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
	435043	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET SPEARFISH, SD 57783

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F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 1/30/23 through 2/2/23. Spearfish Canyon Healthcare was found not in compliance with the following requirements: F609, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 1/30/23 through 2/2/23. Areas surveyed included quality of care, resident rights, and dietary services. Spearfish Canyon Healthcare was found not in compliance with the following requirements: F565 and F584.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life	F 565	Corrective Action For the identification of lack of: Failed to ensure that resident expressed concerns were thoroughly investigated including follow up with complaints and resolved as much as possible to everyone's satisfaction for six of six sampled residents. Resident #14 was interviewed by Social Service Director/Designee regarding concerns. Any concerns noted were made into a grievance and followed up with per policy. Resident #16 was interviewed by Social Service Director/Designee regarding concerns. Any concerns noted were made into a grievance and followed up with per policy.	03/01/2023 TM 3/6/23

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

[signature] | Interim Administrator | 3/6/23

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

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F 565	Continued From page 1 in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview, resident council minutes review, and policy review, the provider failed to ensure resident expressed concerns were thoroughly investigated including follow-up with complainants, and resolved as much as possible to everyone's satisfaction for six of six sampled residents. Findings include: 1. Interview on 2/1/23 from 11:15 to 11:45 a.m. with six residents (14, 16, 26, 32, 36 and 42) who attended resident council revealed: *They met every month. *They were able to voice their concerns. *The activity coordinator D was always present and kept notes of the meeting. *The emergency permit holder (EPH)/administrator A had started on 9/1/22 and attended the December 2022 meeting. *The residents complained about wandering residents coming into their rooms, laying in their beds, using their bathrooms, and taking their belongings.	F 565	Resident #26 was interviewed by Social Service Director/Designee regarding concerns. Any concerns noted were made into a grievance and followed up with per policy. Resident #32 was interviewed by Social Service Director/Designee regarding concerns. Any concerns noted were made into a grievance and followed up with per policy. Resident #36 was interviewed by Social Service Director/Designee regarding concerns. Any concerns noted were made into a grievance and followed up with per policy. Resident #42 was interviewed by Social Service Director/Designee regarding concerns. Any concerns noted were made into a grievance and followed up with per policy. Identification of Others All residents have the potential to be affected. Social Services/designee conducted a sweep of current residents to ensure residents felt their resident concerns were being addressed and any occurrences noted were made into a grievance and followed up, per facility policy.	

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F 565	Continued From page 2 *Resident council stated management had verbally responded with, "put up with it, or use Velcro banner across their room door, a stop sign or close their room door." *The residents felt their concerns had not been resolved. Review of the November-December 2022 and January 2023 resident council minutes revealed: *New business for the November 2022 meeting included: -Shared concern about those residents who previously resided in the memory care unit because they wander excessively. -They felt the environment of the facility was not suited for some of the residents that would excessively wander. -They discussed how these residents wander in and out of other residents' rooms, would sleep in their beds, or get into their personal belongings. *Old business for December 2022 and January 2023 meeting included no mention of any follow up regarding the residents wandering into their rooms, sleeping in their beds and getting into their personal belongings. Interview on 2/1/23 at 4:18 p.m. with activities director D regarding the follow-up of concerns brought up in resident council revealed: *She facilitated the meetings, and minutes were kept of each meeting. *Residents were given an opportunity to voice concerns. *She made a determination during the meeting if it was a discussion or concern. *Concerns were brought up in the interdisciplinary meeting and then referred to the specific department. *She agreed she should have completed a	F 565	Systemic Changes Policy reviewed and no changes made, education provided to staff on policy on or before 03/01/2023. Resident Council will be made aware of process on March 6, 2023. Administrator/designee to provide education to facility staff regarding the process for reporting resident concerns/ grievances on or before 03/01/2023 Administrator/designee to provide education to the IDT team on the process for investigating including follow up of resident concerns on or before 03/01/2023 Monitoring Social Services/designee will audit resident concerns/grievances for investigation and follow-up 3 x weekly beginning on or before 03/01/2023. Any issues identified will be corrected immediately and re-education will be provided at that time. Monitoring results will be reported to the QAPI committee and continued, until the facility demonstrates sustained compliance as determined by the committee.	TM 3/6/23 TM 3/6/23

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F 565	Continued From page 3	F 565		

grievance form from the November 2022 Resident Council meeting referring to the concern of residents wandering.
*She agreed there was no documentation in December 2022 or January 2023 Resident Council minutes that discussed a resolution.

