that no other residents were affected by these deficient practices, the ADON and Nurse Manger (NM) reviewed current provider orders and care plans to ensure that all residents with pressure relieving devices had them in place. 3. The "Pressure Ulcer Prevention and Treatment" policy will be reviewed and updated as appropriate. This policy will	06/27/2025

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F 686	Continued From page 11 (skin wound caused by prolonged pressure) were completed and preventative interventions were consistently implemented for one of one sampled resident (47) who developed additional pressure ulcers (wounds) on his toes. Findings include: 1. Observation on 4/29/25 at 11:35 a.m. of resident 47 in his room revealed: *He was seated in a recliner with the footrest halfway up. -He had on a pair of gripper socks on his feet. Observation on 4/30/25 at 1:48 p.m. of resident 47 in his room revealed: *He was seated in a recliner with the footrest up, and he was covered with a blanket. *A wheelchair was across the room, against the wall, with a pair of protective boots on the seat. Observation on 4/30/25 at 2:59 p.m. and again at 3:07 p.m. of resident 47 revealed he was lying on his bed, his eyes were closed, and a bed cradle device (suspends bedsheets and blankets off a person's legs and feet) was holding the blankets off his feet. Observation on 5/1/25 at 8:12 a.m. and again at 9:27 a.m. of resident 47 in his room revealed: *He was seated in a recliner with the footrest up he was covered with a blanket. *His left foot had two silicone spacers placed between his toes. -The first silicone spacer was between his first and second toes, and the other silicone spacer was between his second and third toes. *A wheelchair was across the room, against a wall, with a pair of protective boots on the seat. 2. Interview on 5/1/25 at 8:32 a.m. with certified	F 686	be uploaded into Relias for all nursing staff to review with a due date of 6/15/25. 4. The ADON or designee will audit resident Treatment Administration Records (TAR) for the completion and documentation of orders then visually verify the placement of pressure relieving devices; five (5) random audits will occur weekly for four (4) weeks, bi-weekly for four (4) weeks, then monthly for one (1) month. Audits will begin on 6/2/25 with the potential to end on 9/2/25 pending 100% compliance and as determined by the QAPI team.	

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	43A136	A. BUILDING _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME	2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747

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F 686	Continued From page 12	F 686		

homemaker N regarding the care needs of resident 47 revealed:
*He received a bed bath two days per week. He used to receive three baths per week. That was changed "about two or three weeks ago" due to the "pressure wound [ulcer] on the second toe of his left foot".
-He was to have a silicone spacer placed between his first toe and his second toe.
-She thought the nurses completed wound care on his toe two times each day.

3. Review of resident 47's electronic medical record (EMR) revealed:
*His admission date was 1/16/24.
*His Brief Interview of Mental Status assessment score was a 3, which indicated he was severely cognitively impaired.
*His diagnoses included: Parkinson's, dementia, chronic pain, post-traumatic stress disorder, disorders of bone density and structure, paralysis of 7th and 11th cranial nerves, pain, neurostimulator for low back pain, vitamin D deficiency, and osteoarthritis of hip.
*His 4/7/25 Braden scale (an assessment of a patient's risk for developing pressure wounds) score was 13-14, indicating he was at moderate risk for skin breakdown.

4. Review of resident 47's physician orders revealed his skin treatment orders included:
*On 12/2/24 "foam boot(s), AM PM NOC [night] for pressure relief."
*On 12/31/24 a physician order for, "foot cradle when in bed for pressure relief."
*On 12/10/24, "Weekly skin charting 1 x wk [one time each week]."
*On 4/23/25, Apply small amount of Amerigel [wound healing product] & [and] light dressing to

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the L [left] 2nd digit [toe] every other day AM NO FOOT SOAKS. Keep Left 1st and 2nd toe separated with use of silicone toe spacer."
*On 4/24/25, "Keep Left 1st and 2nd toe separated with use of silicone toe spacer, Check twice a day AM HS".
*On 4/28/25, "DO NOT put socks on toe pressure relief AM PM NOC".

5. Review of resident 47's podiatry notes included:
*On 1/22/25, he had a wound on the medial left second digit [toe] with bone exposed, and no signs of infection. The treatment ordered was to apply betadine and a Band-Aid daily with a silicone toe spacer, and no foot soaks.
*On 2/12/25, a note indicated he had a "small open sore approximately the size of the tip of a large sharpie" and "the wound is approximatel [approximately] .3 [0.3 cm] in diameter".
*On 3/14/25 a note that indicated he had a "sore to the medial aspect of his left second digit. Compared to his last visit it has filled in significantly and no bone is noted", and "small open sore approximately the size of the tip of a large sharpie."

6. Review of resident 47's 1/22/25 radiology report indicated he was seen for an evaluation for "osteo [osteomyelitis, bone infection] left 2nd digit, pt [patient] has ulcer".
-He had a previous partial amputation of the distal 2nd phalanx [a bone of the toe].
-There was no radiographic evidence of osteomyelitis.
-There were mild degenerative changes "at the first interphalangeal joint."

7. Review of resident 47's baseline care plan

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F 686	Continued From page 14 provided to certified homemakers who cared for him revealed his skin care included his need to wear bilateral foam boots while in bed, and the use of a foot cradle. 8. Review of resident 47's 4/30/25 care plan revealed: *A 4/16/25 focus area that indicated he had the potential to fall. -The intervention for that focus area included "apply my compression stockings assist me with transfers or when I walk remind me to ask for help". *A 4/16/25 focus area indicated he had a pressure injury to his left second toe, "Because I can't move around well on my own." -Interventions for that focus area included bilateral foam boots while in bed and a foot cradle. -The goal for that focus was "to have my skin heal and avoid infection". *A 4/16/25 focus area indicated he required assistance to complete his care. -The interventions for that focus area included "I need bed baths I cannot have foot soaks until my pressure injury is healed", and "foam boots in bed, foot cradle." 9. Review of resident 47's nurse progress notes revealed: *On 4/18/25, it was noted he had an open lesion (wound) on the second inner toe of his foot with dimensions of that wound documented as "1cm" [centimeter]. *On 4/20/25, it was noted he had a wound on his left anterior toes with documentation of "Remove date of 4/13/25. This nurse performs txmt [treatment] 4/19/25 bandage clean dry and intact".	F 686		

