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
	43A135	A. BUILDING ______ B. WING ______	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

(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 Surveyor: 42477 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 9/14/21 through 9/16/21. Eastern Star Home of South Dakota, Inc. was found not in compliance with the following requirements: F604, F657, F658, F692, F745, and F880.	F 000	F 604 Right to be Free from Physical Restraints (1) On October 5, 2021, the Administrator, DON, and MDS Nurse reviewed facility's policies and the current M-rail/Bedrail Assessment, Alarm Assessment, and Potential for Restraint Assessment. The following was implemented based on this review: * A new assessment (Assistive Device/Potential Restraint Assessment) was implemented. * This assessment will be completed prior to any assistive device/potential restraint is implemented, quarterly, and with any change of condition by the MDS nurse. * The MDS nurse will report to the QAPI committee monthly those residents who utilize assistive devices that were identified as a potential restraint.	
F 604 SS=E	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: §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	F 604	(2) On October 5, 2021, the Administrator and MDS nurse reviewed all residents who currently use a personal alarm, M-rail, activity tray, and/or scoop mattress utilizing the new Assistive Device/Potential Restraint Assessment to ensure that the devices that are currently being utilized are done at the least restrictive method. After completion of those assessments, it was decided to discontinue the personal alarm on Resident 17. (3) The DON will be responsible for conducting a minimum of 4 spot checks per month to ensure compliance with the completion and routine review of the Assistive Device/Potential Restraint Assessment. The DON will report the findings to the QAPI Committee monthly times 3 months then quarterly until the QAPI Committee advises otherwise. Completion Date	10/20/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deborah L. Bowar	Administrator	10/08/2021

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

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F 604	Continued From page 1 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: Surveyor: 06365 Based on observation, interview, record review, and policy review, the provider failed to ensure four of four sampled residents (14, 17, 24, and 28) had been assessed for the use of a scooped mattress and chair and/or bed alarms as restraints or enablers. Findings include: 1. Observation on 9/14/21 at 10:30 a.m. revealed resident 17 in her wheelchair at the beauty shop with an chair alarm cord clipped to her collar. Further observation on 9/15/21 of resident 17 at the following times revealed: *8:00 a.m.: -Not in her room, a bed alarm pad was draped across the reclining chair in her room. *8:13 a.m.: -Seated in her wheelchair in the dining room with chair alarm cord clipped to her collar. *10:36 a.m.: -Seated in her wheelchair with a chair alarm cord clipped to her collar in the front lobby lounge facing a large screen television but with her eyes closed. Review of resident 17's current care plan as provided by the facility, with handwritten date notations of 1/22/21 and 4/19/21 in the left margin, revealed the following resident problems and needs: *Modified independence with cognitive skills. *Supervision, cuing, was required for walking with	F 604		

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F 604	Continued From page 2 a walker. *Restraints was checked as "Not Used." *Risk for falls/injury dated 2/7/21 with an added handwritten approaches to "Use seat & bed alarm daily" dated 7/8/21 and "using w/c [wheelchair] with staff assist" dated 8/30/21. *Total dependence with mode of "hoyer lift" handwritten and dated 9/13/21. Assistance required with one or two persons was yellowed out. Review of the following documents from resident 17's record revealed: *An alarm assessment dated 7/9/21 noted: -The resident was reported as "falling during hospital stays with minor injuries." -Her "functional mobility had declined." -The potential benefit of using an alarm was noted as "decrease falls" and the "staff/family" believed the alarm would not "refrain the resident from getting up" and would not "startle the resident." *A Fall Risk Evaluation dated 7/19/21 scored the resident's risk at 22 points. A score of "10 or above represents HIGH RISK." *A significant change Minimum Data Set (MDS) dated 7/19/21 noted the resident's: -Cognitive score as 3, meaning severely impaired. -Ability for walking in the hallway and around the facility was coded as needing weight-bearing support with one person. *A Care Conference Meeting and Review form dated 7/19/21 noted the resident needed more physical assistance and the use of "seat & bed alarm daily," and the resident was "forgetting to ask for assist." *The Quarterly/Annual Review by physical therapy dated 7/20/21 noted the	F 604		

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F 604	Continued From page 3	F 604		

recommendations for restorative therapy services included assist with walking using a four-wheeled walker (FWW) 4-5 times a week.
*The August 2021 Restorative Flow Sheet noted the resident walked with her FWW during 10 of the 17 times the service was offered to the resident.
*A Fall Risk Evaluation dated 9/15/21 noted the resident's score was 12, just slightly above the score of high-risk score of 10. The resident was noted as being "chair bound."

Interview on 9/15/21 at 10:37 a.m. with restorative nursing assistant (RNA) O revealed resident is now a "non-ambulator" [not able to walk] and they use a lift.

Interview on 9/15/21 at 1:50 p.m. with certified nursing assistant (CNA) P revealed:
*Using the chair and bed alarm with this resident prevented falls.
*They started today using a lift for transferring the resident.

Interview on 9/15/21 at 2:10 p.m. with CNA K revealed:
*The alarms helped with fall prevention with this resident.
*The resident moved less but was agitated by alarm sound.
*There was enough staff to monitor this resident and other residents with alarms.

Interview on 9/15/21 at 4:09 p.m. with infection control/minimum data set (MDS) coordinator C revealed she:
*Approved the CNAs to use the lift with the resident today
*Tried to make little changes to the care plans

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F 604	Continued From page 4	F 604		

right away.
*Highlighted in yellow means no longer in place.
*Must have missed handwriting dates on the resident's care plan when changes were made.

2. Observation and interview on 9/14/21 at 9:20 a.m. revealed resident 28 was:
*Seated in her recliner in her room with her feet up.
*A wheelchair was parked facing her and up against the foot end of the mattress.
*A chair alarm cord was clipped to her shirt.
*She could not explain what was clipped to her shirt.
*She said she "broke her ankle" and was told she had to use the wheelchair to "keep off my feet."

Observations of the resident 28 on 9/14/21 during the group exercise before the noon meal and on 9/15/21 during the breakfast meal revealed she was seated in her wheelchair in the dining room with a chair alarm cord clipped to her collar.

The Minimum Data Set (MDS) quarterly assessments dated 3/15/21 and 6/14/21 coded:
*Cognitive score as 3, meaning severely impaired.
*Walking in her room needed one person support with limited assistance on the 3/15/21 MDS.
*Walking in her room did not occur during the observation window for the 6/14/21 MDS.
*Moving about in her hallway was one person support and extensive assistance on both MDSs.
*Moving about away from her hallway was total dependence of one person on both MDSs.

Review of resident 28's current care plan as provided by the facility, with 4 handwritten date notations between 12/22/20 and 6/14/21 in the

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F 604	Continued From page 5	F 604		

left margin, revealed the following resident problems and needs:
*Modified independence with cognitive skills was yellowed out and moderately impaired was checked with a handwritten date of 3/15/21.
*The behavior of wandering/elopement as not exhibited was yellowed out and "behavior occurs" was checked with a handwritten date of 3/15/21.
*Locomotion/ambulation required the assistance of one person.
*Total dependence and wheelchair were checked with a handwritten date of 3/15/21, and a walker was checked but yellowed out.
*Restraints were marked as "Not used."
*"Risk for falls r/t [related to] vision impairment," dated 1/8/21, had multiple modifications to the approaches (actions):
-Approaches yellowed out but not dated included uses a walker to walk plus staff assist, seat and bed alarm to be used daily, and provide frequent reminders to use call light for help.
-Added handwritten approaches dated 3/4/21 included uses a wheelchair, pull tab alarm, and bed alarm used.
-An added handwritten approaches dated 6/14/21 to "attempt to keep in common areas, as able."

An alarm assessment completed on 12/28/20 and reviewed on 3/15/21 and 6/14/21, noted:
*The resident had impaired mobility and was unsafe with transfers but "is forgetful or unwilling to ask for help."
*Had a history of falls.
*The benefits of alarm use were to decrease falls, "staff assist provided as resident forgets to use call lights."
*The action taken before using the alarms was "frequent reminders to use call light."

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F 604	Continued From page 6 The care conference meeting and review forms noted: *Uses seat and bed alarms daily. *Uses a wheelchair to move around. *The resident has had many falls related to poor vision and weakness (3/15/21). *"Determined to help self - many reminders to ask for help" (3/15/21). *"Resistive to assistance, tries to help herself" (6/15/21). The quarterly/annual review by physical therapy dated 3/9/21 and 6/14/21 revealed: *The resident was using her wheelchair for mobility in hallways and walking with one person. *Recommendation for restorative therapy exercises of "NuStep" 4 - 6 times a week. *"As resident has spent more time in w/c [wheelchair], her knees have gotten tighter & lack extension." (6/14/21). Restorative Flow Sheets for March 2021 through June 2021 revealed resident 28 participated in the NuStep exercise 35 times of the 90 times the exercise was offered. Review of Incident/Accident Reports revealed resident 28 fell on four occasions: *6/19/21 at 2:45 p.m. by the west wing door, the resident attempted to stand from her wheelchair and fell while staff were turning off the door alarm that the resident set-off by trying to go out the door. *7/22/21 at 12:20 p.m. in the resident's room, the bed alarm sounded, and staff found the resident on the floor beside her bed. *8/3/21 at 4:30 p.m. in the resident's room, the chair alarm sounded, and staff found the resident on the floor in front of her bathroom door. The	F 604		

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F 604	Continued From page 7	F 604		

resident experienced a fractured left femur.
*8/27/21 at 9:25 p.m. in the resident's room, the chair alarm sounded, and staff found the resident lying on the floor next to her bed.