Interview on 2/2/23 at 11:00 a.m. with director of nursing (DON) B regarding concerns brought up by residents in Resident Council revealed she:
*Started her position on 1/4/23.
*Had known about the concerns of the wandering residents during her walk-through interview with residents.
*Encouraged residents to complete a grievance form.
*Was aware education was provided to staff for redirecting the wandering residents to activities.
*Stated that locks were given to the residents to lock up their personal property in their rooms.
*Was aware there were no new interventions put in place.

Interview on 2/2/23 at 11:23 a.m. with EPH/administrator A revealed he:
*Transitioned from his previous position in the facility to his current position on 9/1/22.
*Was the grievance officer.
*Was aware of the November 2022 resident council concerns about the wandering residents.
*Met with resident 16, who was the council president, in November to discuss interventions that would have been put in place for the residents who had wandered.
*Discussed in December 2022 resident council meeting the interventions that the facility had taken.
-Agreed there was no documentation in the resident council minutes for December 2022 of

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F 565	Continued From page 4 his discussion regarding interventions for those residents that wandered. Review of the undated Grievance/Complaints Filing policy revealed: *"1. Any resident, family member, or appointed resident representative may file a grievance or complaint concerning care, treatment, behavior of other residents, staff members, theft of property, or any other concerns regarding his or her stay at the facility." *"3. All grievances, complaints or recommendations stemming from residents or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing, including a rationale for the response." *"8. Upon receipt of a grievance and/or complaint, the Grievance Officer will review and investigate the allegations and submit a written report of such findings to the Administrator within five (5) working days of receiving the grievance and/or complaint."	F 565		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can	F 584	Corrective Action For the identification of: Failed to provide reasonable care for the protection of personal property from loss or theft by confused wandering residents. Resident #62 was interviewed by Social Service Director/designee related to concerns of personal property loss/theft by other residents. Resident provided a secure area (shadow box or similar) to lock his belongings in with still being able to see them. Resident stated he was satisfied with the remedy.	03/01/2023 TMC 3/16/23

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F 584	Continued From page 5 receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure reasonable care for the protection of personal property from loss or theft by confused wandering residents for one of one sampled resident (62) who had created his own space. Findings include: 1. Observation and interview on 1/31/23 at 10:23 a.m. with resident 62 revealed he: *Had a Velcro banner with "stop do not enter" on	F 584	Identification of Others Social Services Director /Designee interviewed current residents to see if concern for loss/theft by other residents affected other residents. If concerns were noted a grievance was filled out and followed up on per facility policy, if applicable shadow box/lock box provided as needed. Systemic Changes Facility staff will be educated by Social Services/designee on allowing residents to have their personal belongs to the extent possible 03/01/2023 Facility staff will be educated by the DON/Designee on redirection of wandering residents out of residents' rooms on or before 03/01/2023 Monitoring Social Services/designee will interview random selection of residents 2-3 times per week to ensure that residents have not had any personal belongings moved or removed from their rooms. DON/designee will interview random selection staff on random shifts to validate redirection of wandering residents 2-3 times per week. Monitoring results will be reported by Social Services/designee to the QAPI committee and continued until the facility	TM 3/16/23