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F 686	Continued From page 15 *On 4/26/25 and 4/27/25, it was noted he had a wound to his "Left anterior toes". *On 4/28/25, it was noted he had: -A "Stage 1 or greater ulcer" on his left 2nd toe", described as "open area to inner medial aspect, surrounding skin fragile, reddened, with soft-red scab." --The dimensions of that wound were 0.4 cm x [by] 0.1 cm with no depth measurement. --The wound care treatment provided was "Area cleansed w/ [with] wound cleanser, applied Amerigel, covered with band-aid, foam spacer placed between 1st and 2nd digits." -A pressure ulcer to his "left lateral aspect, 3rd toe", described as "small open area-wound bed reddened, older brown-drainage noted between 3rd and 4th toes. Surrounding skin dry and intact, no redness." --The dimensions of this wound were 0.4 cm x 0.2 cm with no depth measurement. --This was a new pressure ulcer. -A pressure ulcer to his "left medial aspect, 4th toe", described as "open area-wound bed reddened, older brown-drainage noted between 3rd and 4th toes. Surrounding skin dry and intact, no redness." --The dimensions of this wound were 0.3 cm x 0.4 cm, with no depth measurement. --This was a new pressure ulcer. -The possible cause for the pressure wounds was listed as "Continuous pressure between toes". -Additional comments included "Nurse was completing ordered wound care for left 2nd toe-nurse noted old-brown discharge along 3rd toe, nurse separated toes to clean area and found two new pressure injuries." "Gauze placed between toes to reduce pressure." "Nurse suggested no socks/stockings to left foot until seen by HCP [health care provider]."	F 686		

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*On 4/29/25, it was noted he had pressure wounds on his 2nd, 3rd, & 4th toes, and "Silicone wedges for toes in place, foam boots while in bed, no tight socks/stockings."

10. Review of resident 47's treatment administration record (TAR) revealed for April 2025:
*The 12/2/24 order for his wound treatment of " Foam boots, AM PM NOC for pressure relief" was not documented as completed for the 4/3/25 NOC, 4/4/25 a.m. and p.m., and 4/25/25 a.m. and p.m. scheduled times.
*The order for his wound treatment of his left second toe "Clean with wound cleanser, apply small amount of Amerigel to wound, cover with band aid, use silicone toe separator daily AM, no foot soaks until resolved" was not documented as being completed on 4/5/25, 4/11/25, and 4/22/25.
-That order was discontinued on 4/23/25.
*The 4/24/25 order for his wound treatment of "Keep left 1st and 2nd toe separated with use of silicone toe spacer, Check twice a day AM HS" was not documented as completed for the 4/25/25 p.m. and 4/30/25 a.m. scheduled times.
*The 4/9/25 order for his wound treatment of "Clean sore every dressing change. Apply Puracel and bandaid to L 2nd medial toe, then toe spacer. AM every other day NO FOOT SOAKS" was not documented as completed on 4/22/25.
-That order was discontinued on 4/23/25.

11. Interview on 5/1/25 at 1:25 p.m. with certified homemaker N regarding the care needs of resident 47 revealed:
*He was no longer able to walk and was dependent on the use of a wheelchair for mobility.
*He was not to wear compression stockings.
*She had received an "email" last week that he

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F 686	Continued From page 17 was not to wear socks due to them rubbing on his toes. *He often sat in his recliner. *He had a wound on one of his left toes. *He sometimes used "puffy boots [protective boots]" to protect his toes. *She confirmed he was not wearing "puffy boots" that morning when he was in his recliner, as "we were just letting his toe air out." *She would have to confirm with the nurse when he was to wear those boots. 12. Interview and EMR review on 5/1/25 at 1:31 p.m. with licensed practical nurse (LPN) E regarding resident 47's toe pressure wound revealed: *She thought he only wore protective boots when he was in bed. *She verified he had physician's orders were to use a bed cradle for blankets and to have protective boots on in the a.m., p.m., and nighttime, for pressure relief. -She stated the bed cradle was only used when he was in bed and not when he was in his recliner. --When in his recliner, he was covered with a "light blanket" that extended over his toes. -She stated the order did not say "continuous" use of the protective boots, and she would have to ask the physician for clarification, as she was unaware of what a.m., p.m., and nighttime meant. *She stated he used a silicone spacer between his left great toe and his left second toe due to them "pulling into each other." *She was not aware that the silicone spacers for his toes had been missing. *She indicated that according to his EMR, the treatment to his left toe was to be changed to "every other day" on 4/23/25.	F 686		

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F 686	Continued From page 18 *She indicated he had pain with the wound care to the toe, as evidenced by saying "owe" and trying to pull his foot back when the nurse performed the treatment. -She confirmed he did not receive any pain medication before having the wound care; he had a nerve stimulator implanted for his hip, but she stated that would not have helped the pain in his toe. 13. Interview on 5/1/25 at 1:44 p.m. with registered nurse (RN) M and RN L regarding the care needs of resident 47 revealed: *He was seen at wound care clinic, every two weeks, for follow-up with his toe pressure wounds. -The wound care clinic would prescribe the treatment for his toe wounds. His current treatment was for Amerigel light dressing to be applied to his toe every other day, and not to have foot soaks or showers. *The silicone toe separator that was to be placed between his left 1st and 2nd toe, was missing once. -Foam was used in place of the silicone that day, additional silicone spacers were ordered, and the silicone spacer was found "after five hours". 14. Observation, interview, and record review, on 5/1/25 at 1:55 p.m. with RN L of resident 47 revealed: *Resident 47 was lying in his bed, the foot cradle was in place holding the blankets above his toes, and he was wearing protective boots with his toes exposed. *Observation of the toes on his left foot revealed: -A Band-Aid around the second toe. -A silicone spacer was between the second and third toes and between the third and fourth toes.	F 686		

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F 686	Continued From page 19 -She removed the silicone spacers and the Band-Aid. -She stated she did not see any pressure injury on his third toe. *After having reviewed resident 47's 4/28/25 and 4/29/25 EMR wound notes, that indicated he had new pressure wounds to his left foot toes, with RN L revealed she did not offer any comment. 15. Interview on 5/1/25 at 2:39 p.m. with RN L revealed she would be re-assessing resident 47's toes and would provide the measurements of all wounds when she was done. 16. Interview on 5/1/25 at 2:59 p.m. with assistant director of nursing (ADON) B and director of nursing (DON) A regarding resident 47's pressure wound revealed: *ADON B's expectation regarding the order of a.m., p.m., and nighttime use of protective boots was for the nurse to have confirmed that the boots were on the residents' feet. *When informed of the observations of protective boots not being on, she stated that it was a "good education moment." -She confirmed he should have had protective boots on when he was in his recliner, and silicone spacers or a foam pad should have separated his toes. *She stated, "The paperwork for his 3rd and 4th toe pressure wounds was just turned in." *The physician's order for a dressing to his second toe was changed on 4/23/25 from daily to every other day. *She stated his second toe wound was healed, and on 4/28/25, new pressure wounds were identified on the toes of his left foot. *She stated the use of a foam separator between his toes could have also caused pressure.	F 686		