A fall risk evaluation for resident 28 was completed on 8/6/21, 8/20/21, and 9/3/21 with a score of 20 points each time. A score of "10 or above represents HIGH RISK."

Resident 28's quarterly/annual review by physical therapy dated 9/14/21 revealed:
*The "NuStep was d/c'd [discontinued] due to hipfx [hip fracture]."
*Resident's walking has declined but "has been able to return to prior level" with transferring.

Employee interviews conducted on 9/15/21 regarding resident 28 revealed the following:
*RNA O at 10:37 a.m. reported the resident had been "non-weight bearing" since she broke her femur but was now allowed to stand on leg "as tolerated."
*CNA P at 1:50 p.m. reported they used to walk with the resident to the dining room but not since her fracture.

Surveyor: 42477
3. Observation on 9/14/21 at 9:15 a.m. of resident 14 revealed he:
*Was sitting in his room in his chair.
*Had a scooped mattress on his bed.
*Had an alarm on his chair and his bed.

Review of resident 14's alarm assessment revealed:
*He had assessments completed on:
-12/28/20.
-3/29/21.

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F 604	Continued From page 8 -6/28/21. *The assessments were for bed and chair alarms. *He had not been assessed for the use of a scooped mattress and if it was a restraint or enabler. 4. Observation on 9/14/21 at 9:25 a.m. of resident 24 revealed she had: *A scooped mattress as a bed. *Chair alarms. 5. Review of resident 24's alarm, assessments revealed" *She had assessments completed on 3/22/21 and 6/21/21. -The assessments were for bed and chair alarms. *She had not been assessed for the use of a scooped mattress as if it was a restraint or enabler. Review of the provider's August 2020 Resident Alarms policy revealed: *"It is the policy of the [facility name] to utilize resident alarms in accordance with the resident's needs, goals, and preferences, so the resident will be able to attain or maintain his/her highest practicable level of physical, mental, and psychosocial well-being." *"1. The use of alarms does not eliminate the need for adequate supervision of the resident..." *"2. The facility shall establish and utilize an approach for the safe and appropriate use of resident alarms, including efforts to identify risks: evaluate and analyze risk; implement interventions to reduce risk; and monitor for effectiveness of the interventions and modifying interventions when necessary." *Implementation of interventions included:	F 604		

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F 604 Continued From page 9

-"a. Resident-directed approaches shall be implemented in accordance with the resident's needs, goals, and preferences."
-"b. Alarms shall be initiated only to address a specific medical symptom or unique risk, when the benefit of the alarm outweighs the risk associated with its use."
-"c. Supervision and other resident-specific interventions shall be implemented and documented."
-"d. Interventions shall be communicated to all relevant staff, including time frames and responsibility."
*"7. When alarms are used, the interdisciplinary team shall determine whether the alarm meets the definition of a restraint."

F 657 SS=E Care Plan Timing and Revision
CFR(s): 483.21(b)(2)(i)-(iii)

§483.21(b) Comprehensive Care Plans
§483.21(b)(2) A comprehensive care plan must be-
(i) Developed within 7 days after completion of the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the

F 604

F 657

F 657 Care Plan Timing and Revision

(1) On 10/05/2021, Administrator and MDS Nurse reviewed the current Care Planning-Resident Participation policy and procedure. The following change was made:
*Upon completion of an intervention or diagnosis on resident's individualized care plan, a date must be written beside the yellowed intervention/care area.

(2) On 10/07/2021, the MDS Nurse reviewed resident 3, 14, 16, 17, 20, 24, and 28's care plans. The following updates were completed:
* Resident 3 - risk for constipation and risk of bleeding added to care plan
*Resident 14 - risk for constipation and risk of bleeding added to care plan
*Resident 16 - risk for impaired skin integrity updated to include PRN Lasix administration and chronic peripheral edema
*Resident 17 - (1) cognitive loss with diagnosis of dementia updated to include assistance required with all ADLs and decision making, continue to cue/explain and involve resident with tasks, (2) risk for altered communication updated to continue to involve resident by asking questions as she is able to answer yes/no, (3) risk for falls/injury updated to state resident does not walk, (4) restorative therapy care plan updated to reflect transfers with hoyer lift and two staff, (5) personal alarm discontinued and care plan updated to reflect that change
*Resident 20 - (1)discharge goal care plan updated to reflect resident wishes to move to an apartment or home when becomes stronger, keep in contact with MD and family to review this during Dr. visits and PRN, (2)risk for bleeding added to care plan, (3) vision impairment to reflect diagnosis of glaucoma, (4) risk for pain care plan updated to reflect chronic lower back pain and interventions,

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F 657	Continued From page 10 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Surveyor: 41088 Based on observation, interview, record review, and policy review, the provider failed to review and update care plans for 7 of 16 sampled residents (3, 14, 16, 17, 20, 24, 28) to reflect their current needs. Findings Include: 1. Interview on 9/14/21 at 9:19 a.m. with resident 20 revealed she: *Admitted recently after breaking her left hip. *Wanted to discharge to a more independent setting when she was stronger. *Had felt depressed due to her move to the nursing home. *Had been taking a blood thinner. Review of resident 20's medical record revealed she: *Was admitted on 6/29/21. *Had been diagnosed with: -Fracture of left hip, heart disease, congestive heart failure, acute anemia, high blood pressure, high cholesterol, glaucoma, type II diabetes, depression, and chronic back pain. Review of resident 20's 6/30/21 care plan revealed: *Her care plan had not been reviewed or revised	F 657	F 657 continued.. Resident 20 continued...(5) psychosocial well-being care plan updated to reflect interventions used, (6) potential altered nutritional intake r/t diabetes to reflect interventions ,(7) congestive heart failure care plan corrected to reflect interventions *Resident 24 - risk for constipation care plan and impaired vision related to diagnosis of glaucoma and cataracts care plan added *Resident 28 -removed Nustep as an intervention as of 10/07/21 (3) All care plans will be reviewed and updated by the MDS Nurse by 10/20/2021. (4) The Administrator will be responsible for conducting a minimum of 2 spots checks per week to ensure compliance with the completion and proper updating of the resident's individualized care plan. The Administrator will report findings to the QAPI Committee monthly times 3 months then quarterly until the QAPI Committee advises otherwise. Completion Date	10/20/2021

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F 657	Continued From page 11 since her admission. *The active diagnoses section was left blank. *It was not individualized and had not reflected her current needs. *There was no mention of discharge plans or her depression diagnosis. Surveyor: 06365 2. Review of resident 17's current care plan as provided by the facility revealed: *The last handwritten date notation in the left margin was 4/19/21. *The following were not updated with the resident's recent decline in her ability to transfer, walk, and eat: -Locomotion/ambulation [mobility/walking] with supervision and walker. -Risk for falls/injury related to seat and bed alarm. Refer to F604, finding 1. -Nutritional status and needs related to a regular diet. Refer to F692, finding 5. *Some items were yellowed out without a date documenting when that was done. 3. Review of resident 28's current care plan as provided by the facility revealed: *Restorative therapy of Nustep bike had stopped but it was listed as an approach. Refer to F604, finding 2. *Some items were yellowed out without a date noting when that was done. Surveyor: 32332 4. Review of resident 6's medical record revealed: *A physician's order for Coumadin (a blood thinner) routinely. *Monthly lab orders to monitor for her Coumadin level.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A135	A. BUILDING ______ B. WING ______	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

(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 657	Continued From page 12	F 657		

Review of her 7/26/21 care plan revealed:
*She had a history of falls and was prone to bruising from the falls.
*She was at risk for impaired skin integrity related to her falls.
*The care plan had not included the use of an blood thinner and risk of bleeding.

Surveyor: 42477
5. Review of resident 14's medical record revealed:
*He had been on Aspirin.
*He had difficulties with constipation.
*Refer to F658, finding 2.

Review of resident 14's 6/28/21 care plan revealed:
*Aspirin had not been included in his care plan.
*Constipation had not been included in his care plan.

6. Review of resident 3's care plan revealed:
*Aspirin had not been mentioned on her care plan.
*Monitoring for signs or symptoms of bleeding had not been added to her care plan.

Review of resident 3's physician documentation revealed she had a history of GI bleeds.