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F 584	Continued From page 6 it, across his open doorway. *Was in bed watching television. *Had complained that several confused residents entered and dismantled his room frequently and he was not able to get up on his own and stop them. *Had tried shutting his door but they still came into his room and there were times when he returned to his room that he could tell his items had been moved or were missing. *Had told confused residents to leave and they had become aggressive, swore at him, once one of them slammed his door and then returned with a butter knife, and another instance one took off her clothes and attempted to climb into his bed at 1:00 a.m. *Had many personal items in his room that he collected or were gifts and he stated they were valuable, sentimental and irreplaceable. -A walrus tooth carved figurine he received from his ex-wife had been missing from his room and the facility replaced it with a similar item he found on the Internet that cost $400 but, it was not the same and not from his ex-wife. *Had his own personal food and snack items in his room. -He was not able to enjoy his snacks after another resident touched and rifled through them touching his Pringles in the can and other food items. *Was in the process of packing up his saber tooth tiger skull, mounted on a handmade tiger wood platform and was sending it to his mothers home. -Felt the item was far too valuable and irreplaceable and would be broken or go missing from his room. *Had complained to the staff repeatedly about the confused residents in his room and felt nothing had been done.	F 584	demonstrates sustained compliance as determined by committee.	

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F 584	Continued From page 7	F 584		

*Filed a grievance with the administrator and the administrator responded but there had been no improvement with the confused residents wandering into his room.

Review of the resident's record revealed he:
*Was admitted to the facility on 8/27/21.
*Had a Brief Interview for Mental Status (BIMS) score of 15 indicating he had no cognitive deficit.
*Was a younger resident with identified care needs that he had determined the facility was the best place for him to live.
*Had filed five grievances beginning in 2022 through January 2023.
-On 7/30/22, the facility had replaced a walrus tusk figure.

Review of resident council meeting minutes revealed:
*In November residents had complained about confused residents wandering into their rooms.
*There was no documentation of follow up in the December or January resident council meeting minutes.

Interview on 2/1/23 at 11:15 a.m. of the resident's at the resident council meeting held with surveyors present revealed;
*Resident's reported wandering residents in the facility was a big problem since the memory unit had closed, they came into others rooms, got in their beds, used their bathrooms, got aggressive, got into altercations, and took and broke personal items belonging to other residents.

Interview on 2/1/23 at 2:03 p.m. with activities director D who attends the resident council meetings revealed:
*Confused residents wandering into other

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residents rooms was an issue brought up at the resident council meeting in November.
*No formal grievance was created and no follow up was done regarding the wandering residents concern brought up at the resident council meeting.
*Options she discussed at the meeting were Velcro sign and redirection.

Interview on 2/2/23 at 9:53 a.m. certified nursing assistant (CNA) H regarding the resident revealed:
*She had worked at the facility for seventeen years.
*Felt she got the equipment and training needed to do her job.
*The new director of nursing asked staff what could she do to help staff and the registered nurses were helpful.
*They used a staff communication book, but she did not feel it was always effective and communication of events had gotten missed.
*The computer/kiosk/Kardex told staff how to care for residents and it was updated well.
*Felt staffing had gotten better and they had a good team.
*Was aware of issues with confused residents wandering into other resident's room.
*They used stop banners to deter confused residents and they were working 50 percent of the time.
*They attempted to redirect confused residents as best they could, and no other interventions were used.
*There are two to three residents that come over here and enter other residents rooms.
*Resident 62 is unable to get up independently and other residents would eat his food, go through his personal belongings, and dismantle

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F 584	Continued From page 9 his room. *It had gotten better in the last month or so, they are still a challenge, the residents with sundowners flock to the med cart and it is disruptive and difficult to pass meds. *We have been told it is their right to wander. *There have been safety concerns, staff have had to intervene where there could have been a possible physical altercation between the residents. One lady takes silverware from the dining room and carries it with her. Another one at night gets violent and frustrated. *There is one confused resident that will shove his walker at people and get physically aggressive. *Management was aware of those issues. *Management had not shared a plan with staff. *The staff are instructed to do the best they can and keep an eye on those wandering residents. Interview on 2/2/23 at 9:26 a.m. with social services coordinator E revealed: *She had worked in the facility since May 2021. *She had a licensed social worker that provided oversight and collaboration. *They corresponded via email, the licensed social worker reviewed the grievances, provided feedback on needed changes, and told her what needed to be done. *Agreed five grievances were on her report from this resident. *We replaced a figurine and could not get the exact same one. -He picked out one online, she was aware it had been a gift and was irreplaceable, so they offered him a lock box. *She agreed residents had the right to have a room with personal items, and it was unfair he felt he had to send his valuable items to his mother's	F 584		