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F 686	Continued From page 20 *She would have to review his EMR to determine how and when the wound started. 17. On 5/1/25 at 3:11 p.m. RN L and ADON B provided the survey team with a document regarding resident 47's toe pressure wounds that included: *The pressure injury to his left first toe was healed. *His left second toe pressure wound measured 0.3 centimeter (cm) in diameter. *His left third toe and left fourth toe pressure wounds measured 0.4 cm in diameter each. *His right great toe had an area of peeling skin that measured one cm in diameter. *They confirmed the resident had additional pressure wounds acquired in the facility. 18. Review of the provider's 2/27/24 Pressure Ulcer Prevention and Treatment policy revealed: *"It is the policy of the [provider's name] that all residents be protected from pressure ulcers and have a protocol in place to treat." *"Pressure Ulcer-Goals". -"Prevention of pressure ulcers. -Early recognition of pressure ulcer development/skin changes. -Implementation of protocols as determined by Braden score. -Document presence or absence of skin issues." *"Pressure Ulcers-Nursing Care Strategies and Interventions". -"A skin assessment will be done on a weekly basis at bath time for those residents at risk or when their condition changes." -"Document Braden scores and implement prevention protocols based on Braden scale score." -"Residents with a Braden Score of 18 or below	F 686		

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F 686	Continued From page 21 with skin issues will be documented on daily." -"Residents will be seen every week by PCP or with changes to evaluate effectiveness of current treatment regimen." -"Any resident with an active skin issue regardless of their Braden score will be documented on daily" *"General Care Issues and Interventions". -"Use pillows or other devices to keep bony prominences from direct contact with each other." -"Raise heels of bed-bound residents off the bed and use foam boot." -"Use pressure-reducing devices, if a pressure-reducing device is ordered it must be ordered for wheelchair, recliner and bed." -"Protect skin from friction and pressure related to oxygen tubing, splints/braces, foley catheters, cpap/bipap masks, glasses, and tight-fitting clothing."	F 686		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure an environment free from potential hazards by not following their policy and ensuring that lighters for two of two sampled residents (33 and 42) who smoked were secured at the nurses' station when	F 689	1. Upon identification that resident 33 and resident 42 did not return their lighters to the nurse's station per policy, the Household Coordinator (HHC) immediately obtained their lighters and educated them on the importance of following the facility's policy to return smoking to return smoking paraphernalia to the nurse's station when not in use. Further, immediate education was provided to the nursing staff on the affected unit on the importance of following the smoking policy. 2. All residents have the potential to be affected in a similar manner. To ensure that no other residents were affected by the same deficient practices, the HHC provided direct education to all residents that smoke as well as the nursing staff.	06/27/2025

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F 689	Continued From page 22 not in use. Findings include: 1. Observation on 4/29/25 of resident 33 in the dining room at 4:43 p.m.: *Resident 33 asked homemaker K for cigarettes. *Homemaker K provided her with two cigarettes but no lighter. *Multiple random daily observations from 4/29/25 through 5/1/25 revealed resident 33 was outside of the unit at the designated smoking area. *Observation on 5/1/25 at 2:30 p.m. of resident 33 in her neighborhood revealed she: *Was wearing a coat and asked another resident to go out to the smoking area with her. *Received two cigarettes from an unidentified staff member. *Had not requested or received a lighter from staff prior to exiting the unit and going outside to the smoking area. *Interview on 4/29/25 at 4:45 p.m. with resident 33 revealed: *She was going outside to smoke. *She had gotten two cigarettes from homemaker K. *She had her own lighter in her possession. *She was only to go out to smoke if she was with another resident who smoked or a staff member. *Sometimes she would turn in her lighter to a staff member, but sometimes she would forget. *Review of the 2/10/25 smoking assessment for resident 33 revealed: *A nurse was supposed to dispense to her a limited supply of cigarettes. *She had signed a smoking agreement. *She had been instructed about the facility's	F 689	3. Upon admission, all residents that smoke will be required to review and sign the Smoking policy as acknowledgement of the rules. The ADON and NM will complete periodic spot checks of residents that smoke to ensure they do not have smoking paraphernalia in their room. 4. The NM or designee will complete audits of residents that smoke to ensure they have returned their smoking items to the nurse's station;five (5) random audits will occur weekly for four (4) weeks, bi-weekly for four (4) weeks, then monthly for one (1) month. Audits will begin on 6/2/25 with the potential to end on 9/2/25 pending 100% compliance and as determined by the QAPI team.	

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MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME	2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747

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F 689	Continued From page 23 smoking policy. *Review of resident 33's electronic medical record (EMR) revealed: *Her most recent Brief Interview for Mental Status (BIMS) assessment score was 8 which indicated she had moderate cognitive impairment. *Her diagnoses included dementia and depression. *Review of resident 33's 2/19/25 care plan revealed: *"I am forgetful because I have vascular dementia." *"I need my nurses to secure lighter and cigarettes at nurses' station." *"I need my aides to support the safe storage of my cigarettes and lighter." *"I need social services to make sure I understand what the smoking policy says." 2. Interview on 5/1/25 at 5:30 p.m. with resident 42 revealed: *He spent as much of the day as possible outdoors as he felt the the walls "close in". *He had possession of his cigarettes and lighter. *He kept them in his possession as he went outside frequently and didn't want to bother the staff. *He knew that the policy said that smoking materials were to be turned to staff upon return from smoking but the staff had not asked him for them. *Review of resident 42's EMR revealed: *His most recent BIMS assessment score of 15 indicated that was cognitively intact. *His diagnoses included post traumatic stress disorder (PTSD) and depression.	F 689		

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F 689	Continued From page 24	F 689		

*Review of the 4/1/25 smoking assessment for resident 42 revealed:
*His smoking paraphernalia should have been stored at the nurses' station.
*The resident was aware of and demonstrated clear understanding of the facility smoking standards.
*He had signed a smoking agreement.
*He had been instructed on the facility's smoking policy.

*Review of resident 42's 4/17/25 care plan revealed:
*"I need my nurses to secure lighter and cigarettes at nurses' station."
*"I need my aides to support the safe storage of my cigarettes and lighter."
*"I need social services to make sure I understand what the smoking policy says."

3. Interview on 4/30/25 at 4:00 p.m. with human services social worker G revealed:
*She had been employed by the provider for about two months.
*She expected that staff would be ensuring that all cigarettes and lighting materials for residents who smoked were returned to the staff when the resident reentered the building after smoking.
*She was not aware that resident 33 and resident 42 had possession of their lighters.
*All staff were responsible for ensuring that the smoking policy was followed, including the returning and storing of smoking materials at the nurses' station for the resident's safety.

