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
	435129	A. BUILDING ______ B. WING ______	C 01/07/2022

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

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E 000	Initial Comments Surveyor: 32332 A complaint survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities was conducted on 1/7/21. Dells Nursing and Rehab Center Inc. was found not in compliance with the following requirements: E0004 and E013.	E 000		
E 004 SS=E	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), §485.625(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: * [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	E 004	Administrator, maintenance director, and/or a designee will revise, review, or create emergency preparedness policy and procedure manual to include a facility and community-based risk assessment utilizing an all-hazards approach, a signed MOU for temporary shelter, and the process for communication, cooperation, and collaboration with local county, and state officials as needed. Administrator will provide education to management team and necessary individuals before 02/25/2022. QAPI committee will review and revise Emergency Plan and policies annually or as necessary.	02/26/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Samuel Van Voorst	Adminstrator	1/31/22

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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E 004	Continued From page 1 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: Surveyor: 06365 Based on interview and document review, the provider failed to evaluate at least annually and maintain a comprehensive emergency preparedness (EP) program. Findings include: 1. Review of the most current copy of the provider's EP policy and procedure manual revealed dates under the table of contents page listed: *Policies revised: "02/2017." *Policies reviewed: "02/2017." Interview on 1/7/22 at 1:30 p.m. with administrator C revealed that was the most current manual except for some additional documents he had not yet printed. Administrator C provided a copy of those documents, which included:	E 004		

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E 004	Continued From page 2 *Three policies and procedures dated "10/2021" that addressed the subjects of: -Waiver 1135 and alternate care sites. -Loss of telephone services - communication plan. -An evacuation plan and sheltering in place. *A memorandum of understanding (MOU) for temporary shelter "entered on "October 15th, 2021," that was not signed and dated by both the requester and provider of the MOU. Further review of the EP manual revealed it did not include the following components of a comprehensive EP program: *A facility and community-based risk assessment utilizing an all-hazards approach. *The process for communication, cooperation, and collaboration with local, county, and state officials.	E 004		
E 013 SS=E	Development of EP Policies and Procedures CFR(s): 483.73(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and	E 013	Administrator, maintenance director, and/or a designee will revise, review, or create all necessary policies and procedures in regards to the emergency preparedness plan including an updated disaster tree, infectious disease outbreak situations, alternate sources of energy, subsistence shelter in place, location of supplies, and how to dispose sewage and waste if system were to be affected by a disaster. Table of contents will be revised to include heating failures. Administrator or designee will provide education to management team and necessary individuals before 02/25/2022.	02/26/2022

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E 013	Continued From page 3 procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.	E 013	QAPI committee will review and revise Emergency Plan and policies annually or as necessary.	

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E 013	Continued From page 4 These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Surveyor: 06365 Based on interview and document review, the provider failed to include detailed procedures addressing multiple requirements of an emergency preparedness program. Findings include: 1. Review of the facility's emergency preparedness (EP) manual revealed the disaster policy and procedure included heating failure as a disaster; however: *Heating failure was not listed on the table of contents on page 1 of the disaster plan. *There was no detailed procedure page to direct staff when responding to a heating failure. Further review of the EP manual revealed there were no detailed procedures to address: *Alternate sources of energy to maintain comfortable temperature levels. *Infectious disease outbreak situations. *Subsistence needs when sheltering in place, including: -How much food and water were needed for how many persons would be served. -Where those supplies were stored. -How and where additional supplies would be obtained if sheltering in place lasted longer than three days. -How disposal of sewage and waste would occur if that system was affected by a disaster.	E 013		

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E 013	Continued From page 5 Alternate care sites were listed in the evacuation plan dated October 2021 as temporary shelter to maintain continuity of care in the event of an evaluation. Administrator C did not provide documentation such as memorandums of understanding to demonstrate arrangements had been made with those locations. The disaster calling tree did not include contact information for local, county, or state officials that should have been contacted when an emergency situation occurred. Refer to E004.	E 013		

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S 000	Compliance/Noncompliance Statement Surveyor: 32332 A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted on 1/7/22. Dells Nursing and Rehab Center Inc. was found not in compliance with the following requirement: S115.	S 000		
S 115	44:73:01:07 Reports Each facility shall fax, email, or mail to the department the pertinent data necessary to comply with the requirements of all applicable administrative rules and statutes. Any incident or event where there is reasonable cause to suspect abuse or neglect of any resident by any person shall be reported within 24 hours of becoming informed of the alleged incident or event. The facility shall report each incident or event orally or in writing to the state's attorney of the county in which the facility is located, to the Department of Social Services, or to a law enforcement officer. The facility shall report each incident or event to the department within 24 hours, and conduct a subsequent internal investigation and provide a written report of the results to the department within five working days after the event. Each facility shall report to the department within 24 hours of the event any death resulting from other than natural causes originating on facility property such as accidents. The facility shall conduct a subsequent internal investigation and provide a written report of the results to the department within five working days after the event.	S 115	Time cannot be turned back to a time prior to the identification of lack of reporting issues with the heating system to the South Dakota Department of Health. Administrator or designee will audit that the South Dakota Department of Health is being notified of reportable events weekly for four weeks and monthly for two additional months. Administrator or designee will present findings form these audits at monthly QAPI meetings for review. Administrator or designee will provide education to management team and necessary individuals before 2/25/2022.	02/26/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Samuel Van Voorst	Administrator	1/31/22

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S 115	Continued From page 1	S 115		

Each facility shall report a missing resident to the department within 48 hours. The facility shall conduct a subsequent internal investigation and provide a written report of the results to the department within five working days after the event.

Each facility shall also report to the department as soon as possible any fire with damage or where injury or death occurs; any partial or complete evacuation of the facility resulting from natural disaster; or any loss of utilities, such as electricity, natural gas, telephone, emergency generator, fire alarm, sprinklers, and other critical equipment necessary for operation of the facility for more than 24 hours.

Each facility shall notify the department of any anticipated closure or discontinuation of service at least 60 days in advance of the effective date.

Each facility shall report to the department any unsafe water samples for pools or spas.

This Administrative Rule of South Dakota is not met as evidenced by:
Surveyor: 32332
Based on the provider's emergency plan and interview, the provider failed to report issues with their heating systems during a cold weather spell to the South Dakota Department of Health (SD DOH). Findings include:

1. Observation on 1/7/22 at 12:00 p.m. of the provider's four hallways revealed:
*The Happy Trails hallway (west) temperature was 60.1 degrees Fahrenheit (F) by the exit door.
-The double doors at the top of the hall by the

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S 115	Continued From page 2 nurses' station had been closed. -All rooms on the west hall had been unoccupied. *The Garden Terrace hall temperatures had ranged from 69.8 degrees F to 72.6 degrees F. *The Rising Sun hall temperatures had ranged from 73.8 degrees F down to 68.7 degrees F. *The dining room at the end of the entrance hall had been 73.6 degrees F. Interview on 1/7/22 at 12:30 p.m. with administrator in training (AIT) A revealed: *One of two boilers had shut down during the night of 1/6/22 mainly affecting the Happy Trails hall. *On the morning of 1/6/22 all residents behind the double doors in the Happy Trails hall were temporarily placed in open rooms in the other two halls. *The head of maintenance (B) had located a company who sold the part required to fix the boiler on 1/6/22 and was awaiting delivery on 1/7/22. Interview on 1/7/22 at 2:30 p.m. with AIT A, administrator C, and head of maintenance B revealed the provider had not notified the SD DOH of the boiler problems but should have done so at the time of the occurrence.	S 115		