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home.
*Our primary intervention for managing confused residents wandering into other residents' rooms was signage, educating staff on redirecting, offering different activities, and making sure needs were met, snacks, toileted etc..
*She agreed it would be frustrating for the resident to watch confused residents come into his room, go through his personal belongings, and not to have been able to do anything about it.
*She agree it would be frustrating for the resident to not be able to have personal items in his room and feel they are safe.

Interview on 2/2/23 at 9:58 a.m. with EPH/administrator A regarding Quality Assurance and Improvement(QAPI) revealed:
*He is the emergency administrator since September 2022.
*QAPI met monthly.
*The medical director comes more often than quarterly.
*The consultant pharmacist attends quarterly and sends a monthly summary too.
*Direct care staff are invited when they are oriented, they are reminded that they can attend QAPI meetings annually too.
*They had a direct care staff come in September.
*Usually direct care staff bring their concerns to administration and they are shared at QAPI.
*QAPI and the governing board were aware of the issue with confused residents wandering into other residents rooms.
*They do not currently have a performance improvement plan for this.
*He was aware of the situation with the confused resident with the knife.
-She took the silverware from the dining room after the meal.

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F 584	Continued From page 11 -Staff were now more vigilant during the meals to make sure she is not taking the silverware. -He told staff to always pick up the silverware to make sure she does not have access to the silverware after meals. Review of the facility's undated Personal Property policy revealed: *"2. Each resident is encouraged to maintain his/her room in a home-like environment by bringing personal items (i.e., photographs, knickknacks, etc.) to place on nightstands, televisions, etc." Review of the facility's 2018 Resident Rights policy revealed: *"1. Federal and State laws guarantee certain basic rights to all residents of this facility,. These rights include the resident's right to:" "ee. retain and use personal possessions to the maximum extent that space and safety permit"	F 584		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to	F 609	Corrective Action For the identification of lack of: Failed to ensure that two separate injuries to arms for one resident was thoroughly investigated and documented as well as reported to the South Dakota Department of Health Resident #9 incident was reported by Administrator/Designee to the South Dakota Department of Health on 02/01/2023. Investigation completed with findings coinciding with the original investigation.	03/01/2023 TM 3/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435043	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET SPEARFISH, SD 57783

(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 609	Continued From page 12 the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review the provider failed to ensure two separate injuries to her arm(s) for one of one resident (9) were thoroughly investigated and documented as well as reported to the South Dakota Department of Health (SD DOH). Findings include: 1. Review of resident 9's progress notes revealed: *On 11/8/22 the resident sustained a bruise to her right forearm from rubbing her arm between a wall and the railing. *On 12/2/22 the resident sustained bilateral wrist swelling and discoloration from striking a staff member. 2. Interview on 2/1/23 at 4:48 p.m. with EPH/administrator A about resident 9's incident report form revealed: *He was not able to provide any documentation that an investigation had been completed. *There was no documentation the SD DOH or	F 609	Identification of Others All residents have the potential to be affected. Administrator/Designee to review last 30 days of incidents to validate that all required reporting was completed. If discrepancies found, they were corrected as applicable. Systemic Changes Policy and procedures reviewed and no changes made, staff provided education on policy on or before 03/01/2023. Administrator/DON/IDT has a learning session with South Dakota Department of Health complaint office on March 2, 2023 to learn about how to complete and investigation of resident incidents as well as appropriate follow-up for resident grievances and reporting to appropriate agency. TM 3/2/23 Provide education and training to facility staff about caring for residents with dementia, including planning and implementation of individualized approaches of care. Monitoring Administrator/Designee will monitor progress notes and Risk Management Monday-Friday to ensure any items that	

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	435043	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET SPEARFISH, SD 57783