*Interview on 5/1/25 at 2:06 p.m. with certified homemaker J revealed:
*She had been employed by the facility for 14

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F 689	Continued From page 25 years. *The smoking policy required residents to request their smoking materials from the staff and to return them to staff after returning to the unit from the outdoor smoking area. *The smoking materials did not always get turned in to the staff. *Resident 33 would sometimes turn in her lighter to the staff and sometimes the staff would retrieve the lighter from her. *Resident 42 kept his smoking materials and did not turn them in to staff. *Interview on 5/1/25 at 3:30 p.m. with household coordinator H revealed. *She was the coordinator for the unit where residents 33 and 42 resided. *She expected residents' smoking materials to be checked in and out at the nurses' stations with each use per the facility smoking policy. *She was aware that the the residents' smoking materials were not always checked in and out. *It was difficult to keep track of lighters as residents would buy new ones when out on shopping trips and keep them in their possession. *Interview on 5/1/25 at 5:15 p.m. with director of nursing (DON) A revealed: *It was their facility policy for residents' smoking materials to be kept at nurses' station. *She expected residents' smoking materials to be checked in and out of the nurses' station per their policy for the safety of all of the residents. *She was not surprised to hear that some residents were in possession of their smoking materials. *She agreed that residents having lighters in their possession was a safety issue.	F 689		

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F 689	Continued From page 26 *Review of the provider's undated nursing care resident smoking policy and agreement revealed: *"All cigarettes and smoking materials will be left at the nurses' station." *"At no time will residents on the Nursing Care Units be allowed to keep matches, lighters, or fire producing devices in their rooms." *"The designated smoking shelter is located west of the building on the second level." *"Smokers who require supervision must be supervised by volunteer or staff." *"Residents that are able to leave the unit independently may take their lighting devices with them but return them to the nurses' station once they have returned to the unit." *"All smoking paraphernalia [materials], including but not limited to, cigarettes, matches, lighters, will be kept at the nursing state or designated area. Residents are not allowed to keep their smoking material in their rooms."	F 689		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880	1. Upon identification from the surveyors that nursing staff E, O, R, and S were not following the appropriate precautions for residents 10, 49, and 360 on Enhanced Barrier Precautions (EBP), the Infection Prevention Nurse (IPN) provided immediate verbal education regarding the importance of following EBP guidelines. Upon identification that the storage and maintenance of wound care supplies in the wound care cart on Nasa household did not meet infection prevention criteria, the NM immediately corrected the issue by removing outdated items and cleaning the items that were able to be disinfected.	06/27/2025

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F 880	Continued From page 27 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (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	F 880	2. All residents in the facility have the potential to be affected in a similar manner. To ensure that no other residents were affected by the same deficient practices, the IPN completed a review of each EBP room to ensure appropriate PPE and door signage was available. The IPN provided education to all nursing staff via competency. The wound care cart that was temporarily trialed has been removed; wound care supplies will be placed in cleanable basins in the secure med rooms on each unit. 3. The EBP competency is completed upon hire and annually. The EBP policy has been reviewed and remains appropriate per CDC guidelines. PPE for residents requiring EBP will be placed in a standard area in each resident's room for continuity of care/access; back up supplies have been placed at each nurse's station. The IPN will round weekly to ensure there is a sufficient number of supplies available to nursing staff. 4. The IPN or designee will complete audits during cares provided to residents on EBP to ensure the proper PPE is donned and doffed appropriately; ; five (5) random audits will occur weekly for four (4) weeks, bi-weekly for four (4) weeks, then monthly for one (1) month. Audits will begin on 6/2/25 with the potential to end on 9/2/25 pending 100% compliance and as determined by the QAPI team.	

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F 880	Continued From page 28 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 record review, observation, interview, and policy review, the provider failed to ensure proper infection control practices were followed regarding: *Hand hygiene and personal protective equipment (PPE) use by four of four observed staff (E, O, R, and S) for one sampled resident (360) with a physician order for contact precautions related to an infected unhealed chest wound and two sampled residents (10 and 49) on enhanced barrier precautions (EBP) who resided in the NASA unit. *The storage and maintenance of wound care supplies in one of one observed treatment cart located in the NASA unit. Findings include: 1. A review of resident 360's electronic medical record (EMR) revealed: *He was admitted on 4/16/25 and resided in the NASA unit. *He had a diagnosis of chronic kidney disease, stage 5, which required dialysis (a process that filters waste and excess fluids from the blood when the kidneys are unable to do so effectively) three times a week. *He had a recent dialysis fistula (a connection	F 880		

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made between an artery and a vein for dialysis access) placed in the upper right arm.
*He had a double-lumen central line (a tube inserted into a large vein above the heart that comes out from under the skin and is used to deliver fluids and medications) in his right chest.
- He had no physician orders for the care and treatment of the central line.
*He had a history of chronic empyema (infected fluid in the space between the lungs and chest wall) with the placement of a chest tube.
*He currently had an unhealed left-sided chest wound secondary to the chest tube removal and was on an antibiotic (actively infected).
*A 4/28/25 physician progress note indicated he was diagnosed with a surgical wound infection.
*He had a physician order to change the left-sided chest wound dressing twice daily.
*He had a physician order to use silver nitrate sticks as needed when bleeding from the chest wound (draining wound) occurred.
*He had a diagnosis of a bacteria called Methicillin-resistant Staphylococcus aureus (MRSA); a type of Multidrug-Resistant Organism (MDRO) resistant to several antibiotics.
*The MRSA was colonized (the organism was present on or in the body) and could spread to others through direct or indirect contact with the resident or his environment.
*His history and physical dated 4/17/25 included a physician's order for "contact" precautions (a transmission-based precaution) for the unhealed chest wound and a history of MRSA.
-He was not on "contact" precautions the physician ordered on 4/17/25.

2. Observations on 4/30/25 from approximately 3:00 p.m. through 5:00 p.m. and on 5/1/25 from approximately 8:00 a.m. through 10:30 a.m. in the

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F 880	Continued From page 30 NASA unit revealed: *Residents 10, 49, and 360 had signs posted on the outside door frames of their rooms that indicated what personal protective equipment (PPE), such as gloves and gowns, staff and visitors were required to wear when entering the rooms. *There were no PPE supplies available outside or inside the doors of residents 10, 49, and 360 rooms. *LPN E, agency LPN O, and homemakers R and S were observed entering residents 10, 49, and 360 rooms without performing hand hygiene or putting on gowns and gloves during direct resident care and while performing environmental tasks. -Those staff touched contact surface areas of beds, linens, call lights, handles on the drawers of the bathroom carts, dresser drawers, door handles, wheelchairs, and bedside tables. *LPN E, agency LPN O, and homemakers R and S were observed exiting resident 10, 49, and 360's rooms without performing hand hygiene. *Resident 360 did not have a sign posted for "contact precautions" to ensure his 4/17/25 physician order was followed. 3. Observation and interview on 4/30/25 at 3:09 p.m. with agency licensed practical nurse (LPN) O on the NASA unit revealed: *Wound care supplies were not stored in resident rooms. *Wound care supplies were labeled and stored separately for residents in gray plastic bins in the medication storage room, the treatment cart, and the unit's supply closet. *Wound care supplies were removed from the bins and taken into the resident's room for wound care treatment as they were scheduled.	F 880		