7. Review of resident 16's medical record revealed:
*She had chronic peripheral edema.
*She was supposed to wear Ted hose daily.
*She had an order to receive a prn Lasix dose if she gained more than three pounds in two days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A135	A. BUILDING ______ B. WING ______	09/16/2021

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EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

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F 657	Continued From page 13	F 657		

Review of resident 16's care plan revealed:
*Edema had been mentioned on the care plan.
*There was no mention of monitoring her weight every two days.
-Nor giving her an as needed (prn) dose of Lasix if she had gained more than three pounds.
*Ted hose had not been mentioned.

8. Review of resident 24's medical record revealed:
*She had glaucoma and cataracts.
*She had chronic constipation.

Review of resident 24's 6/21/21 care plan revealed:
*Glaucoma and cataracts were not mentioned.
*Chronic constipation had not been mentioned.

Interview on 9/15/21 at 4:09 p.m. with minimum data set (MDS) and infection control coordinator C revealed she:
*Had been in her role for about eight years.
*Was responsible for completing the resident care plans.
*Completes a baseline care plan within a day or two of admission.
*Classified scooped mattresses as pressure reduction devices.
*Agreed scooped mattresses were not being used as pressure reduction devices.
*Had not included things like constipation or anticoagulants on the care plans.
*Agreed it is important for staff to monitor for signs and symptoms of bleeding and constipation.
*Stated the care plans were completed on admission, quarterly, and as needed when resident changes occurred.
*Was aware resident 20's care plan had not been

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
	43A135	A. BUILDING ______ B. WING ______	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

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F 657 Continued From page 14 — F 657

updated since her admission and it should have been.
*Must have missed putting dates on the residents' care plans when changes were made.
*Tried to make little changes to the care plans right away.

Interview on 9/16/21 at 11:39 a.m. with the director of nursing (DON) B revealed: *Her expectation was the use of a blood thinner should have been added to the care plan to monitor for signs of bleeding.

Interview on 9/16/21 at 12:26 p.m. with administrator A revealed she expected:
*Care plans to be individualized and updated to reflect the current needs of the residents, and to be completed in a timely manner.
*Care plans to include items such as anticoagulants and constipation.

Review of the provider's September 2013 Resident Assessment policy revealed:
*"As part of the assessment process, the functional, medical, mental, nursing, and psychosocial needs of each resident must be evaluated. The assessment process must include participation of the interdisciplinary team, the resident, the resident's family or legal representative..."

F 658 SS=E — Services Provided Meet Professional Standards
CFR(s): 483.21(b)(3)(i) — F 658

§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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A135	A. BUILDING ______ B. WING ______	09/16/2021

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EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

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F 658	Continued From page 15 This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, interview, record review, and policy review, the provider failed to follow professional standards of practice for: *Administering medication through an enteral tube for one of one resident (1) who required her medication through an enteral tube. *Three of sixteen sampled residents (3, 14, and 16) received treatment in order to help prevent constipation. *One of two sampled residents (14) received a nebulizer treatment with supervision. Findings include: 1. Observation on 9/15/21 at 2:00 p.m. of registered nurse (RN) G administering medication to resident 1 through an enteral tube revealed the RN: *Poured 300 milliliters of water into a measuring cup. *Checked for the placement of the tube and checked for any residual formula that might have remained in the stomach. *Set up one tablespoon of Beneprotein powder one scoop of Upcal powder. *Crushed one Baclofen pill and three Vitamin D pills and added those medications to the powdered medication. *Added 30 ml of water to the medication mixture. *Without administering a water flush to ensure the enteral tube was in place, RN G gave all medication at the same time through the tube using a large syringe. *Followed the medication with a 100 ml water flush. *Gave twelve ounces of Coke through the enteral tube that was ordered to clear the tube weekly.	F 658		

F 658 Continued From page 16

*Followed the Coke with 200 ml of water.

Interview at that time with RN G regarding the medication provided through the tube revealed:
*Resident 1 did have an order to crush all oral medications.
*She did not have an order to give all medications together at the same time.
*RN G confirmed:
-The above medication administration was her normal process for medicating resident 1.
-She had administered the medication without first testing the tube with a water flush.
-She had not been instructed to give the medications separately.

Interview on 9/15/21 at 5:15 p.m. with director of nursing B confirmed the provider's policy had not been followed.

Review of the provider's undated Medication administration via enteral tube revealed:
*The pharmacist was to have been utilized as a resource concerning potential reactions between medications.
*When a liquid suspension was not available medications were to have been crushed and mixed with water.
*"Medication will be administered separately, not combined or added to an enteral feeding formula."

Surveyor: 42477
2. Observation and interview on 9/14/21 at 10:00 a.m. with RN H revealed:
*Surveyor heard a resident yelling from nearby.
*RN H walked out of resident 14's room.
*She stated:
-He had been constipated.

F 658 F 658 Services Provided Meet Professional Standards

(1) On 10/05/2021, the Administrator and DON reviewed the current Medication Administration via Enternal Tube policy. The following change was implemented:
* Verify physician orders for medication and enternal tube flush amount along with ensuring that there is an order stating that all medications can be administered together per scheduled med pass.

(1A) Order received from Resident 1's primary care physician on 09/21/2021 to administer all scheduled medications together via g-tube.

(1B) On 10/07/2021, all nursing staff were trained to the newly revised Medication Administration via Enternal Tube Policy and Procedure.

(2) On 10/05/2021, Adminstrator and DON reviewed standing orders for costipation prevenion as well as the BM logs. Currntly, the CNAs chart each of the resident's BMs on 2 forms and the NOC Charge Nurse reviews the BM logs and implements the standing orders based on the number of days without a BM. The following changes were implemented:
* A new Bowel Elimination Policy was established.
* Prior BM logs will be discontinued and a new individual form was created entitled " Bowel Movement Monthly Monitoring Record". This form will reflect not only if a BM or BMs were had daily but also if the nurse implemented any standing orders or PRN orders to help induce a BM.

(2A) Mandatory staff inservice will be held on 10/20/2021 to review changes.

(2B) The DON will be responsible for conducting a minimum of 2 spot checks per week to ensure compliance with the completion of the "Bowel Movement Monthly Monitoring Record" for each resident and also to ensure proper follow-up/ standng orders/PRN orders are implemented. The DON will report these findings monthly times 3 months then quarterly until the QAPI Committee advises otherwise.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A135	A. BUILDING ______ B. WING ______	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

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F 658	Continued From page 17 -He will sometimes yell out while trying to use the restroom. Review of resident 14's bowel movement (BM) records revealed: *He had many gaps in his bowel elimination records. *From: -9/1/21 through 9/14/21 he had 8 recorded days without a BM. -8/1/21 through 8/31/21 he had 12 recorded days without a BM. -7/1/21 through 7/31/21 he had 10 days recorded without a BM. --This included a three-day period. -6/1/21 through 6/30/21 he had 13 days recorded without a BM. --This included three and four-day periods. -5/1/21 through 5/29/21 he had 13 days recorded without a BM --This included a three-day period. Review of resident 14's medication administration record (MAR) revealed: *He was scheduled to receive Colace 100 milligram (mg) two times per day. *He had an as needed (prn) order for milk of magnesia for constipation. *In May 2021 he had been given MOM two times. -Neither of which had been given during the three-day gaps of constipation. *In June 2021 he had a new prn order for Bisacodyl 10 mg, which started on 6/16/21. *He had received MOM four times in June. *He had received Bisacodyl one time in June. -Neither prn medication had been given throughout his three without a BM. --He had received MOM once on day three of his four-day gaps without a BM.	F 658	F 6858 Continued... (3) On 10/05/2021, Administrator and DON reviewed the current Nebulizer Treatment Policy and Procedure. The following changes were implemented: •If resident is unable to self-administer neb, nurse or med-aide must stay in room until neb is completed. If nurse or med-aide are not available, CNA can monitor resident once the neb is administered to resident and will notify nurse or med-aide upon completion or any if any complications arise. (3A) Mandatory staff inservice will be held on 10/20/2021 to review changes. (3B) The DON will be responsible for completing 2 spot checks per week to ensure proper administration of nebulizer treatments with staff present if unable to self-administer. The DON will report findings monthly to the QAPI Committee for 3 months then quarterly until the QAPI Committee advises otherwise. Completion Date	10/20/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A135	A. BUILDING ______ B. WING ______	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE REDFIELD, SD 57469**

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F 658	Continued From page 18 *In July he had a 3 day gap without a BM. -Neither prn constipation medication had been given during that time. 3. Review of resident 16's bowel movement records revealed: *From May 2021 through September 2021 she had: -A three-day gap without a bowel movement two times in May 2021. -One three-day gap in July 2021. Review of resident 16's MAR revealed: *She was scheduled to receive MOM and Docusate. *She had a prn order for MiraLax and Bisacodyl. *In May 2021: -None of the prn medications had been administered during her two, three-day gaps without a BM. *In July 2021: -She had not been given any prn medications during her three-day periods without a BM. 4. Review of resident 3's BM records revealed: *She had many documented gaps in her record. *In May 2021, she had: -Two, three-day periods without a recorded BM. *In June 2021 she had one, three-day periods without a BM. *In July 2021, she had: -A three-day period without a BM. -A four-day period without a BM. *In August 2021, she had: -Two, three day periods without a BM. -A four day period without a BM. Review of resident 3's MAR revealed: *In May 2021 she had:	F 658		