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F 609	Continued From page 13 State Ombudsman had been notified of resident 9's incidents. *He thought he only had to report resident-to-resident incidents. Interview on 2/2/23 at 8:45 a.m. with EPH/administrator A and director of nursing B about resident 9's incident report form revealed: *He was able to provide two handwritten incident report forms for the two incidents involving resident 9, they reflected internal investigations had been done, but the forms did not indicate whether abuse or neglect was suspected or present. *There was no documentation the State Ombudsman or SD DOH had been notified. 3. Review of the provider's undated policy "Abuse Investigation and Reporting" revealed: *Reporting -1. "All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of the property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies": -a. "The State licensing/certification agency responsible for surveying/licensing the facility". -b." The local/State Ombudsman;" -5. "The Administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident".	F 609	need further investigation/reporting are completed. Monitoring results will be reported by Administrator/designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880	Corrective Action For the identification of lack of: Appropriate use of single user disposable razors	03/01/2023 TM 3/16/23

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	435043	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 14 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880	Appropriate hand hygiene and glove use as well as procedural technique during wound care. The Administrator, DON, and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for any pertinent identified areas. All facility staff who provide or are responsible for any pertinent cares and services will be educated/re-educated by 03/01/2023 by Administrator, DON, and/or designee. Identification of Others All residents have the potential to be affected by lack of: Appropriate process and follow through for the above identified Items. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by the Infection Preventionist/designee. 03/01/2023 Director of Nursing/Designee discarded all disposable razors currently in use. New disposable razors were made available to staff. Completed on 02/02/2022 Director of Nursing/Designee discarded all disposable nail clippers currently in use. New nail clippers were made available to staff. Completed on 02/02/2023	

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F 880	Continued From page 15 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure: *One of one certified nurse assistant (I) had not reused disposable razors on more than one resident. *One of one licensed practical nurse (F) had performed proper hand hygiene procedures during one of two observed wound care treatments. Findings include: 1. Observation and interview on 1/31/23 at 9:30 a.m. with certified nurse assistant (CNA) I in one	F 880	CNA(I) was educated on the process and procedure on the use of disposable razors and nail clippers on or before 03/01/2023 LPN(F) no longer works in the facility as of 2/18/2023 Systemic Changes Infection Preventionist/designee will provide education to Facility clinical staff and must return demonstrate proper infection control procedure for disposable razors and nail clippers. 03/01/2023 TM 3/16/23 DON/Designee will provide education to facility clinical nurse staff will be educated and must return demonstrate proper infection control procedure for wound dressing changes. 03/01/2023 TM 3/16/23 Root Cause Analysis conducted and answers to the 5 whys. Nurses and CNAs are missing the needed knowledge and education to provide proper steps for wound care and disposable razor/nail clipper use. Providing needed education and competencies of facility policies related to proper steps for wound care and proper shaving hygiene protocols. Changes in key management roles in the facility to ensure proper training and competencies are completed.	

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F 880	Continued From page 16 of the bathing rooms revealed: *She was finishing up cleaning and sanitizing the whirlpool tub. *There were two disposable razors and a nail clipper sitting on top of the tub. *When asked if she used the disposable razors on one resident or reused them for multiple residents, she said: -"To be honest, yes." -"I will swish the razor around in the sanitizer water that I'm cleaning the bathtub with to sanitize the razors and nail clippers." *She placed the two razors in the sharps container after she was done cleaning the tub. Interview on 2/1/23 at 4:43 p.m. with director of nursing (DON) B and registered nurse consultant (RNC) N about the reuse of nail clippers and disposable razors revealed: *Each resident should have had their own nail clippers. *They provided the disposable razors if a resident did not have their own. -It was not their policy or practice to reuse nails clippers and razors on more than one resident. Review of the provider's 2018 "Cleaning and Disinfection of Resident-Care Items and Equipment" policy revealed: *"d. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment)." -"3. Single resident-use items are cleaned/disinfected between uses by a single resident and disposed of afterwards (e.g., bedpans, urinals)." *"e. Single-use items are disposed of after a single use (e.g., thermometer probe covers)." *"5. Only equipment that is designated reusable	F 880	Staff require a strong and stable management team to supervise and maintain proper competencies. To keep staff at the highest level of knowledge and competency to provide the highest level of patient care. Administrator/DON contacted the South Dakota Quality Improvement Organization (QIN) on 02/20/2023 and spoke with Susan Wilcox. The administrator sent Susan a copy of 2567 for her to review F880 and then we had a discussion on our 5 whys. We will continue collaboration with Susan and the South Dakota Quality Improvement Organization (QIN). Resources were provided by Susan Wilcox with Great Plains QIN to include strategies to improve infection prevention processes and communication tools. Monitoring Administrator, DON, and/or designee will conduct auditing and monitoring of use of disposable razors/nail clippers for proper use 2-3 times weekly over all shifts. Administrator, DON, and/or designee will conduct auditing and monitoring of wound dressing changes to ensure proper procedure 2-3 times weekly over all shifts. Monitoring for determined approaches to ensure effective implementation and	