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F 880	Continued From page 31 *He stated there was "sometimes a cart stocked with PPE supplies inside or outside the resident's room" when residents were on precautions. *He confirmed resident 360 was on EBP for his open wound to the left chest. *He confirmed that Resident 360 was started on Doxycycline (an antibiotic) 100 milligrams (mg) by mouth twice daily for seven days on 4/25/25 for his chest wound infection. *He was unsure that resident 360 had a central line to his right chest and what care and treatment was to be provided. -He did report that he had confirmed with nurse management that resident 360 did have a central line. *He agreed that there were no PPE supplies stored outside or inside resident 360's room for staff and visitors to use to follow EBP and contact precautions for infection control. 4. Observation on 4/30/25 at 3:18 p.m. of homemaker R in the whirlpool room on the NASA unit with agency LPN O revealed: *Agency LPN O knocked and opened the door to the whirlpool tub room. *Homemaker R was assisting resident 360 with his bath. *Homemaker R was wearing gloves but no gown. *Agency LPN O informed her that a "gown should be worn because of the resident's wound". *Homemaker R stated, "I didn't know I was supposed to put a gown on." *Agency LPN O exited the room. *Homemaker R told resident 360, "I haven't had to wear a gown since I started working with you". "They [surveyors] are here and {the surveyors are} changing everything around". *Agency LPN O returned with a gown for homemaker R, who put on the gown and	F 880		

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F 880	Continued From page 32 completed the resident's bath. *After his bath, homemaker R assisted the resident back to his room in his wheelchair. -She assisted him from his wheelchair to his recliner chair. -She did not perform hand hygiene or put on gloves or a gown. 5. Observation and interview on 4/30/25 at 3:34 p.m. with homemaker S outside resident 360's room revealed: *An EBP sign was posted on the door frame. *She had a housekeeping cart parked outside the door of resident 360's room. *She stated she was cleaning his room and changing his bed linens. *She had no gloves or gown on. *She indicated that she did not wear PPE when cleaning resident rooms. *She stated she would only wear gloves and a gown when she assisted residents with personal care if they were on EBP. *She stated that the PPE should have been stored in a 3-drawer cart in the resident's bathroom. *No PPE supplies were found in the 3-drawer cart in the resident's bathroom. -The top drawer contained a variety of personal care cleansers and wipes. -The middle drawer contained incontinent products (pullups) and black trash bags. -The bottom drawer contained what appeared to be clear plastic bags. *She then searched the black 3-drawer wicker stand between the resident's bed and recliner. -No PPE supplies were found in those wicker drawers. *She did not complete hand hygiene or wear any PPE when she touched surface areas in his room	F 880		

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F 880	Continued From page 33 and when she handled his dirty bed linens. 6. Interview and observation on 4/30/25 at 3:42 p.m. of resident 10, 49, and 360's rooms with the director of nursing (DON) A regarding PPE revealed: *She stated that the PPE supplies for staff and visitors should have been set up and available outside of residents' rooms for those residents on EBP or contact precautions. *She agreed there were no PPE supplies outside of those residents' rooms. *She then stated the PPE supplies were kept in the 3-drawer carts in the residents' bathrooms. *She was unable to find any PPE supplies stored in those residents' bathroom carts. *She stated she would have to talk and clarify with the infection preventionist nurse where the PPE supplies should have been stored for staff and visitors to use to follow EBP and contact precautions for infection control. 7. Wound care observation on 4/30/25 at 3:46 p.m. of agency LPN O with resident 360 in the whirlpool bath area in the NASA unit revealed: : *Wound care supplies had been set up before the observation began. *Those supplies were on the counter, on top of clean paper towels. *Agency LPN O performed hand hygiene and put on a pair of gloves and a gown. *He added soap and warm water to a small basin. *He opened a sterile 4X4 gauze package and placed the gauze into the warm soapy water. *A transparent dressing was in place over the resident's left chest wound. *With his gloved hands, agency LPN O threw the wet, soapy gauze 4X4 into the trash and removed the transparent dressing from the resident's chest	F 880		

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F 880	Continued From page 34 wound. *He removed those soiled gloves and discarded them. *He did not perform hand hygiene and put on a pair of gloves. *A sterile 4X4 gauze was opened and placed into the warm soapy water. *He cleaned, rinsed, and dried the resident's wound. *He poured normal saline into a small basin. *A sterile 2X2 gauze was opened and placed into the normal saline. *He placed that gauze on the wound. *He then placed a dry, sterile 2X2 gauze pad on the wound. *He applied tape to all four edges of the dry gauze pad to secure it in place. *He then removed his gown and gloves and performed hand hygiene. 8. Interview on 4/30/25 at 5:15 p.m. with DON A revealed: *DON A stated that RN/infection preventionist Q had indicated that it was up to each unit or neighborhood to decide where to stock the PPE for staff and visitors for residents on EBP precautions. -Some residents would rummage through the supplies and throw them in the trash if the supplies were left in their room. -Each unit/neighborhood should have also had PPE stored at the nurse's station for the staff to use. 9. Interview on 5/1/25 at 8:09 a.m. with homemaker R revealed: *She had stocked resident 360's bathroom cart with gowns the previous evening after his bath. *She did not know she was to wear a gown and	F 880		

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F 880	Continued From page 35 gloves with resident 360 when in direct contact with the resident's skin, clothing, soiled linens, or potentially contaminated surfaces in his room. -She stated that she had been aware he was on EBP. *She indicated that each resident on EBP had different precautions to take and not everyone would be the same. 10. Observation on 5/1/25 at 8:21 a.m. in resident 360's bathroom revealed: *His bottom drawer of the cart was stocked with gowns. *Disposable gloves were available in the bathroom and stored in glove dispensers on a wall between the sink and toilet. 11. Interview on 5/1/25 at 9:08 a.m. with LPN E on the NASA unit revealed: *The treatment cart was parked across from the nurse's station. *Wound care supplies should have been kept in the treatment cart. *The treatment cart was stocked with the supplies stored in the supply closet. *Staff were to take the treatment cart and park it outside the resident's room when doing the resident's treatments. *Staff were not to take the treatment cart into resident rooms to keep it from potential contamination. *The cart was stocked with multi-use supplies for residents. *Resident supplies should have been kept separated in the treatment cart. -Each resident should have had a bin for their personal supplies. *Those resident-specific bins were removed from the treatment cart and taken into the resident	F 880		