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	43A135	A. BUILDING ______ B. WING ______	09/16/2021

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EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

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F 658	Continued From page 19 -A prn order to receive Bisacodyl. -Not received her prn constipation medication during her two, three day periods without a BM. *In June 2021 she had: -A prn order to receive Bisacodyl and MOM. -Not been given her prn medication during her three day period without a BM. *In July 2021 she had: -A prn order to receive Bisacodyl. -Not received her prn medication during her three day period without a BM. -Received one dose of prn Bisacodyl on day four without a BM. *In August 2021 she had: -A new order for Colace on 8/18/21. -A new order for Miralax on 8/6/21. -Prn order for Bisacodyl. --Not been given Bisacodyl during her four day period without a BM. --Not been given Bisacodyl during her two three day periods without a BM. Review of a 8/4/21 fax to resident 3's doctor revealed: *"Resident has been going multiple days without a bm. Her only med is Senna [at symbol] 0800 [8:00 a.m.] and prn Bisacodyl suppositories. We are going to start prune juice every morning with breakfast. May we have orders for something more med wise?..." *Resident 3's physician responded on the same day to give MOM prn. *The nurse responded again and asked for something scheduled in the morning. *The physician responded with an order for Miralax. *MOM was not on resident 3's MAR for August 2021.	F 658		

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	43A135	A. BUILDING ______ B. WING ______	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

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F 658	Continued From page 20 Review of the provider's current standing orders revealed: *If a resident had not had a bowel movement for 3 days they were to receive: -MOM. -Bisacodyl. *If the resident had not responded to the above interventions then they were to notify the doctor and complete a nursing assessment. Review of the provider's 2/17/16 Bowel and Bladder policy revealed: *"...Documentation will be maintained on the bowel and bladder flow sheet noting that resident had been toileted or changed. Daily documentation will continue on the daily BM log to monitor and prevent constipation issues. If constipation issues arise refer to the standing order for implementation of medications." Review of the provider's October 2012 Bowel Elimination policy revealed: *"The nurse aides on duty will complete the resident bowel record at least daily, prior to the completion of their shift. The resident bowel elimination record is to be kept in the chart room to maintain confidentiality. The nurse aides will report any abnormalities to the charge nurse on duty and the charge nurse will assess and treat as needed..." *"The night nurse will check the bowel record nightly and assess and treat as needed. The night nurse will monitor for trends and notify the doctor as needed." 5. Observation on 9/14/21 at 9:30 a.m. of resident 14 revealed: *RN H had been in his room setting up his nebulizer treatment.	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A135	A. BUILDING ______ B. WING ______	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

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F 658 — Continued From page 21

*After she placed his nebulizer mask on him and turned on his treatment she walked back out to the nurse's desk.

Review of resident 14's 7/5/21 quarterly self-assessment screening revealed:
*Resident had a brief interview for mental status (BIMS) of 3.
*He had been marked as not able to safely self administer nebulizer treatment once set up by nursing staff.

Interview on 9/16/21 at 11:39 a.m. with director of nursing (DON) B revealed:
*Resident BMs were documented on their BM record.
*They had standing orders to treat constipation.
*She agreed staff should be following orders and giving prn medications as prescribed.
*She agreed resident 14 was to receive supervision during his nebulizer treatments.

F 692 SS=E — Nutrition/Hydration Status Maintenance
CFR(s): 483.25(g)(1)-(3)

§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-

§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

Provider's Plan of Correction (F 658 / F 692):

F 692 Nutrition/Hydration Status Maintenance

(1) On 09/30/2021, scale discrepancy was fixed with the insertion of a new control board.

(2) On 10/07/2021, Administrator, DON, Dietary Manager, and Dietitian reviewed current policies and procedures pertaining to weighing of residents, ongoing monitoring of nutrition and assessments, and monitoring of residents who receive enternal feedings. The following implementations were made:
*The Dietitian will review residents who receive enternal feedings monthly.
* The Dietitian will attend monthly QAPI meetings followed by an interdisciplinary Resident Weight meeting held with Dietitian, Dietary Manager, DON, and MDS Nurse.
* Dietary Manager and Dietitian will continue to review monthly those residents who trigger for continued weight loss until weight is stable for 3 months.
*Dietitian will continue to review residents' chart upon admission, quarterly review, and with any significant change.
*When weighing a resident, if there is a 5 pound weight gain or 5 pound weight loss noted, staff will immediately re-weigh resident with recalibrating scale to ensure weight is accurate. If weight loss or gain is noted then a Stop and Watch form will be completed and given to the DON. The DON will review the weight loss or gain to determine if it is due to oral intake or fluid retention or loss. If it is determined due to decreased oral intake, Dietitian will be notified and consulted by the DON and Dietary Manager.
* Dietary Manager will continue to monitor/track all weights weekly.

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
	43A135	A. BUILDING ______ B. WING ______	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

(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 692	Continued From page 22 §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on observation, interview, record review, and policy review the provider failed to ensure: *Residents (3, 10, 14, 15, 16, 17, 24, and 28) who were at nutritional risk received ongoing monitoring of nutrition and assessments. *Residents (3, 14, 15, 24)who had weight fluctuations were re-weighed for accuracy. *One of one sampled resident (1) who received enteral feedings were assessed frequently for nutritional monitoring. Findings include: 1. Observation on 9/14/21 at 12:11 p.m. in the facility's dining room revealed: *Resident 3, 14, 16, and 24 were eating lunch. *Resident 16: -Was being assisted by registered nurse (RN) J. -Was on a pureed diet. -Would spit out food if it was not pureed well enough. -Ate approximately 75 percent of her food. *Resident 3 had been sitting at another table. *Her food had been placed in front of her. *She continued to have her head down and appeared to be sleeping. *After about 15 minutes a staff member came over to resident 3 and began assisting her to eat. *Resident 14 sat at another table with his wife who was a part of the assisted living facility.	F 692	F 692 continued.. (3) Mandatory staff inservice will be held on 10/20/2021 to review changes. (4) The Administrator will be responsible for completing 2 spot checks per week to ensure proper monitoring of nutrition/weights and assessments. The Administrator will report the findings to the QAPI Committee monthly times 3 months then quarterly until the QAPI Committee advises otherwise. Completion Date	10/20/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A135	A. BUILDING ______ B. WING ______	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

(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 692	Continued From page 23 Review of resident 14's vital flow sheet revealed: *He had many weight fluctuations. *Some of the fluctuations included: -A six-pound weight loss in two days. -A six-pound weight gain in one week. *There had been no re-weights to check the accuracy of the weights. Review of resident 14's Stop and Watch form revealed: *The form had been filled out by nursing staff if they had noticed a change in a resident's status *The forms included: -A description of the change. -The resident's name. -The staff person's name. -The nurse it had been reported to. -The intervention the charge nurse implemented. *He had a stop and watch form filled out for a four-pound weight loss in a three-day period at the end of July 2021. *The intervention for July was that staff would continue to monitor. *He had another stop and watch form filled out in August 2021. *The August entry was for a six-pound weight loss in three days. *The intervention for August was for staff to supervise and assist at meals. Review of resident 14's registered dietician (RD) F notes revealed: *RD F documented dietary assessments on: -11/16/20. -5/25/21. -7/28/21. *RD F documented the following in November 2020: -He had COVID-19 in October 2020.	F 692		

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
	43A135	A. BUILDING ______ B. WING ______	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

(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 692	Continued From page 24 -He had a significant weight loss of 6.1% in 1 month. -They would continue to monitor. *RD F's next dietary assessment in May of 2021 stated: -There had been no significant weight change noted. *RD F's dietary note in July of 2021 stated: -Resident 14's intakes were down from May assessment. -He had not had any significant weight changes. 2. Review of resident 16's vital flow sheet revealed: *She had weighed 172 pounds in January of 2021. *Her last recorded weight was 140 lbs. on 9/14/21. *She had many weight fluctuations that had not been weighed. Review of resident 16's RD assessments revealed: *She had dietician assessments on the following dates: -11/16/20. -5/25/21. -7/25/21. *RD F stated in her November 2020 assessment: -Resident had COVID-19 in October 2020. -Had experienced weight loss which could be related to COVID-19. -She had an 8.2% weight loss in one month. -She had experienced a 6.6% weight loss in six months. -RD F would update the doctor. -She would be continued on her diet which consisted of: --Power protein.	F 692		

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F 692	Continued From page 25	F 692		

--Regular, high potassium diet.
*In May 2021 RD F documented:
-She was now on a pureed diet.
-She was on a regular, high potassium diet.
-She had been experiencing chewing and swallowing difficulties.
-She had a 10% weight loss in one month.
-11.4% weight loss in three months.
-12.7% weight loss in six months.
-She would update the physician on the weight loss.
-She was going to request to liberalize diet and added supplements for wound healing.
*In July 2021 RD F documented:
-Resident was on a pureed enriched diet.
-She had been receiving supplements two times per day
*She had no other dietician notes.

