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 _____	08/31/2023

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

(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 8/29/23 through 8/31/23. Dells Nursing and Rehab Center Inc was found not in compliance with the following requirements: F582, F604, F625, F655, F658, F684, and F880.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide	F 582	Unable to correct the noncompliance for lack of SNF ABN forms provided. Will ensure that residents receive the correct forms going forward. Administrator, DON, and interdisciplinary team will review and revise policies and procedures as necessary. SSD or designee will audit correct SNF ABN forms given weekly for 4 weeks and monthly for 2 months. SSD or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	10/15/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Calyn Weiss	Administrator	10/04/2023

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
	435129	A. BUILDING _____ B. WING _____	08/31/2023

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

(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 582	Continued From page 1 notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure the appropriate Medicare notices with options were given to two of two sampled residents (24 and 41) prior to their discharge from skilled services. Findings include: 1. Review of resident 24's electronic medical record revealed: *She was in the facility receiving skilled services and had benefit days left. *She signed the Notice of Medicare Non-coverage (NOMNOC) on 8/23/23 with the benefit's expiration of 8/25/23.	F 582		

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 _____	08/31/2023

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

(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 582	Continued From page 2 *The resident was not given a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) form. *The resident was not given an alternative payment or appeal options located on the SNF ABN form. 2. Review of Resident 41's electronic medical record revealed: *She was in the facility receiving skilled services and had benefit days left. *She signed the NOMNOC on 3/24/22 with the benefit's expiration of 3/28/23. *The resident was not given an SNF ABN form. *The resident was not given an alternative payment or appeal options located on the SNF ABN form. 3. Interview on 8/29/23 at 3:43 p.m. with social services designee C regarding resident 24 and 41's SNF ABN forms revealed: *The residents were only given the NOMNOC forms to sign. *It was her understanding that they did not need to provide the SNF ABN forms. *She was unaware as to when to use the SNF ABN forms. 4. Review of the provider's undated "Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123" policy revealed no SNF ABN form was referenced.	F 582		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:	F 604	Resident 5's air mattress will have proper assessment and documentation to indicate the use of a low air-loss mattress.	10/15/2023

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 _____	08/31/2023

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

(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 604	Continued From page 3 §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (5) was appropriately assessed and had the documentation to indicate the use of a low air-loss mattress on the bed with four side bolsters (air filled side rails) as a restrictive or enabling device. Findings include: 1. Observations on the following dates and times	F 604	Hospice nurse and MDS coordinator or designee will do proper assessments on any new mattresses upon admissions and quarterly. Hospice will inform DON, MDS coordinator, Administrator or designee of any new device that could be viewed as a restraint. Administrator, DON, and/or designee will review, revise, create as necessary policies and procedures for the above identified area. Administrator, DON, MDS, and/or designee identified as necessary will ensure all facility staff responsible for above task will receive education/training with demonstrated competency and documentation. MDS coordinator or designee will audit appropriate assessments and documentations on all necessary residents weekly for 4 weeks and monthly for 2 months. MDS or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	

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 _____	08/31/2023

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

(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 604	Continued From page 4 revealed: *On 8/29/23 at 10:03 a.m. revealed the bed in resident 5's room had a low air-loss mattress. The mattress top and bottom sides were approximately five to six inches taller than the flat part of the mattress. There was a cut-out in the middle on both sides. *On 8/29/23 at 2:19 p.m. of resident 5 after having been assisted into her bed revealed two staff used the full body lift to place her in the middle of the bed. She was then assisted by those two staff members for personal cares and positioned on her back. The bolster sides were still inflated. *On 8/30/23 at 3:00 p.m. of resident 5 revealed she was laying in the middle of her bed, turned on her side and resting her back against a pillow. The bolster sides were still inflated. *On 8/31/23 at 1:30 p.m. of resident 5 revealed she was laying in the middle of her bed, turned on her left side and resting her back against a pillow. The bolster sides were still inflated. Interview on 8/31/23 at 4:30 p.m. with director of nursing B revealed: *There had been no assessment completed on the air mattress with the side bolsters. *She had not considered the side bolsters as a restraint, when resident 5 moved towards the sides of the bed the bolsters had not stayed as high. *Stated hospice had placed the mattress on the bed. *She thought it had been requested by resident 5's family due to her fall risk. *Resident 5 has had falls out of her bed even with the bolsters present and was able to get out of the bed despite her extensive care needs.	F 604		