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	43A136	A. BUILDING _____ B. WING _____	C 05/01/2025

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F 880	Continued From page 36 rooms for wound care treatments. -The bins should have been cleaned after being in the resident rooms, before putting them back into the treatment cart to prevent potential cross-contamination. -The bins were to be cleaned with the Micro-kill one germicidal alcohol wipes. *The bins in the treatment cart were cardboard. -She agreed cardboard was not a cleanable surface as it was porous (allows liquids or air to pass through it). -Cardboard would not have been considered cleaned and disinfected from contamination if a cleaning wipe had been used on it. *The multi-use scissors were to be cleaned with the Micro-kill one germicidal alcohol wipes after use and between uses for each resident. -She confirmed the two pairs of multi-use scissors in the top drawer were visibly soiled with dry, white residue. *She agreed that residents 10 and 360 had wound care supplies stored together in a cardboard bin and their supplies were not separated to prevent cross-contamination. *She confirmed there was an opened and used Optifoam dressing in the top drawer that had no open date and had not been labeled with a resident identifier. *She confirmed there was a tube of Hydrogel wound cleanser that had expired. *She confirmed there was a bottle of normal saline that should have been discarded after it had been opened and used. *She confirmed there were outdated Mepilex and Calcium Alginate with silver dressings in the bottom drawer. *The supplies should have been checked frequently and if outdated, they should be discarded.	F 880		

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F 880	Continued From page 37 *She stated that PPE should be worn by staff for residents on EBP or contact precautions. -She indicated that the infection preventionist nurse would put the signage on the resident's door and relay the infection control precaution information to the nursing staff on the units. *She confirmed that resident 360 was taking doxycycline 100mg by mouth twice daily for 7 days for an infection, but was unsure what infection the resident was being treated for. *She was aware that the resident had a fistula in his arm and a central line in his chest. -She was unsure of the care and treatment that should be provided to the central line. -She stated she wore gloves when she checked the resident's fistula after dialysis. *She was unsure if resident 360 should have been on EBP or contact precautions for a MDRO. -She stated, "It depends on what the infection is". 12. Observation on 5/1/25 at 9:39 a.m. in the NASA unit revealed: *Resident 10 did not have gowns stocked in his bathroom and they were not readily available in or near his room for staff to follow EBP. *Resident 49 had gowns stocked in his bathroom for EBP. -Gloves were stocked in dispensers in the bathrooms. *There were no gowns or gloves readily available for visitors to follow EBP. 13. Observation and Interview on 5/1/25 at 10:03 a.m. with RN/nurse manager P in the NASA unit revealed: *She was observed cleaning, organizing, and discarding supplies from the treatment cart. *She confirmed that the bins in the treatment cart were cardboard which was not a cleanable	F 880		

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F 880	Continued From page 38	F 880		

surface.
*She agreed that residents 10 and 360 had wound care supplies stored together in a cardboard bin and their supplies were not separated to prevent cross-contamination.
*She confirmed the two pairs of multi-use scissors in the top drawer were visibly soiled with dry, white residue.
*She confirmed supplies that were opened, unlabeled, and outdated should not have been used and should have been discarded.

14. Interview on 5/1/25 at 1:35 p.m. with RN/infection preventionist Q revealed:
*EBP should be used for residents with implanted medical devices, chronic wounds, catheters, chest wounds/tubes, tracheostomy, or any history of an MRDO.
*She would be notified by the resident care coordinator who worked with the provider by phone or email that EBP or contact precautions should be started.
-If she was gone, then the DON, assistant director of nursing (ADON), or the nurse manager for the unit would be called and notified and should know to initiate the precautions for a resident.
*She would place the resident on EBP or contact precautions at the time of admission if indicated or after she was notified.
-She would have placed the signage on the resident's door and stocked the resident's cart with the PPE supplies.
*She would notify the units and staff via email.
*She was notified that resident 360 was started on an antibiotic on 4/25/25 via email after the provider rounds for the resident.
*She stated, "Carts with PPE supplies were not set up in the resident rooms with residents on

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F 880	Continued From page 39 EBP". -PPE supplies were stocked "wherever it works best for the residents and staff". -"It was easiest to have PPE supplies at the nurse's stations for the staff" instead of in their rooms. *Carts with stocked PPE supplies should have been outside the resident's room for residents on contact precautions. -Staff were responsible for re-stocking the PPE supplies in the unit. *She did expect staff to follow the EBP and use the proper PPE when in direct contact with the residents. *She has gone to each unit to educate staff and notified staff frequently through emails. *Nursing staff cleaned resident rooms in the units. *She confirmed one homemaker would clean the resident's room while another homemaker completed the resident's bath. *She encouraged the staff to wear gowns and gloves when cleaning rooms for residents on EBP. -It was not required that staff were to wear a gown when cleaning the rooms for residents on EBP. *Staff should wear gloves when wiping surfaces in the EBP rooms. *She confirmed resident 360 had an order for contact precautions included in the physician and history and physical dated 4/17/25. *There were no orders for EBP or contact precautions on resident 360's EMR orders that staff could view for them to follow. *She was unsure why the EBP was not sufficient for his open wound and active wound infection with a history of MRSA. *She stated, "I thought he would still just be on	F 880		

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F 880	Continued From page 40 EBP precautions". *Staff were not following the physician's order for contact precautions. -Contact precautions were a transmission-based precaution (TBP) needed to limit the transmission of the resident's infection. 15. Observation on 4/29/25 at 11:37 a.m. and again on 5/1/25 at 8:46 a.m. revealed a treatment cart across from the nurses' station by the exit door. *This cart was unattended and unlocked. *In the top drawer of this treatment cart were: -Two pairs of scissors, one was a bandage scissor that had dried residue on the blades, the other pair of scissors had black handles and dried residue on the blades. -A package of Optifoam dressing that was torn open and had an uneven piece removed from the corner of the dressing. *In the third drawer, there were: -Several Aquaphor product tubes with resident 10's on them. -A container of sterile normal saline solution that was opened and had no open date on it, stored next to a lubricating jelly tube that was 3/4 empty, with no name of a resident on it, and sticky to the touch. -Dermal wound cleanser 3/4 gone with no resident name on it, stored next to Curad bandaids -In a cardboard container with resident 10's name handwritten in black marker was a tube of Remedy moisturizing skin cream stored next to the Aquaphor tubes (2) that were opened with resident 360's name on them. -Next to the Aquaphor was a tube of open hydrogel wound dressing.	F 880		