Review of resident 16's stop and watch forms revealed:
*She had a stop and watch form completed on 5/11/21 and 5/18/21 for weight loss.
*The 5/11/21 form stated:
-"[ineligible] during last hosp [hospital] stay."
*The 5/18/21 form stated:
-"[certified dietary manager's name], I charted the continued decline."
*She had no other stop and watch forms completed for weight loss.

3. Review of resident 3's vital flow sheet revealed:
*Some of those weights included:
-Eight-pound loss in 10 days.
-Five pound gain in four days.
-Five and a half loss in three days.
*She had weight fluctuations that had not been re-checked.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A135	A. BUILDING ____ B. WING ____	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

(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 692	Continued From page 26	F 692		

Review of resident 3's stop and watch forms revealed:
*She had a stop and watch form completed in February 2021 and July 2021.
*Her February note stated:
-She was down five pounds.
-The charge nurse sent a fax to the doctor.
*Her July note stated:
-She had lost eight pounds.
-The charge nurse had faxed a note to the doctor.

Review of resident 3's RD notes revealed:
*She had an admission assessment on 2/19/21.
*Her next RD assessment was on 8/13/21.
*Her admission RD assessment included:
-She had a five-pound weight loss since admission.
-RD F would continue to monitor.
*Her next RD assessment in August 2021 included:
-She was on ground meats and supplements three times per day.
-Her one-month weight loss and three-month weight loss were both considered significant weight losses.
-Her diet would be changed to an enriched diet.
-She would update the doctor on the weight losses.

4. Review of resident 24's vital flow sheet revealed:
*She had been around 170 pounds since April 2021.
*She had a weight on:
-8/30/21 of 173.5 pounds.
-9/3/21 of 170 pounds.
-9/6/21 of 172.5 pounds.
-9/10/21 of 165.5 pounds
-9/13/21 of 160 pounds with a note saying, "scale

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A135	A. BUILDING ______ B. WING ______	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

(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 692	Continued From page 27	F 692		

off."
*There had been no rechecks documented.

Review of resident 24's RD notes revealed:
*She had RD assessments completed on 11/16/20 and 8/25/21.
*RD F's 11/16/20 note included:
-Resident 24 had weight loss but it was probably related to COVID-19.
-RD F would update the physician on significant weight loss.
-Resident 24 was started on a four-ounce supplement two times per day for weight loss.
*RD F's next 8/25/21 note included:
-They discontinued the supplement in July due to weight gain.
Surveyor: 06365

5. The Nutrition Assessment completed by registered dietitian (RD) F revealed the following weight changes for resident 17:
*On 2/8/21, the resident weighed 169.5 lbs.
*On 5/3/21, the resident weighed 173.5 lbs. The nutrition diagnosis noted "overweight/obesity."
*On 7/15/21, the resident weighed 155.5 pounds, with a diagnosis of significant weight loss
*The percent of loss between 7/15/21 and:
-2/8/21 was 8.26%
-5/3/21 was 10.37%

Observations of resident 17 on 9/15/21 in the dining room for breakfast revealed:
*At 8:13 a.m., the resident's hands were in her lap with glasses of beverages on the table.
*At 8:30 a.m., bowls of hot cereal and pureed fruit were in front of her, but she was not eating.
*At 8:40 a.m., registered nurse (RN) G sat down next to the resident and began feeding her.

(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 692	Continued From page 28 Observation on 9/15/21 at 12:30 p.m. during lunch revealed resident 17 was one of a few residents still seated in the dining room. Her plate of food was still in front of her and over 50% of her food remained on her plate. Review of the minimum data set (MDS) assessments dated 6/7/21 and 7/19/21 revealed: *Weight loss of 5% or more in one month or 10% or more in 6 months were checked. *The resident's weight on the 6/7/21 MDS, coded as a discharge assessment, was 161 *The resident's weight on the 7/19/21 MDS, coded as a significant change assessment, was 153 Review of dietary interdisciplinary notes dated 7/15/21 signed by RD F revealed: *The resident had returned from the hospital following a cholecystectomy procedure. *Currently on a regular diet with cut-up meat. *Eating 61% of meals and 25% of the four-ounce supplement twice a day. *Weight loss is significant, 8.5% in 3 months, and 11.4% in 6 months. *Will request enriched diet. Review of Dietitian Recommendation dated 7/15/21 revealed request for enriched diet was authorized by the physician and noted by licensed practical nurse (LPN) R on 7/16/21. Review of resident 17's current care plan for nutritional needs with a date of 2/7/21 revealed the following updates: *Risk for weight loss, added on 7/8/21. *"Sits at feeder assist table," added on 7/8/21. *Enriched diet, added on 7/19/21.	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A135	A. BUILDING ______ B. WING ______	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE REDFIELD, SD 57469**

(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 692	Continued From page 29	F 692		

Review of Care Conference Meeting and Review dated 7/19/21 with notes by the dietary manager/licensed social worker (DM/LSW) D revealed the resident was assisted with meals.

A discharge return anticipated MDS assessment dated 9/5/21 noted a weight of 139. (Calculated against the weight of 161 on 6/7/21, that is a severe loss of 13.7% in three months.)

Review of Nurses Notes revealed:
*The resident returned from the hospital on 9/8/21.
*A speech therapy evaluation on 9/14/21 with a trial of thin liquids, soft solids, and pureed foods.
*A recommendation on 9/14/21 for pureed textures and regular/thin liquids.

Following resident 17's hospital return on 9/8/21, no changes had been made to the care plan, and:
*RD F had not documented dietary notes since 7/15/21.
DM/LSW D had not documented notes since 7/19/21..

Interviews with the following employees revealed:
*Certified nursing assistant (CNA) P reported on 9/15/21 at 1:50 p.m. that there have been problems with the scale used to weigh the residents for "about a month."
*CNA K, at 2:10 p.m., confirmed the scale has been a problem and "maintenance keeps recalibrating."
*RD F on 9/16/21 at 10:42 a.m. reported she was not aware of a recent change to pureed diet, and she should have been notified within 24 hours of that change.
*The dietary manager/licensed social worker (DM/LSW) D reported at 11:25 a.m.:

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
	43A135	A. BUILDING ____ B. WING ____	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

(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 692	Continued From page 30 -She was not involved in the process of changing a resident's diet or food texture. -She had been informed of speech therapy recommendations by the director of nursing (DON) B. -We try different nutritional approaches between assessments but have not documented monthly. 6. The Nutrition Assessment completed by registered dietitian (RD) F revealed the following weight changes for resident 28: *On 12/23/20, the resident weighed 132 lbs. *On 05/10/21, the resident weighed 101 lbs. The nutrition diagnosis noted "unintended weight loss" with an intervention to enrich the diet. *On 6/24/21, the resident weighed 96.5 pounds with a diagnosis of "inadequate" intake. *The percent of loss between 6/24/21 and: -12/23/20 was 26.89% (That is a severe loss in six months.) -5/10/21 was 4.46% Observations of resident 28 on 9/15/21 in the dining room revealed: *At 8:13 a.m., the resident was seated at the table with beverages served. *At 8:30 a.m., she had eaten her breakfast except for her toast. She was setting her coffee cup down on top of a table knife. Interview with her at that time confirmed she had not seen the knife in that spot. *At 12:25 p.m., the resident's plate of food was still on the table and over 50% of her food remained. Review of the minimum data set (MDS) assessments between 3/15/21 and 9/13/21 revealed: *All were checked for weight loss of 5% or more	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A135	A. BUILDING ______ B. WING ______	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

(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 692	Continued From page 31	F 692		

in one month or 10% or more in 6 months.
*Weight on the 3/15/21 MDS, coded as a quarterly, was 105
*Weight on the 6/14/21 MDS, coded as a quarterly, was 96
*Weight on the 8/3/21 MDS, coded as a discharge return anticipated, was 85
*Weight on the 9/13/21 MDS, coded as a significant change, was 87s

A dietitian recommendation dated 5/10/21 noted significant weight loss times 3 months and requested orders for an enriched diet.

The physician's authorization was noted by director of nursing (DON) B on 5/11/21.