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 _____	08/31/2023

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

(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 604	Continued From page 5 Review of resident 5's care plan revealed: *Revised on 2/27/23 "[Resident] is totally dependent on 1-2 staff for repositioning and turning in bed and as necessary. [Resident] has a bed rail in place to help with repositioning and bed mobility. [Resident] bed will be placed in it's lowest position with a fall mat in place while in bed." *Revised on 6/7/23 "[Resident] has an intermittent air mattress on her bed." *There was no mention the air mattress had air filled bolsters attached to it. Review of the provider's undated Physical Restraint policy revealed: *A concave mattress that prevented the resident from getting out of bed would have been considered a restraint. *To properly use the mattress to assist a resident in maintaining independence, the resident and the device should have been assessed for the following: -"The resident is able to remove the device without assistance from staff." -"The device has to assist resident in maintaining independence." -"Device must be approved by resident, family and IDT [interdisciplinary team] committee." -"Device must be in care plan and reviewed quarterly (or sooner if issues)." *Procedure to implement a device that could have been considered a restraint included: -Determine the type of device requested to have been used. -Seat belts, lap belts, lap trays, side-rails, grab bars, and recliners were the only devices listed to have been considered as a restraint. -The resident's primary care provider should have provided an order to implement the device. The	F 604		

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 _____	08/31/2023

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

(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 604	Continued From page 6 order was to have stated the device was to assist the resident in maintaining their independence, mobility, and/or the ability to reposition themselves. -All devices were to have been added to the care plan and assess quarterly.	F 604		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced	F 625	Unable to correct the noncompliance for lack of Bed Hold Policy forms provided. Will ensure that residents receive the correct forms going forward. Administrator, DON, or designee will provide education on the bed-hold policy to all nurses by 10/15/2023. Administrator, DON, and interdisciplinary team will review and revise policies and procedures as necessary. SSD or designee will audit correct bed hold forms given weekly for 4 weeks and monthly for 2 months. SSD or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	10/15/2023

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 _____	08/31/2023

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

(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 625	Continued From page 7	F 625		

by:
Based on record review, interview, and policy review, the provider failed to provide residents who had transferred to the hospital with an appropriate Bed Hold notice indicating the duration that the bed would have been held for four of four sampled residents (3, 13, 27, 42). Findings include:

1. Review of resident 27 and 42 electronic medical records revealed there was no bed hold notices given to the residents or the resident's representatives when those residents transferred to the hospital.

2. Review of resident 3's electronic medical record revealed she had been transferred to the hospital on 8/30/23. There was no signed bed hold form found in her medical records.

Interview with resident 3 on 8/30/23 at 2:00 p.m. revealed she:
*Remembered going to the hospital in town and then was transferred to a hospital in Sioux Falls.
*Could not remember if any information had been given to her about holding her bed while she was out of the facility.

3. Review of resident 13's electronic medical record revealed he had been hospitalized on 6/3/2023. There was no signed bed hold form found in his medical records.

Interview on 8/31/23 at 10:48 a.m. with administrator A revealed:
*The resident or resident's representative had been given the bed hold notice that was signed on admission.
*The provider held the resident's bed when they

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 _____	08/31/2023

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

(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 625	Continued From page 8 were transferred to the hospital or went on leave from the facility. *The provider had not asked the resident's family if they wanted to hold the resident's bed because "they just do that [hold a resident's bed] and wait until the family decides that they don't want the resident's bed held." Interview on 8/31/23 at 11:47 a.m. with social service designee C revealed: *The resident and the resident's families had been made aware of the bed hold policy at admission. *When the resident had required a transfer, she would have put in a notice to the resident's family and the ombudsman that the resident's bed had been held. *The bed hold policy would not have been discussed with the resident or the family representative after the admission process was complete. Review of the facility's undated Bed Hold policy revealed: *"E. Bed-Hold *1. The notice of Bed-Hold Policy is provided to the Resident/financially responsible party upon admission and at the time of transfer."	F 625		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident	F 655	Unable to correct the noncompliance for lack of baseline care plan provided within 48 hours of admission. Will ensure going forward that new residents will have a base line care plan done within 48 hours of admission. Administrator, DON, and interdisciplinary team will review and revise policies and procedures as necessary.	10/15/2023