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F 880	Continued From page 17 shall be used by more than one resident." *"6. Single use items will be discarded after a single use." 2. Observation and interview on 1/31/23 at 11:00 a.m. of licensed practical nurse (LPN) F during resident 63's wound dressing change revealed: *She gathered supplies from the wound care cart. *She took a pair of scissors from her pocket and placed it on the bedside table with the wound care supplies. -There was no barrier placed underneath the wound care supplies. *She placed a paper towel on top of the supplies. *Without performing hand hygiene or putting gloves on, she removed the resident's shoe and sock. *She placed another paper towel on the floor beneath the resident's foot. *She put on a pair of clean gloves without performing hand hygiene. *She removed the gauze and inspected the wound, touching it with her gloved hand. *With the same gloves on, she: -Retrieved the normal saline and poured some into a cup. -Grabbed a clean gauze pad, dipped it into the normal saline, and cleansed the wound. -Grabbed the foam dressing and scissors, and cut the dressing. --Placed the scissors in her shirt pocket after she was done cutting the dressing without sanitizing the scissors. -Placed the foam dressing over the resident's wound. *She removed her gloves, threw away the unused supplies and the soiled gloves, then washed her hands.	F 880	ongoing sustainment. Any other areas identified through the Root Cause Analysis. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by administrator, DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	

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	435043	A. BUILDING _____ B. WING _____	C 02/02/2023

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SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET SPEARFISH, SD 57783

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F 880	Continued From page 18 Interview on 1/31/23 at 11:20 a.m. with LPN F about the above wound care procedure revealed she should have: *Placed a barrier on the bedside table before putting the wound care supplies down. *Performed hand hygiene before putting on the gloves. *Changed her gloves and performed hand hygiene after handling the resident's wound and soiled dressing. *Not have placed the scissors in her pocket. Interview on 2/1/23 at 4:43 p.m. with DON B and RNC N about the above observation revealed: *They were aware of the above wound observation. *It was their expectation that staff should perform hand hygiene before putting gloves on, after taking gloves off, and in-between glove changes. Review of the provider's 2022 "Handwashing/Hand Hygiene" policy revealed: *"Policy Statement: This facility considers hands hygiene the primary means to prevent the spread of infections." *"Policy Interpretation and Implementation:" -"2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors." -"7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:" —"b. Before and after direct contact with residents." --"f. Before donning [putting on] sterile gloves." --"g. Before handling clean or soiled dressings, gauze pads, etc."	F 880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 19 --"i. After contact with a resident's intact skin." --"j. After contact with blood or bodily fluids." --"k. After handling used dressings, contaminated equipment, etc." --"m. After removing gloves." -"8. Hand hygiene is the final step after removing and disposing of personal protective equipment." *"Procedure: Applying and Removing Gloves." -"1. Perform hand hygiene before applying non-sterile gloves." -"5. Perform hand hygiene [after removing gloves]." Review of the provider's 2018 "Wound Care" policy revealed: *"Steps in the Procedure:" -"2. Wash and dry your hands thoroughly." -"4. Put on exam glove. Loosen tape and remove dressing." -"5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly." -"6. Put on gloves." -"8. Pour liquid solutions directly on gauze sponges on their papers." -"19. Use clean field saturated with alcohol to wipe overbed table." -"21. Wipe reusable supplies with alcohol as indicated (i.e., outsides of containers that were touched by unclean hands, scissor blades, etc.). Return reusable supplies to resident's drawer in treatment cart." -"23. Wash and dry your hands thoroughly."	F 880		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435043	A. BUILDING _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET SPEARFISH, SD 57783