Review of dietary interdisciplinary notes signed by RD F revealed:
*A gap of almost 5 months between RD F's admission note of 12/23/20 and her 5/10/21 note.
*On 5/10/21:
-Resident's intake was noted as 39% of meals and 43% of supplements 1-2 times a day.
-"Requires plate orientation."
-Loss of 9.8% in 3 months is "significant." (Loss of greater than 7.5% is considered severe.)
-"Will request to enrich diet."
*On 6/24/21, weight was noted at 96.5 pounds with "no other wts [weights] in chart to assess."
*On 8/13/21:
-Continued on enriched diet
-Double portions at lunch
-Supplements "TID" [3 times a day]

The dietary manager/licensed social worker (DM/LSW) D documented interdisciplinary notes on 6/15/21 and 9/14/21 with similar information as provided by the RD F.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A135	A. BUILDING ______ B. WING ______	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE** **REDFIELD, SD 57469**

(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 692	Continued From page 32	F 692		

Review of resident 28's current care plan for nutritional needs with a date of 1/8/21 revealed the following updates:
*Risk for weight loss, added on 6/28/21
*Enriched diet, added on 5/10/21
*Supplements "3x a day," added on 6/14/21. "2x/day" was yellowed out.
*"Orientate to food - plate - glass - silverware" was added on 6/14/21
*"Repeated attempts need made to assist" with meal, "Provide time/space when agitated - attempt at later time," added 7/22/21

Interviews with the following employees revealed:
*Certified nursing assistant (CNA) P reported on 9/15/21 at 1:50 p.m. that there have been problems with the scale used to weigh the residents for "about a month."
*CNA K, at 2:10 p.m., confirmed the scale has been a problem and "maintenance keeps recalibrating."
*RD F on 9/16/21 at 10:42 a.m. had no explanation for severe weight loss but had been aware of it.

Surveyor: 32332
7. Observation on 9/15/21 at 2:00 p.m. of resident 1 during a medication pass revealed she required all medications to be crushed and delivered through an enteral tube. Review of resident 1's reviewed 3/1/21 care plan revealed:
*Her enteral feeding tube was to have been used for all nutrition, fluids and medications.
*The dietitian was to have reviewed the adequacy of the tube feedings, water flushes, and weights.

Review of resident 1's medical record revealed:
*Her current physician's orders indicated she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A135	A. BUILDING ______ B. WING ______	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

(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 692	Continued From page 33 to have: -The tube feeding at 125 milliliters (ml) per hour for twelve hours every day. -Three hundred ml of water three times daily through her tube. -One can of Coke weekly through her tube. *Review of her dietitian's assessments from December 2020 through September 2021 revealed she had been assessed by the dietitian on the following dates: -12/23/20. -1/18/21. -4/7/21. -6/9/21. -7/28/21. -9/1/21. *There were no dietitian entries for February, March, May, and August 2021. Interview on 9/16/21 at 9:30 a.m. with the certified dietary manager (CDM) D regarding resident 1's missing dietitian assessments revealed the CDM stated the dietitian would have to speak for that. Refer to F692, finding 8 regarding RD F's interview on 9/16/21 at 10:42 a.m. Review of the September 2013 Enteral Nutrition Care Policy revealed: *The RD would assess and/or review the nutritional status of residents receiving internal nutrition every month. *The RD would review: -The formula that was being administered. -Weight. -Skin condition. -Labs. -Physical symptoms. -Tolerance to feeding.	F 692		

(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 692	Continued From page 34 -Oral/food fluid intakes when applicable. -Check the pump for flow rate. -Assess down times. -Check input/output records. -Check the medication administration records for the amount of feeding administered. Surveyor: 41088 8. Observation on 9/14/21 from 12:00 p.m. to 12:23 p.m. and on 9/15/21 from 12:10 p.m. to 12:40 p.m. of resident 10 during meal time revealed: *Staff were not observed to cue or encourage him to eat or drink. Review of resident 10's medical record revealed: *Admission on 11/25/20. *His brief interview for mental status (BIMS) score of three indicated severe cognitive impairment. *Weight loss since his admission. *Staff were to assist with set up, cueing, and encouragement to eat. Review of resident 10's nutritional assessments from December 2020 through July 2021 revealed he had been assessed on the following dates: -12/23/20 -2/19/21 -5/25/21 -7/15/21 *His initial assessment on 12/23/20 took place a month after he had been admitted to the facility. *The nutrition intervention sections on the 12/23/20, 2/19/21, and 5/25/21 assessments all stated: "con't [continue] same". *His 5/25/21 assessment showed a 5.7% weight loss in one month; 14% weight loss in 3 months;	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A135	A. BUILDING ______ B. WING ______	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

(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 692	Continued From page 35	F 692		

and 12.4% weight loss in 6 months indicating significant weight loss.
*His 7/15/21 assessment showed 1.8% weight loss for one month; 11.7% weight loss in 3 months; and 12.8% weight loss in 6 months indicating significant weight loss.

Resident 10's dietician recommendation sheets revealed:
*5/25/21: Diet- enriched, pureed, supplements TID [three times a day].
-"Please note sig [significant] wt [weight] loss. No new recommendations at this time."
*7/15/21: "Currently on enriched, pureed diet with mech [mechanical] soft textures for pleasure, Supplements TID [three times a day]."
-"Please note wt [weight] loss."
-Request was made for a speech therapy evaluation to assess diet textures.

A speech therapy evaluation was completed for resident 10 on 7/22/21 with an order to change to a mechanical soft diet with chopped meat.
*Order comments: "May need to pace pt [patient]. Give drink if he has too much food in his mouth."

Interview on 9/15/21 at 11:45 a.m. with dietary manager/licensed social worker D revealed:
*She was aware resident 10 had lost weight.
*She had informed the dietician of his weight loss either by phone or email.
-The dietician completed nutritional assessments quarterly and as needed.
*Stated those assessments were usually completed a day or two after she informed the dietician of the resident's change.
*Resident 10 had a diet change on 4/28/21 for a pureed diet and did not like it.
*Resident 10 had tolerated his current diet of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A135	A. BUILDING ____ B. WING ____	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

(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 692	Continued From page 36 mechanical soft with chopped meat better and had started to gain the weight back. *Nursing staff would let her know about weight losses or gains. *Nursing staff would complete a stop and watch form. *She would contact the RD to inform them of the change. *She did not know if the RD would complete more frequent assessments on someone with significant weight losses, the RD "had her own schedule." Interview on 9/16/21 at 9:21 a.m. with RN G revealed: *She was familiar with resident 10 and was aware he had significant weight loss. *Staff were expected to cue him to eat. *Since his diet had been changed to mechanical soft with ground meat he had been eating better. *He had not eaten well with pureed meals. *Since the diet change, he had gained some weight back. *A lot of his calories were used by wandering around the facility. Interview on 9/16/21 at 9:23 a.m. with CNA K revealed: *Resident 10 ate better when he ate independently but would accept cues and encouragement to eat. *If staff noticed he was not eating they tried to cue and encourage him. *Since he had a diet change, he had been eating better. Interview on 9/16/21 at 10:42 a.m. with registered dietitian F revealed she: *Had worked for the facility for several years.	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A135	A. BUILDING ______ B. WING ______	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

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F 692	Continued From page 37 *Had been responsible for completing the dietary assessments for all the residents at the facility. *Tried to assess quarterly. *Worked from home during the COVID-19 outbreak. -Had also not been able to come into the building during the pandemic. -Stated the electronic medical record had only been used for a few things and had not contained the residents' daily documentation. *Had been on maternity leave from March 2021 until May 2021. *Did not have anyone covering her during that time. *Would typically complete more frequent assessments on someone who was experiencing significant weight losses. *Was aware resident 1 had required a monthly dietitian assessment. *Was questioned about medication administration and water flushes, she stated she did not deal with the water flushes; that was up to the nurses and physician. *Stated if anything had been updated in-between the quarterlies it would be in the chart. *Agreed she had not been updating or reassessing in-between the quarterlies as she should have to address weight loss concerns. *Agreed that some quarterly assessments had been late. *Had not attended care conferences. Surveyor 42477: Review of the provider's January 2021 Weight Monitoring policy revealed: *"Weight can be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period of time) may	F 692		

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
	43A135	A. BUILDING ______ B. WING ______	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

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F 692	Continued From page 38 indicate a nutritional problem." *"1. The facility will utilize a systemic approach to optimize a resident's nutritional status. The process includes: a. Identifying and assessing each resident's nutritional status and risk factors. b. Evaluating/analyzing the assessment information. c. Monitoring the effectiveness of interventions during care conferences or sooner if necessary." *"5. Documentation: a. The physician will be informed of a significant change in weight and may order nutritional interventions. b. The physician should be encouraged to document the diagnosis or clinical conditions that may be contributing to the weight loss. c. Meal consumption information is recorded at each meal and will be referenced by the interdisciplinary care team at care conferences." Review of the providers September 2013 Nutritional Assessment policy revealed: *"Documentation of a resident's nutritional care is the responsibility of the Dietary Professionals. This will include the Registered/ Licensed Dietitian, Dietetic Technician, and the Dietary Manager. *A nutritional assessment would be completed for any of the following: *"2. Following a significant change." *"3. Monthly for any resident receiving tube feedings. A monthly tube feeding assessment must include nutritional adequacy of calories, protein and fluids." *"4. On any resident will progressing disease conditions putting the resident at significant nutritional risk." *"5. On each resident prior to his/her annual Care Conference or every 92 days."	F 692		

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	43A135	A. BUILDING ______ B. WING ______	09/16/2021

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EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE REDFIELD, SD 57469**