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 _____	08/31/2023

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

(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 655	Continued From page 9 that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure four of four	F 655	MDS or designee will audit resident baseline care plans weekly for 4 weeks and monthly for 2 months. MDS or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	10/15/2023

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 _____	08/31/2023

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

(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 655	Continued From page 10	F 655		

newly admitted sampled residents (3, 22, 24, and 43) had a baseline care plan that was established and reviewed with the resident, their representative, or their responsible family member. Findings include:

1. Review of resident 3's electronic medical record revealed:
*She was admitted on 7/26/23
*There was no baseline care plan.
*There was no documentation that the resident, their representative, or their responsible family member had received the baseline care plan.

2. Review of resident 24's medical record revealed:
*She was admitted on 7/27/23
*There was no baseline care plan.
*There was no documentation that the resident, their representative, or their responsible family member had received the baseline care plan.

Interview on 8/31/23 at 4:00 p.m. with director of nursing (DON) B revealed:
*The process they used for the initial resident care plan was that it was started after the resident was admitted.
*The interdisciplinary team would each contribute to the care plan.
*The first care plan conference was usually conducted with the resident and/or representative approximately a week after admission.
*She was now aware an initial care plan was to have been completed within forty-eight hours after the resident's admission.
3. Review of resident 22's electronic medical record revealed:
*She was admitted on 2/27/23.
*There was no baseline care plan.

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 _____	08/31/2023

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

(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 655	Continued From page 11 *There was no documentation that the resident, their representative, or their responsible family member had received the baseline care plan. 4. Review of resident 43's medical record revealed: *He was admitted on 6/19/23. *There was no baseline care plan. *There was no documentation that the resident, their representative, or their responsible family member had received the baseline care plan. Review of the provider's undated Policy & Procedure for Admission revealed: *The initial care planning would have been formulated through a cooperative effort of the DON, Minimum Data Set coordinator, and the charge nurse. *There was no information of when that care plan would have been completed. *There was no information if the resident and/or representative would have reviewed the care plan and how that would have been documented.	F 655		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the following care-specific details regarding one of one sampled resident's (40) skin tear and skin treatment had been documented. Findings include:	F 658	Unable to correct prior noncompliance of the proper procedure followed for resident 40's skin tear. DON or designee will monitor thorough documentation and reports given at shift change by nursing staff and to adhere to facilities Skin Tear Treatment policy. Administrator, DON, or designee will provide education Skin Tear Treatment policy to all nurses by 10/15/2023. Administrator, DON, and interdisciplinary team will review and revise policies and procedures as necessary.	10/15/2023

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 _____	08/31/2023

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

(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 658	Continued From page 12 1. Observation and interview on 8/29/23 at 10:40 a.m. with resident 40 revealed she had a dressing to her right upper arm. She stated it was a skin tear from bumping the corner of the end table by her recliner. 2. Observation and interview on 8/30/23 at 4:10 p.m. with resident 40 and licensed practical nurse (LPN) D revealed: *Resident 40 approached the nurses station and it was noticed she had three large steri-strips on her right forearm covering what appeared to have been a skin tear. *Resident 40 stated she received the skin tear from the corner of her end table by her recliner. *LPN D stated she was not aware resident 40 had a skin tear. *She had not been informed of resident 40's skin tear during the report that morning. Review of resident 40's interdisciplinary progress notes prior to 8/30/23 revealed there was no documentation regarding the right forearm skin tear. Interview on 8/30/23 at 4:50 p.m. with LPN D, administrator A, and Minimum Data Set (MDS) coordinator E revealed: *LPN D stated she had not noticed the right forearm skin tear when she had completed a comprehensive skin observation after resident 40's bath that morning. *LPN D, administrator A, and MDS coordinator E were not aware of how or when resident 40 had acquired the right forearm skin tear. No incident had been reported. Review of an 8/30/23 5:21 p.m. interdisciplinary	F 658	DON or designee will audit correct Skin Tear Treatment policy is being followed weekly for 4 weeks and monthly for 2 months. DON or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	

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 _____	08/31/2023

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

(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 658	Continued From page 13	F 658		

progress note revealed: "Resident approached this nurse at the desk and asked to have her arm looked at. There are steri-strips applied to the right forearm. Resident stated to this nurse and state surveyor [name] that she bumped her arm on the stand next to her chair. Steri-strips are intact on arm. Slight blood noted on the 2 edges. This nurse spoke w/ [with] the previous night nurse and she was the one who placed the dressing on there. Adding dressing monitoring to the TAR [treatment administration record]."