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 1/30/23 through 2/2/23. Spearfish Canyon Healthcare was found in compliance.	E 000		

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

Interim Administrator 2/23/23

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.

RECEIVED
FEB 23 2022
SD DOH-OLC

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
	435043	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET SPEARFISH, SD 57783

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K 000	INITIAL COMMENTS A recertification survey for compliance with the life safety code (LSC) (2012 existing health care occupancy) was conducted from 2/1/23. Spearfish Canyon Healthcare was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K321, K345, and K363 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		

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

TITLE: Interim Administrator

(X6) DATE: 2/23/23

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

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FEB 23 2022
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STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	435043	A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	**2/1/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	**1020 N 10TH STREET SPEARFISH, SD**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain one random hazardous area (kitchen pantry) as required. Findings include: 1. Observation on 2/1/23 at 9:30 a.m. revealed the kitchen pantry was located within the kitchen area. The pantry was over 100 square feet in area and had large amounts of combustibles stored in it (canned goods and cooking oils). The door was not equipped with a self-closing device. The doors from the kitchen to the resident dining room had throw-bolts installed, were self-closing, and were equipped with magnetic hold-opens tied into the fire alarm system. Testing of the kitchen doors at 9:35 a.m. revealed they would not close to latch if the throw-bolts were not in the fully retracted position (a manual operation). Interview with the maintenance director at 9:40 a.m. confirmed those findings. The deficiency affected one of numerous requirements for hazardous storage rooms and had the potential to affect 100% of the occupants of the smoke compartment.
K 345	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101

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The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	435043	A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	**2/1/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	**1020 N 10TH STREET SPEARFISH, SD**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 345	Continued From Page 1 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to maintain one of one fire alarm systems as required. Findings include: 1. Record review on 2/1/23 at 8:00 a.m. revealed the annual fire alarm inspection report dated 4/20/22 did not list sensitivities for the ionization-type smoke detectors. Ref: 2010 NFPA 72 Section 14.6.2.4, Figure 14.6.2.4 Section 7.12-7.14 and page 11 of 11 2. Interview with the maintenance director at the time of the record review confirmed those findings. He stated the contractor who provided the testing only confirmed a pass or fail condition. He added the fire alarm annual inspection occurred prior to his employment in November 2022. The deficiency affected 100% of the occupants.
K 363	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	435043	A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	**2/1/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	**1020 N 10TH STREET SPEARFISH, SD**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 363	Continued From Page 2 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain impediment-free closing for two randomly observed corridor doors in the basement (laundry and old boiler room) as required. Findings include: 1. Observation on 2/1/23 at 9:00 a.m. revealed the basement corridor doors to the laundry room and the corridor door to the old boiler room were held open with wood floor wedges. The floor wedges would prevent the doors from closing and maintaining a smoke-tight corridor in a fire emergency. Interview with the maintenance director at the time of the observation confirmed those findings. The deficiency had the potential to affect 100% of the occupants of the smoke compartment.

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
	10686	A. BUILDING: _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET SPEARFISH, SD 57783

(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) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 1/30/23 through 2/2/23. Spearfish Canyon Healthcare was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 1/30/23 through 2/2/23. Spearfish Canyon Healthcare was found in compliance.	S 000		

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

TITLE: Interim Administrator

(X6) DATE: 2/23/23

RECEIVED
FEB 23 2022
SD DOH-OLC