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F 880	Continued From page 41 16. Observation on 5/1/25 at 2:57 p.m. of the treatment cart revealed: *There were medical supplies that were being used for wound dressing changes for residents on the NASA unit. *The cart contained the following: -One Lubricating Jelly with an expiration date of 3/24/23. -One 1 oz tube of Hydrogel wound dressing with an expiration date of 5/2024. -One bottle of Peroxide 3% with an expiration date of 2/15/25. -Five Mepilex 6x6 inch foam dressings, three of those with an expiration date of 11/28/23 and two with an expiration date of 10/28/23. -One Maxorb II Calcium Alginate with silver 4x4 inch wound dressing with an expiration date of 6/1/24. -One package of 855 series foam hydrogel electrocardiogram electrodes with an expiration date of 7/12/24. -One cotton tipped applicator box that was half full with an expiration date of 3/8/24. -Blue disposable isolation gowns with an expiration date of 12/2023. 17. Interview on 5/1/25 at 1:35 p.m. with RN/infection preventionist Q regarding the stocking of the facility's supplies revealed: *Purchasing/property management officer Y was in charge of stocking each supply room on every neighborhood/unit at the facility. -It was his responsibility to ensure the supplies were not expired prior to placing them into the supply room. *Nursing staff who took supplies from the supply room should have been checking for outdated supplies prior to placing them on the treatment cart.	F 880		

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F 880	Continued From page 42	F 880		

18. Interview on 5/1/25 at 6:20 p.m. with director of nursing (DON) A regarding outdated supplies on the treatment cart revealed:
*She expected nursing staff who worked night shifts:
-To check the treatment cart for any outdated resident care supplies.
*She stated they had been trialing the use of the treatment cart for the last three months.
-She indicated the treatment cart it had not really been getting used by the staff.
-She stated that she was not surprised that there were expired supplies on the cart.

Review of the provider's 8/10/23 Wound Care - Dressing Change Policy included "Date and initial all bottles and jars upon opening (unless product is single use)."

Review of the provider's 7/27/21 Storage of Medications policy revealed:
*"The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner."
*"The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed."

Review of the provider's 11/18/24 Physician Orders policy revealed:
*"It is the policy of the ([provider's name] that all treatments and medications be ordered by the resident's Primary Care Provider upon admission and as needed throughout resident stay at [provider name]."
*"Admission physician orders should include:
*"Special medical procedures required for the

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safety and well-being of the resident."
*"Other orders as deemed necessary or appropriate."
*"All medical records and physician orders specifically must be checked for accuracy every 24 hours."

Review of the provider's 8/10/23 Wound Care - Dressing Change Policy revealed:
*"Review the resident's care plan, current orders, and diagnoses to determine if there are special resident needs."
*"Date and initial all bottles and jars upon opening (unless product is single use).
*"The following equipment and supplies will be necessary when performing this procedure."
*"Personal protective equipment (e.g. gowns, gloves, mask, etc., as needed)."

Review of the provider's undated Enhanced Barrier Precautions Policy revealed:
*"Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities."
*"EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and glove during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing."
*"EBP are indicated for all residents within the facility with any of the following:"
*"Infection or colonization with a CDC-targeted MDRO with [when] Contact Precautions do not otherwise apply; or."
*"Wounds and/or indwelling medical devices even if the resident is not known to be infected or

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F 880	Continued From page 44 colonized with a MDRO." *"Wounds generally chronic wounds, not short-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage or similar bandage." *"Examples of chronic wounds include, but are not limited to:" *"Unhealed surgical wounds." *"Indwelling medical device examples include:" *"Central lines." *"Examples of MDRO's." *"Additional epidemiologically important MDROs may include, but are not limited to:" *"Methicillin-resistant Staphylococcus aureus (MRSA)." *"Enhanced Barrier" Precautions:" *"Applies to all residents with any of the following:" *"Infection or colonization with an MDRO." *"Wounds and/or indwelling medical devices (e.g. central line) ...regardless of MDRO colonization status." *"PPE used for these situations." *"During high-contact resident care activities:" *"Dressing." *"Bathing/showering." *"Transferring." *"Changing linens." *"Device care or use: central line." *"Wound care: any skin opening requiring a dressing." *"Required PPE." *"Gloves and gown prior to the high-contact care activity." *"Face protection may also be needed if performing activity with risk of splash or spray." *"Contact" Precautions:" *"All residents infected or colonized with a MDRO in any of the following situations:"	F 880		

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F 880	Continued From page 45 *"Present of acute ..., draining wounds." *"PPE used for these situations:" *"Any room entry." *"Required PPE." *"Gloves and gown." *"Don before room entry, doff before room exit; change before caring for another resident."	F 880		
F 909 SS=E	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to assess bed rails for safe use for five of five sampled residents (24, 28, 41, 44, and 47) who had bed rails on their beds. Findings included: 1. Observation on 4/29/25 at 9:57 a.m. of resident 28's room revealed grab bars were on both sides of the bed. Review of resident 28's electronic medical record (EMR) revealed: *He was admitted on 1/13/25. *A device evaluation for his use of bed rails was last completed on 1/13/25. -He utilized the bed rails for turning and repositioning while in bed.	F 909	1. Upon identification that beds were not properly assessed for resident entrapment risk, the Physical Therapist (PT) measured each bed, mattress, and bed rail for residents that were actively using bed rails. 2. All residents in the facility have the potential to be affected in a similar manner. To ensure that no other residents were affected by the same deficient practices, all resident bed frames, mattresses, and bed rails have been measured and documented by the PT per regulations as of 5/16/25. 3. As part of a regular maintenance program that will identify areas of possible entrapment, a regular inspection of all bed frames, mattresses, and bed rails will be completed annually, and with each new instillation of a bed, mattress, and bed rail. A spreadsheet of the above will be kept and maintained. The need for new items is placed via work order through Team Dynamics (TDX). 4. The DON will perform audits of work orders input into TDX to ensure the appropriate measurements are completed following in instillation of new beds, mattresses, or bed rails; five (5) random	06/27/2025

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F 909	Continued From page 46 There was no documentation that an assessment of the bed rails had been completed to determine safe use or measurements of the bed rails for risk of entrapment and injury. 2. Observation and interview on 4/29/25 at 10:00 a.m. with resident 24 in his room revealed: *He had bed rails on both sides of his bed. *He was unsure why he had the bed rails, and stated they had come with the bed when he was admitted to the facility. Review of resident 24's EMR revealed: *He was admitted on 10/21/24. *He had a Brief Interview for Mental Statues (BIMS) assessment score of 11, which indicated he had moderate cognitive impairment. *A device evaluation for his use of bed rails was last completed on 3/9/25. -He utilized the bed rails for turning and repositioning while in bed. *There was no documentation that an assessment of the bed rails had been completed to determine safe use or measurements of the bed rails for risk of entrapment and injury. 3. Observation and interview on 4/29/25 at 11:17 a.m. with resident 41 in his room revealed: *He had bed rails on both sides of his bed. *He stated he does not use them; and they came with the bed when he was admitted to the facility. Review of resident 41's EMR revealed: *He was admitted on 12/4/23. *He had a BIMS assessment score of 15, which indicated he was cognitively intact. *A device evaluation for his use of bed rails was last completed on 1/29/25. -He utilized the bed rails for turning and	F 909	audits will occur weekly for four (4) weeks, bi-weekly for four (4) weeks, then monthly for one (1) month. Audits will begin on 6/2/25 with the potential to end on 9/2/25 pending 100% compliance and as determined by the QAPI team.	