Interview on 8/31/23 at 9:30 a.m. with LPN D revealed:
*When a resident had an injury the nurse was to assess the injury, notified the physician for orders, and notify the family.
*After the above had been completed the treatment was noted on the TAR and documentation in the resident's medical record was completed.
*If it was an injury of unknown origin an incident report was to have been completed.
*Since resident 40 knew how the injury happened no incident report was completed.

Interview on 8/31/23 at 11:47 a.m. with director of nursing B revealed:
*She had called the night nurse who had given the above information to LPN D.
*Her expectation would have been to complete the documentation of the skin tear that should have included notification of resident 40's physician and the family and/or representative:
*Documentation of the skin tear should have been completed and the treatment started as ordered by the physician.
*She was not aware how resident 40 had received the skin tear.

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 _____	08/31/2023

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

(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 658	Continued From page 14 Review of the provider's undated Skin Tear Treatment policy revealed: *"Identified skin tears will be evaluated by nursing." *"The skin tear will be treated per standing orders for treatment of skin tears and physician order to be written in resident chart unless upon nursing judgement it is decided the injury needs to be evaluated by a physician." *"Document on the MAR [medication administration record] treatment of skin tear and to monitor skin tear daily til [until] healed. Document in the nurse's notes when the skin tear is healed." *"Document in the nurses notes the following information: -Mechanism of injury if known. -Size of the skin tear. -treatment rendered. -notification of physician and family."	F 658		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and hospice agreement review, the provider failed to develop a collaborative comprehensive	F 684	Reviewed facility care plans for residents (4, 5, 8, 9, 14, 19, 22) to collaborate with hospice care plans. Upon hospice admission MDS Coordinator, DON, or designee will create resident care plan in accordance with hospice care plan. Hospice nurse will follow up with MDS coordinator, DON, or designee following hospice patient visits to update any resident care plan changes. MDS Coordinator, DON, or designee will educate all necessary staff on hospice/facility resident care plans by 10/15/2023. Administrator, DON, and interdisciplinary team will review and revise policies and procedures as necessary.	10/15/2023

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 _____	08/31/2023

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

(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 684	Continued From page 15 care plan that included descriptions of hospice care for seven of eight sampled residents (4, 5, 8, 9, 14, 19, 22) receiving hospice services. Findings include: 1. Observation on 8/29/23 at 11:54 a.m. of resident 8 in the dining room revealed: *She was sitting in her wheelchair. *She was slumped forward and leaning to the left. *There was a safety strap buckled laterally across her chest. *There were no other positioning devices in place. Interview at that time with Minimum Data Set (MDS) coordinator E revealed that resident 8 had Parkinson's disease and utilized the safety strap to stay stabilized in her wheelchair. Observation on 8/29/23 at 3:43 p.m. of resident 8 in her room revealed: *She was lying in bed with her eyes closed. *Her legs were bent at the knees and hips, and her legs were leaning to her left side. *Her torso and head were positioned face-up. *She had one pillow underneath her head. *When asked if she was comfortable, resident 8 answered, "No." *Certified nursing assistant (CNA) H assisted the resident with repositioning her upper body and placed a pillow under her lower back to help position the resident on her left side. *The CNA explained afterward that resident 8 had a condition where she frequently returned to the same "hunched over" position. Observation on 8/30/23 at 10:06 a.m. of resident 8 in her room revealed: *She was lying in bed with her eyes closed.	F 684	DON or designee will audit collaborative care plans weekly for 4 weeks and monthly for 2 months. DON or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	