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F 692	Continued From page 39 Review of the provider's Dietary Manager job description revealed: *The dietary manager was supposed to ensure the dietary needs of the residents were met in compliance with state and federal regulations. *Perform all duties effectively and timely. *"Maintain contact with the Registered Dietitian ensuring that all needed assessments are completed, ensure that menus are approved at least yearly or when a change is needed, new admissions and any diet concern regarding residents." Review of the provider's Registered Dietitian's job description revealed: *"Developing nutritional care of residents in accordance with current federal, state, and local guidelines and to assist with policy and procedures regarding the nutritional needs of the residents at [facility name]." *"4. Assist in nutrition screening, assessment, and care planning for all newly admitted residents and upon a significant change, readmit, quarterly, and annually." *She reported to and was supervised by the administrator. *She was to attend resident care conferences as needed. *She was to communicate with the dietary manager through a communication log or sheet, or in person of any concerns and updates that were recommended after each visit.	F 692	F 745 Provision of Medically Related Social Services (1) On 10/07/2021, Administrator and LSW reviewed the current policies and procedures pertaining to resident social history documentation and care conference documentation. The following changes were implemented: * Social History will be completed upon admission, annually, and with any significant change by the LSW. * Social Service Care Conference Record form established for LSW/SSD documentation following care conferences. * LSW or SSD will attend/participate in care conferences with completion of the Social Service Care Conference Record form, which will be then be placed under the Social Services tab in resident's chart. (2) The Activity Director will be responsible for conducting a minimum of 4 spot checks per month to ensure compliance with the completion of the Social Service Care Conference Record for proper documentation. The Activity Director will report findings to the QAPI Committee monthly times 3 months then quarterly until the QAPI Committee advises otherwise.	
F 745 SS=E	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental	F 745	Completion Date	10/20/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A135	A. BUILDING ______ B. WING ______	09/16/2021

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EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

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F 745	Continued From page 40	F 745		

and psychosocial well-being of each resident.
This REQUIREMENT is not met as evidenced by:
Surveyor: 06365
Based on observation, interview, record review, and job description review, the provider failed to identify and promote individualized approaches and social services that met the mental and psychosocial needs for thirteen of sixteen sampled residents (3, 6, 8, 9, 10, 11, 13, 14, 16, 17, 20, 24, 28). Findings include:

1. Review of resident 17's record for social service documentation revealed:
*A social history interview dated 1/29/21.
*The resident had admitted to the facility on 1/21/21.
*The last date the social history was changed was 7/14/21.
*The dietary manager/licensed social worker (DM/LSW) D signed the social history on 9/16/21.

Review of resident 17's care conference meeting and review social service notes revealed:
*On 4/19/21, "OK."
*On 7/19/21, "OK, good family support - lots of phone calls."

There was no documentation in the record to indicate the DM/LSW D had input regarding:
*The use of seat and chair alarms as potential restraints. Refer to F604, finding 1.
*Her psychosocial well-being related to her diagnoses of anxiety and recent changes in mood.

2. Review of resident 28's record for social service documentation revealed:
*A Social History interview dated 1/6/21.

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	43A135	A. BUILDING ___ B. WING ___	09/16/2021

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EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

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F 745	Continued From page 41 *The resident was admitted to the facility on 12/21/20. *The last date the Social History was changed was blank. *The DM/LSW D signed the Social History on 1/6/21. Review of resident 28's Care Conference Meeting and Review social service notes revealed "OK" on both 3/15/21 and 6/15/21. There was no documentation in the record to indicate the DM/LSW D had input regarding: *The use of seat and chair alarms as potential restraints. Refer to F604, finding 2. *Psychosocial support related to the impact of her cognitive impairment on: -Interactions with others. -Behavioral symptoms. -Wandering and elopement. -Visual limitations. -Diagnosis of depression. Surveyor: 32332 3. Review of resident 11's medical record revealed: *Her 3/15/21 care plan indicated she required antianxiety and antidepressant medication. *She was to have been observed for changes in her moods, behaviors, and psychotic symptoms. *Review of her 3/15/21 care conference meeting revealed DM/LSW D's addition to the review indicated "OK." -There was no indication of the resident's current mood or behaviors. -DM/LSW D had not documented her status in the interdisciplinary notes.	F 745		

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	43A135	A. BUILDING ______ B. WING ______	09/16/2021

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EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

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F 745	Continued From page 42 4. Review of resident 13's medical record revealed: *Her 7/12/21 care plan indicated she had potential for wandering and delusions, and potential for mood and behavior problems. *Review of her 7/12/21 care conference meeting revealed DM/LSW D's addition to the review indicated "OK. Good family support." -There was no indication of the resident's current mood or behaviors. -DM/LSW D had not documented her status in the interdisciplinary notes. 5. Review of resident 6's medical record revealed: *Her 4/26/21 care plan indicated she had potential for wandering and hallucinations, and potential for mood and behavior problems. *Review of her 4/26/21 care conference meeting revealed DM/LSW D's addition to the review indicated "OK." -There was no indication of the resident's current mood or behaviors. -DM/LSW D had not documented her status in the interdisciplinary notes. Surveyor: 41088 6. Review of resident 10's medical record revealed: *Admission to the facility on 11/25/20. *His diagnosis of psychosis. *Medication had been prescribed for his psychotic symptoms. *His social history was completed on 1/6/21, more than a month after his admission. Review of resident 10's care conference meeting and review notes. *He had a care conference on 2/22/21 and	F 745		

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	43A135	A. BUILDING ______ B. WING ______	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE** **REDFIELD, SD 57469**

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F 745	Continued From page 43 5/17/21. *The 2/22/21 social services note stated:"Ok. Good family support." *The 5/17/21 social services note stated: "Ok." *No information had been included to describe the resident's current mood, symptoms, or behavior issues. 7. Review of resident 20's medical record revealed: *Admission to the facility on 6/29/21. *Her diagnosis of depression. *Medication had been prescribed for her depression symptoms. *Her social history had not been completed. -The family history questionnaire form had a note attached stating the family had not returned the information. -No documentation had been provided to support further contacts with the family had been made to complete the form. Review of resident 20's care conference meeting review notes revealed: *He had a care conference on 7/5/21. *"Ok. Good family support." *There was no information to describe the resident's current mood, symptoms, or behavior concerns. *The only signature on the care conference meeting and review sheet was infection control/MDS coordinator C. 8. Review of resident 9's medical record revealed: *She had admitted on 11/24/20. *Her social history had been completed on 4/6/21. -It had not indicated a revision had been made.	F 745		

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	43A135	A. BUILDING ____ B. WING ____	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

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F 745	Continued From page 44	F 745		

Review of resident 9's care conference meeting and review notes revealed:
*She had a care conference on 5/17/21.
*The social services note stated: "Ok. Great family involvement."
*There was no information to describe the resident's current mood, symptoms, or behavior concerns.
*No other care conference meeting reviews had been provided.

9. Review of resident 8's medical record revealed:
*He had admitted on 7/25/16.
*His diagnoses of bipolar disorder and depression.

Review of resident 8's care conference meeting and review noted revealed:
*He had a care conference on 5/24/21 and 8/23/21.
*On 5/24/21 the social services note stated: "Ok. Wife visits frequently."
-No information had been included to describe the resident's current mood, symptoms, or behavior concerns.
*On 8/23/21 the social services not stated: "Ok. Wife visits QD [daily]."
-No information had been included to described the resident's current mood, symptoms, or behavior concerns.
Surveyor: 42477
10. Review of resident 14's social services notes revealed:
*He had been admitted to the facility on 12/31/19.
*His social services note was dated 1/6/21.
-There were no other social services notes other than the one on 1/6/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A135	A. BUILDING ______ B. WING ______	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

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F 745	Continued From page 45	F 745		

Review of resident 14's care conference meeting and review notes revealed:
*He had a care conference on 3/29/21 and 6/28/21.
*The social services note stated the same thing:
-"Great family support."

11. Review of resident 16's social services notes revealed:
*She was admitted to the facility on 9/8/16.
*The document only contained one social service note which had been dated 9/14/21.

Review of resident 16's care conference meeting and review notes revealed:
*She had a care conference on 3/29/21 and 6/28/21.
*On 3/29/21 the social services note stated:
-"Ok"
*On 6/28/21 the social services note stated:
-"Ok. Good family support."

12. Review of resident 24's social services notes revealed:
*She had been admitted on 4/2/20.
*She had one social service note dated 4/6/21.

Review of resident 24's care conference meeting and review notes revealed:
*She had a care conference on 3/22/21 and 6/21/21.
*On 3/22/21 the social services note stated:
-"Ok"
*On 6/21/21 the social services note stated:
-"Ok. Good support.