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F 909	Continued From page 47 repositioning while in bed. *There was no documentation that an assessment of the bed rails had been completed to determine safe use or measurements of the bed rails for risk of entrapment and injury. 4. Observation on 4/29/25 at 11:35 a.m. of resident 47's room revealed bed rails were on both sides of the bed. Review of resident 47's EMR revealed: *He was admitted on 1/16/24. *He had a BIMS assessment score of 3, which indicated he had severe cognitive impairment. *A device evaluation for his use of bed rails was last completed on 4/7/25. -He utilized the bed rails for turning and repositioning while in bed. *There was no documentation that an assessment of the bed rails had been completed to determine safe use or measurements of the bed rails for risk of entrapment and injury. 5. Observation on 4/29/25 at 2:51 p.m. of resident 44's room revealed bed rails were on both sides of the bed. Review of resident 44's EMR revealed: *He was admitted on 1/3/24. *He had a BIMS assessment score of 11, which indicated he had moderate cognitive impairment. *A device evaluation for his use of bed rails was last completed on 4/5/25. -He utilized the bed rails for turning and repositioning while in bed. *There was no documentation that an assessment of the bed rails had been completed to determine safe use or measurements of the bed rails for risk of entrapment and injury.	F 909		

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	43A136	A. BUILDING _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME	2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 909	Continued From page 48	F 909		

6. Interview on 4/30/25 at 2:36 p.m. with physical therapist (PT) D revealed she:
*Had been employed with the facility since 6/6/2016.
*Had been asked by the previous director of nursing in 2023 to assess the bed rails of the residents who had used them.
-Assessed all the residents who had them from the beginning of February 2023 to the end of March 2023.
*Had not been doing any regular maintenance inspections on the bed rails since she finished assessing them in 2023.

7. Interview on 4/30/25 at 2:50 p.m. with physical plant manager II C revealed he:
*Stated he had not completed measurement assessments for the safe use of the bed rails for any residents.
*Has done maintenance on the residents' beds, and work orders from staff on the bed rails when the bed rails come loose.
*Was unaware that PT D had not completed the measurement assessments for the bed rails since 2023.

8. Interview on 4/30/25 at 5:00 p.m. with director of nursing (DON) A regarding the bed rail assessments revealed she:
*Stated that since PT D had assessed them in 2023, they would keep the mattress, beds and the rails as one unit and move them to the residents' room when needed.
*Was unaware they needed regular maintenance inspections on the bed rails to determine safe use or measurements of the bed rails for risk of entrapment and injury.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A136	A. BUILDING _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME	2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747

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F 909	Continued From page 49 9. Review of the provider's undated Bed Safety policy revealed: "1. The residence sleeping environment will be inspected for safety. Inspection of all bed frames, mattresses and bed rails will be conducted monthly by the Maintenance Department and Household Coordinator as part of a regular preventative maintenance program." "2. To try to prevent deaths slash injuries from the beds and related equipment (including the frame, mattresses, side rails, headboard, footboard, and bed accessories), Facility shall promote the following approaches: a. Inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapments. b. Review that gaps within the bed system are within dimensions established by the FDA note: the review shall consider situations that could be caused by a resident's weight, movement, or bed position. d. Ensure that bedrails are properly installed using the manufacturer's instructions and other pertinent safety guidance to ensure proper fit example avoid bowing, ensure proper distance from the headboard and footboard, etc."	F 909		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A136	A. BUILDING 02 B. WING _____	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME	2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 4/30/25. Michael J Fitzmaurice South Dakota Veterans Home was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at E004 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	E 000	Statement of Compliance: The following represents the plan of correction for the alleged deficiencies cited during the survey that was conducted on 4/29/25 through 5/1/25. Please accept this plan of correction as Michael J Fitzmaurice South Dakota Veterans Home's credible allegation of compliance with the completion date of 5/30/25.	05/30/2025
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:	E 004	1. Upon identification that a review and update for the emergency preparedness plan and organizational flow chart had not been completed for 2025, the senior secretary along with all members of the senior staff team completed an immediate review of the emergency preparedness plan. 2. All residents in the facility have the potential to be affected in a similar manner. To ensure all residents are not affected by this deficient practice, the emergency preparedness plan was thoroughly updated as of 5/30/25. 3. An annual Microsoft Task has been created to prompt the Physical Plant Manager II (PMII) to review the emergency preparedness plan. The Task reminder has been set for January 5th to recur annually. The emergency preparedness plan will be communicated with all staff. Further, the plan will be placed in binders throughout the facility.	

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

DEP SECRETARY | 09JUNE2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A136	A. BUILDING 02 B. WING _____	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME	2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747

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E 004	Continued From page 1 * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to review and update the emergency preparedness plan and organizational flow chart for 2025. Findings include: 1. Record review on 4/30/25 at 10:15 a.m. revealed the provider's emergency preparedness plan had not been updated in quite some time. The employee roster located on the inside cover of the plan was dated 12/12/2007. Numerous employees listed on the roster were no longer employed by the facility. Interview on 4/30/25 at 1:00 p.m. with the	E 004	4. The Superintendent will complete annual audits each January to ensure the emergency preparedness plan is reviewed and updated appropriately. The results will be discussed in senior staff meetings and with the QAPI committee.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A136	A. BUILDING 02 B. WING _____	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME	2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747

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E 004	Continued From page 2 physical plant manager (responsible for emergency preparedness) operating officer confirmed those findings.	E 004		
K 000	INITIAL COMMENTS A recertification survey was conducted on 4/30/25 for compliance with 42 CFR 483.70 (a) & (b) requirement for Long Term Care Facilities. Michael J Fitzmaurice South Dakota Veterans Home was found in compliance.	K 000		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10523	A. BUILDING: _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 4/29/25 through 5/1/25. Michael J Fitzmaurice South Dakota Veterans Home was found in compliance.	S 000		
S 000	Compliance/noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 4/29/25 through 5/1/25. Micheal J Fitzmaurice South Dakota Veterans Home was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Aaron Pollard

TITLE: Deputy Secretary/Administrator

(X6) DATE: 05/16/2025