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 _____	08/31/2023

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

(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 684	Continued From page 16 *She was in the same hunched position as the above observation. *There were extra pillows underneath her head, legs, and back to aid in positioning. Interview on 8/30/23 at 10:18 a.m. with CNA I regarding resident 8 revealed: *Resident 8 received hospice services. *She was repositioned every two hours. *They transferred her into her wheelchair before meals and transferred her back to bed after meals. *The safety strap was utilized as the resident requested. Observation and interview on 8/30/23 from 11:54 a.m. to 12:20 p.m. with CNA I and hospice aide G while they were transferring resident 8 from her bed to her wheelchair revealed: *Hospice aide G explained that they would be using a stand-and-pivot transfer method with resident 8 since she was very tired. -They would have used the sit-to-stand machine if the resident had been more awake. *The hospice aide stated she used either a rolled-up blanket or a pillow on resident 8's left side to prevent her from folding forward. *Hospice aide G stated she was unaware of the resident's care plan. She stated she had no access to the resident's care plans. Interview on 8/30/23 at 2:10 p.m. with CNAs H, I, and J about resident 8's care plan revealed: *CNA I confirmed that neither she nor the hospice aide were aware of the resident's care plan regarding positioning devices. *CNAs H and J confirmed that they were not aware of the resident's care plan regarding positioning devices.	F 684		

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 _____	08/31/2023

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

(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 684	Continued From page 17 *They all confirmed that they were unaware of any hospice care plan for resident 8, or any other resident who received hospice services. *When the hospice aide was there, she would assist them with different resident care tasks such as transferring, feeding, bathing, grooming, and dressing. Interview on 8/31/23 at 2:40 p.m. with licensed practical nurse D regarding communication between the hospice provider and the provider's staff revealed: *The hospice provider sends its hospice notes in the mail. *Hospice aide G was "very good" about informing her and other staff about her task list for the day when she visited. *She was not aware of any care plans from that hospice provider. Interview on 8/31/23 at 3:18 p.m. with MDS coordinator E about hospice care plans revealed: *She was not aware of any care plans from that hospice provider. *It was their process to include that the resident was receiving hospice services in their resident care plans. *The previous nurse from the hospice provider "had not been sending" the hospice care plans. *The new hospice nurse informed the provider's management team about the hospice care plans. -None of the hospice provider's resident care plans had been shared with them until that day. Review of resident 8's care plan revealed: *There were two separate interventions that mentioned the use of a pillow for positioning: -"[Resident 8] requires her left side propped up on a pillow to keep her upright when in wheelchair,"	F 684		

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 _____	08/31/2023

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

(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 684	Continued From page 18 which was initiated on 11/8/18. There was no revision date. -"[Resident 8] requires a wedge pillow under her left arm for support," which was initiated on 1/29/19 and revised on 12/28/20. *Hospice services were initiated on 6/19/23. *The following interventions were included under the hospice focus area: -"RN [registered nurse]: 1 to 2 times a week." -"Social worker: 1 to 2 times a month." -"Nurse Aide: 4 to 5 times a week." -"Chaplaincy Services: 1 to 2 times a month." -"Date Initiated: 06/20/2023." *There were no descriptions of the services the hospice provider would have been providing to those residents on hospice, or the expected amount of time that the hospice providers would have been with the resident each week. 2. Review of resident 4's care plan revealed: *Hospice services were initiated on 7/28/23. *The following interventions were included under the hospice focus area: -"RN: 1 to 2 X a week [times a week] and PRN [as needed]." -"Social worker: 1 X a month and PRN." -"Nurse Aide: 3 to 4 x a week and PRN." -"Chaplaincy Services: 1 X a month and PRN." -"Date Initiated: 07/28/2023." *There were no descriptions of the services the hospice provider would have been providing to those residents on hospice, or the expected amount of time that the hospice providers would have been with the resident each week. 3. Review of resident 5's care plan revealed: *Hospice services were initiated on 10/8/21. *There were no descriptions of how often a hospice RN, aide, social worker, or chaplain	F 684		

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 _____	08/31/2023

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

(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 684	Continued From page 19 would have visited the resident. *There were no descriptions of the services the hospice provider would have been providing to those residents on hospice, or the expected amount of time that the hospice providers would have been with the resident each week. 4. Review of resident 9's care plan revealed: *Hospice services were initiated on 3/31/23. *The following interventions were included under the hospice focus area: -"RN:1 to 2 times a week & PRN." -"Social worker: 1 to 2 times a month & PRN." -"Nurse Aide: 4 times Weekly." -"Chaplaincy Services: 1 to 2 times a month & PRN." -"Date Initiated: 03/31/2023." *There were no descriptions of the services the hospice provider would have been providing to those residents on hospice, or the expected amount of time that the hospice providers would have been with the resident each week. 5. Review of resident 14's care plan revealed: *Hospice services were initiated on 5/9/22. *The following interventions were included under the hospice focus area: -"RN:1-2X a week and PRN." -"social worker:1-2X a month or PRN." -"Nurse Aide up to 4x a week." -"Chaplaincy services:1-2X a month and PRN." -"Date Initiated: 11/28/2022." *There were no descriptions of the services the hospice provider would have been providing to those residents on hospice, or the expected amount of time that the hospice providers would have been with the resident each week. 6. Review of resident 19's care plan revealed:	F 684		

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 _____	08/31/2023

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

(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 684	Continued From page 20 *Hospice services were initiated on 8/22/23. *The following interventions were included under the hospice focus area: -"RN: 1 to 2 times a week & PRN." -"Social worker: 1 to 2 times a week & PRN." -"Nurse Aide : 4 to 5 times a week & PRN." -"Chaplaincy Services: 1 to 2 times a month & PRN." -"Date Initiated: 08/22/2023." *There were no descriptions of the services the hospice provider would have been providing to those residents on hospice, or the expected amount of time that the hospice providers would have been with the resident each week. 7. Review of resident 22's care plan revealed: *Hospice services were initiated on 4/18/23. *The following interventions were included under the hospice focus area: -"RN: 1 to 2 times a week and PRN." -"Social worker: 1 to 2 times a month and PRN." -"Nurse Aide: 5 times a week M-F [Monday through Friday]." -"Chaplaincy services: 1 to 2 times a month and PRN." -"Date Initiated: 04/21/2023." *There were no descriptions of the services the hospice provider would have been providing to those residents on hospice, or the expected amount of time that the hospice providers would have been with the resident each week. Review of progress notes in resident 22's electronic medical record from 3/29/23 through 8/30/23 revealed there was no discussion about the care or services that hospice had been providing, nor that the hospice provider was involved or invited to the resident's care planning conferences.	F 684		

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 _____	08/31/2023

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

(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 684	Continued From page 21 8. Review of the provider's 2018 "Hospice and Nursing Facility Services Agreement" revealed: *"II. Appointment and Authority" -"Hospice hereby contracts with Facility to provide Room and Board Services, Purchased Hospice Services and/or Inpatient Services to Patients in accordance with the terms of this Agreement and with each Patient's plan of care." -"Facility hereby contracts with Hospice to provide Hospice Services to Facility residents in accordance with the terms of the Agreement and with each Patient's plan of care." *"III. Responsibilities of the Parties" -"3.1 Hospice Responsibilities" --"3.1.6 Provision of Hospice Services. ...Hospice shall provide Hospice Services to each Patient in accordance with the plan of care for that Patient ..." --"3.1.10 Communication. (a) Hospice and Facility shall communicate with one another regularly and as needed for each particular Hospice Patient. After every communication between Hospice and Facility, each Party shall document the communication in its respective clinical records to ensure that the needs of Hospice Patients are met twenty four (24) hours per day." --"3.1.16 Coordination of Services. ...(c) Provide Facility with the following information specific to each Hospice Patient residing at Facility: (i) the most recent plan of care ..." -"3.2 Facility Responsibilities" --"3.2.12 Coordination with Hospice. ...Facility's representative will perform the following duties:" ---"(a) Collaborate with Hospice staff and coordinate Facility staff's participation in the care planning process;" ---"(d) For each Hospice Patient in the Facility obtain (i) the most recent plan of care ..."	F 684		

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 _____	08/31/2023

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

(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 684	Continued From page 22 -"3.3 Joint Responsibilities/Mutual and Hospice Promises." --"3.3.1 Development and Implementation of Plan of Care." ---" ...Hospice and Facility shall jointly develop and agree upon the Patient's plan of care." ---" ...Hospice and Facility each shall maintain a copy of each Patient's plan of care in the respective clinical records maintained by each Party." ---"3.3.1a The plan of care shall identify the care and services needed and specifically identify whether Hospice or Facility is responsible for performing the respective functions that have been agreed upon and included in the plan of care." --"3.3.2 Modification of Plan of Care. Hospice and Facility shall jointly coordinate and participate in periodic review and modification of each Patient's plan of care at intervals consistent with regulations and as specified in the plan of care ... Hospice and Facility each shall maintain a copy of any modification to each Patient's plan of care in the respective clinical records maintained by each Party."	F 684		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880	All nurses will receive training on hand hygiene during a dressing change. LPN D has reviewed dressing change policy and identified mistake. All necessary staff will receive training on hand hygiene during feeding assisted residents. MDS Coordinator E has reviewed the dining assistance policy and identified mistake. The administrator, DON, and/or a designee in consultation with the medical director will review, revise, and create as necessary policies and procedures for the above identified areas.	10/15/2023

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 _____	08/31/2023

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

(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 880	Continued From page 23 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 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	F 880	All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by 10/15/2023. ALL residents and staff have the potential to be affected if staff to not adhere to identified areas. Administrator, DON, dietary manager, medical director, and any others as necessary will ensure ALL staff responsible for the assigned task(s) have received education/training with demonstrated competency and documentation. DON or designee will audit proper hand hygiene on dressing changes and dining assistance 2 times weekly for 4 weeks and monthly for 2 months. DON or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	

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 _____	08/31/2023

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

(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 880	Continued From page 24 (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 infection prevention and control practices were appropriately followed for the following: *Hand hygiene and glove use during one of one observed dressing change by one of one licensed practical nurse (LPN) D. *Hand hygiene during one of two dining observations by one of one Minimum Data Set (MDS) coordinator E while assisting a resident with the meal service. 1. Observation on 8/30/23 at 9:35 a.m. of LPN D performing a dressing change for resident 23 revealed she: *Had removed clean gauze from the gauze container in the resident's room after cleansing the wound on the resident's buttocks. *Had removed the soiled gloves and, without performing hand hygiene, had placed a new pair of gloves on her hands. *Picked up the new gauze that had been touched	F 880		

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 _____	08/31/2023

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

(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 880	Continued From page 25	F 880		

by those same gloves, folded the gauze two times, then placed the gauze on the wound before placing a new adhesive dressing.

Interview on 8/30/23 at 2:44 p.m. with LPN D regarding the above dressing change revealed she:
*Agreed that she should have performed hand hygiene in between removing the first set of gloves and placing a new pair of clean gloves on her hands.
*Agreed she should have changed her gloves before grabbing a clean gauze and placing it on the clean barrier.

Interview on 8/31/23 at 2:50 p.m. with director of nursing (DON) B and registered nurse (RN) E revealed:
*They agreed that hand hygiene should have been performed after removing her gloves and placing a clean pair of gloves on her hands during the above observed dressing change.
*All supplies should have been placed on the barrier so the nurse would not to have been tempted to grab clean gauze out of the container without washing or sanitizing her hands prior to changing her gloves.
*They agreed that the clean gauze should have been placed on the barrier with a new pair of clean gloves after hand hygiene was performed.

Review of the facility's undated "Non-sterile Wound Dressing Change" policy revealed:
*"3. Assemble necessary equipment"
*"8. Remove soiled gloves
*9. Wash hands
*10. Put on clean gloves"

2. Observation on 8/30/23 from 5:33 p.m. to 5:55

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 _____	08/31/2023

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

(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 880	Continued From page 26 p.m. in the dining room revealed: *Residents 7 and 22 were seated at one of the assisted dining room tables. *MDS coordinator E used hand sanitizer prior to sitting down between residents 7 and 22. *Without putting on a pair of gloves, she used her bare right hand to pick up resident 7's cheeseburger and French fries and guided the food to resident 7's mouth. -She touched the resident's food with her bare right hand a total of four times. *She had not performed hand hygiene prior to assisting the next two residents. Interview on 8/31/23 at 9:46 a.m. with dietary manager F about the above observation revealed: *It was her expectation for staff to use utensils while feeding a resident. *She stated that staff should have used gloves if they were touching a resident's ready-to-eat foods. Interview on 8/31/23 at 9:55 a.m. with MDS coordinator E regarding the above observation revealed: *She stated she had not received education regarding food safety since she started her employment. *She was unaware that she should not have touched a resident's food with her bare hands. Interview on 8/31/23 at 9:58 a.m. with administrator A regarding the above observation revealed: *It was her understanding that the use of gloves while assisting a resident to eat could have been viewed as an issue with dignity. -She indicated she would not have used gloves	F 880		

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 _____	08/31/2023

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

(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 880	Continued From page 27 either in the above-described observation. *She was unaware that it was not a proper food safety practice to touch ready-to-eat foods with bare hands. Review of the provider's 4/4/23 "Dining Assistance" policy revealed: *Under the policy section: -"Proper hand hygiene will be performed and maintained throughout the duration of meals. Utensil will be used at all times, prohibiting touching of foods." *The policy had not specified when staff should and should not have been using gloves during dining assistance.	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
	435129	A. BUILDING _____ B. WING _____	08/31/2023

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

(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 from 8/29/23 through 8/31/23. Dells Nursing and Rehab Center Inc. was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Calyn Weiss
TITLE: Administrator
(X6) DATE: 10/15/2023

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.

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
	10613	A. BUILDING: _____ B. WING _____	08/31/2023

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

(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 8/29/23 through 8/31/23. Dells Nursing and Rehab Center Inc was found not in compliance with the following requirements: S210 and S236.	S 000		
S 210	44:73:04:06 Employee Health Program The facility shall have an employee health program for the protection of the residents. All personnel shall be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Any personnel absent from duty because of a reportable communicable disease which may endanger the health of residents and fellow employees may not return to duty until they are determined by a physician or physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the facility failed to ensure that one of five sampled employees (K) received a health screening for communicable diseases within fourteen days of hire. Findings include:	S 210	Employee K's medical files were reviewed and revised to reflect the correct health screening for communicable diseases. Unable to correct the noncompliance target date of 14 days of date to hire. Employee health program process for new employees will be reviewed and revised as needed and all staff responsible for admissions will be re-educated for correct compliance by 10/15/2023. Business office manager or designee will audit area identified to ensure compliance for all new hires weekly for 4 months and monthly for 2 months. Business office manager or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	10/15/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Calyn Weiss

TITLE: Administrator

(X6) DATE: 10/04/2023

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
	10613	A. BUILDING: _____ B. WING _____	08/31/2023

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

(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 210	Continued From page 1 1. Record review of certified nursing assistant K's personnel file revealed the employee: *Had been hired on 5/31/23. *Had been under the age of 18 at the time of hire. *Had not been evaluated for communicable diseases by a licensed health professional. Interview on 8/31/23 at 4:45 p.m. with facility administrator A revealed: *She had been aware that the employee had not completed the health evaluation. *It had been difficult to get parental approval for the evaluation as the employee was under the age of 18. *She did not offer any additional information on any efforts made to complete the screening. Further review of employee's personnel file revealed: *There had been no documentation requesting a consent for a communicable disease evaluation from the employee's parent or guardian.	S 210		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate	S 236	Employee K's medical files were reviewed and revised to reflect the correct tuberculin screening and requirements. Unable to correct the noncompliance target date of 14 days of date to hire. The tuberculosis policy will be reviewed and revised as needed and all staff responsible for admissions will be re-educated on correct process for compliance by 10/15/2023. Business office manager or designee will audit area identified to ensure compliance for all new hires weekly for 4 weeks and monthly for 2 months.	10/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10613	A. BUILDING: _____ B. WING _____	08/31/2023

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

(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 236	Continued From page 2 baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure one of five sampled employees (K) were screened for tuberculosis within fourteen days of hire. Findings include: 1. Record review of certified nursing assistant (CNA) K's personnel file revealed the employee: *Had been hired on 5/31/23. *Had been under the age of 18 at the time of hire. *Had not been given a tuberculin screening test by a licensed health professional. Interview on 8/31/23 at 4:45 p.m. with facility administrator A revealed: *She had been aware that the employee had not completed the tuberculin screening test. *It was difficult to get parental approval for the evaluation as the employee was under the age of 18. *She did not offer any additional information on any efforts made to complete the screening.	S 236	Business office manager or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	

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
	10613	A. BUILDING: _____ B. WING _____	08/31/2023

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

(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 236	Continued From page 3 Further review of CNA K's personnel file revealed: *There had been no documentation that a consent for a tuberculin screening test had been requested from the employee's parent or guardian. Review of the provider's 7/2021 "Employee TB testing" policy revealed: *Every new healthcare worker would receive QuantiFERON Gold testing within 14 days of employment. *"Human resources will notify the department supervisor for each new hire that does not get their test completed or provide documentation of a previous text in the required time frame."	S 236		

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 **01 - MAIN BUILDING 01** B. WING _____	**08/30/2023**

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

(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
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 8/30/23. Dells Nursing And Rehab Center Inc was found in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Calyn Weiss
TITLE: Administrator
(X6) DATE: 10/15/2023

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.