13. Review of resident 3's social services notes revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A135	A. BUILDING ______ B. WING ______	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

(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 745	Continued From page 46 *She had an admission family questionnaire completed on 2/9/21 *She did not have any social services notes. Review of resident 3's care conference meeting and review notes revealed: *She had a care conference on 5/3/21 and 8/2/21. *On 5/3/21 the social services note stated: -"Ok- great family support." *On 8/2/21 the social services note stated: -"Ok- great family support. Daughter visits freq. [frequently] son calls." Interview on 9/15/21 at 11:45 a.m. with DM/LSW D revealed she: *Had not had any additional social service notes on the residents. *Agreed she needed to improve her documentation. *Agreed most of the resident's social service notes were the same. Review of the licensed social worker's job description revealed: *Her position summary: -"Plans, organizes, supervises, and directs all administrative and operational activie4s [activities] of the Social Services Department in accordance with current federal, state, and local standards, guidelines and regulations, and the facility's established policies and procedures." *"10. Contributes to the facility efforts to maintain and/or improve quality of care through participation in the following:" -"a. Attends Care Conference meetings[.]" -"b. Services as a member of the QAPI [quality assurance process improvement] Committee[.]" -"c. Attends Department Head meetings[.]"	F 745		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A135	A. BUILDING ____ B. WING ____	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

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F 745	Continued From page 47 -"d. Attend and provide educational information at mandatory in-services [.]" *"12. Advocate for residents and assist them in assertion of their rights."	F 745		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(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	F 880	F 880 Infection Prevention and Control (1) Time cannot be turned back to a time prior to the identification of lack of: * Appropriate wearing of laundry apron and gloves within the laundry area * Appropriate hand hygiene and glove use when assisting with dining and toileting needs * Appropriate disinfection and sanitation of mechanical lifts between residents (2)The Administrator, DON, and Infection Control Nurse met on 10/07/2021 and reviewed the following policies: *Handling of Soiled Linen *Hand-washing *Transfer With Hydraulic or Electric Hoyer Lift *Transfer With Non-Mechanical Stand-Aide (2A) Changes were made to the Handling of Soiled Linen policy as follows: * While wearing the appropriate PPE for handling soiled linen (plastic apron and gloves), staff shall remain in the area where the soiled linen is located. Once task is completed, PPE will be removed and hand hygiene performed prior to going into another location to complete further tasks. All staff who provide above service will be educated/re-educated by October 20, 2021 during the Mandatory Inservice by the DON and Infection Control Nurse.	

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F 880	Continued From page 48 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on observation, interview, and policy review, the provider failed to maintain infection control practices for: *One of one laundry staff (E) in wearing of	F 880	F 880 Continued.. (3) All residents have the potential to be affected if staff do not adhere to: *Appropriate wearing of laundry apron and gloves within the laundry area. *Appropriate hand hygiene and glove use when assisting residents with dining and toileting needs. *Appropriate disinfection and sanitation of mechanical lifts between residents. (3A) All staff completing these assigned tasks have potential to be affected. Policy education/re-education about roles and responsibilities for the above identified assigned tasks will be provided by October 20, 2021 during the Mandatory In-Service by the DON and Infection Control Nurse. (4) Root cause analysis conducted answered the 5 Whys: *All staff are educated in proper hand hygiene and cleaning of mechanical lifts. *All staff are educated in resident cares/ wants/needs come first. *All staff are educated to provide prompt resident care especially pertaining to toileting in order to prevent dignity and skin issues. *In conclusion, the root cause of these problems was failure to provide care following proper infection prevention and control as well as staff needing to take the time to ensure these measures are completed. (4A) Administrator, DON, and Infection Control Nurse will ensure all facility staff responsible for the assigned tasks have received/training with demonstrated competency. Administrator contacted the South Dakota Quality Improvement Organization (QIN) on 10/07/2021 and discussed in detail the root cause analysis findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A135	A. BUILDING ______ B. WING ______	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE** **REDFIELD, SD 57469**

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F 880	Continued From page 49 laundry apron and gloves within the laudry area. *One of one registered nurse (RN) J in appropriate hand hygiene and glove use while assisting residents (16 and 23) with dining. *Four of five certified nursing assistants (CNA) (I, K, L, and M) after assisting residents (12 and 22) with cares. *Appropriate disinfection and sanitization of mechanical lifts between residents (3 and 16). Findings include: 1. Observation on 9/14/21 at 10:00 a.m. revealed: *CNAs I and K were helping residents back to their rooms after breakfast. *Had not performed hand hygiene after helping resident 12. 2. Observation on 9/14/21 at 10:30 a.m. revealed: *Laundry staff E in the main lobby of the facility *She had been wearing plastic gloves and a plastic apron. *She had been assisting a staff member with a resident. 3. Observation on 9/14/21 at 11:39 a.m. of CNA L revealed she: *Came out of resident 3's room with the lift. *Took the lift into resident 16's room. *Had not disinfected the lift in between residents. 4. Observation on 9/14/21 at 12:11 p.m. with RN J revealed: *She was assisting two residents (16 and 23). *Both residents required a lot of assistance and only ate when RN J fed them. *RN J did not sanitize her hands before to feeding either resident. *Some pureed food had dropped on resident 23's clothing protector.	F 880	F 880 continued.. (5) Administrator, DON, and Infection Control Nurse will conduct auditing and monitoring for areas identified above. Monitoring of determined approaches to ensure effective infection control and prevention include a minimum of 3-5 times weekly for 4 weeks, Administrator, DON, and Infection Control Nurse making observations across all shifts to ensure staff compliance with: *Necessary infection control and prevention plan that includes compliance in the above identified areas. *Any other areas identified thru the Root Cause Analysis. After 4 weeks of monitoring demonstrating expectations are being met monitoring may reduce to twice monthly for 1 month. *Monthly monitoring will continue at a minimum of two months. Monitoring results will be reported by Administrator, DON, and/or Infection Control Nurse to the QAPI Committee and continued until the facility demonstrates sustained compliance then as determined by the committee and Medical Director. Completion Date	10/20/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A135	A. BUILDING ____ B. WING ____	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

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F 880	Continued From page 50	F 880		

-RN J scooped that food up with a spoon and fed it to resident 23.
*She wiped their mouths with their spoons.
*In between feeding residents 16 and 23 she:
-Put on a glove to feed resident 23.
-Took off that same glove.
-Did not sanitize her hands.
-Start feeding resident 16.
-Then put on that same soiled glove and feed resident 23.
*This was the process she used for the entire meal service.

5. Observation and interview on 9/15/21 at 9:45 a.m. with laundry staff E revealed she:
*Had worked in the facility for about 30 years.
*Used a plastic apron and plastic gloves to sort soiled laundry.
*Would walk through a door, to the laundry room to take off the plastic apron and gloves.
*Agreed she was wearing a soiled plastic apron and gloves in the lobby yesterday.
*Agreed she should not be wearing the soiled apron and gloves outside of the soiled laundry sorting room.

6. Observation on 9/15/21 at 10:00 a.m. of activities aide/CNA M revealed she:
*Brought resident 22 in her bathroom so she could use the restroom.
*Helped resident 22 get situated.
*Walked out of resident 22's room and had not performed hand hygiene.

Interview on 9/15/21 at 5:24 p.m. with minimum data set/infection control coordinator C revealed:
*Staff were expected to perform hand hygiene after caring for residents.
*She agreed laundry staff E should not leave the

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	43A135	A. BUILDING ______ B. WING ______	09/16/2021

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EASTERN STAR HOME OF SOUTH DAKOTA, INC	126 W 12TH AVENUE REDFIELD, SD 57469

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F 880	Continued From page 51 soiled laundry area with her soiled gown. *Staff were expected to disinfect lifts after use. *Staff should be practicing hand hygiene while feeding residents. *She agreed that RN J had not practiced appropriate infection control while feeding residents 16 and 23. Review of the provider's August 2015 Transfer with Hydraulic or Electric Hoyer lift policy revealed: *"Lifts will be wiped with a Super Sani-Cloth follow each use unless the lift is being used by only one resident." *"All lifts will be cleaned with a Super Sani-Cloth nightly and documented on the monthly cleaning schedule. Review of the provider's November 2015 Transfer with Standup Lift policy revealed the lifts were to be wiped with a Super Sani-Cloth after each use unless lift is used by only one resident. Review of the provider's February 2015 Hand-Washing policy revealed: *"Proper hand washing is the single most effective means of preventing disease and infection transmission in our facility. The purpose of this procedure is to outline the steps to follow to ensure proper hand washing." *Hands should be cleaned during some of the following situations: -Before and after resident contact. -Before and after handling food. -After handling anything that could be contaminated or dirty.	F 880		

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

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	43A135	A. BUILDING ______ B. WING ______	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE REDFIELD, SD 57469**

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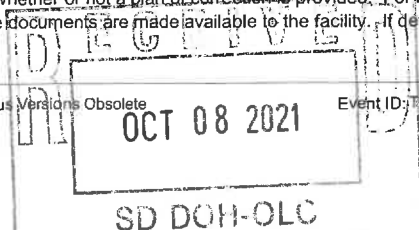
E 000	Initial Comments Surveyor: 42477 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 9/14/21 through 9/16/21. Eastern Star Home of South Dakota, Inc. was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deborah L. Bowar	Administrator	10/07/2021

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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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
	43A135	A. BUILDING **01 - BUILDING 01** B. WING ________	**09/15/2021**

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EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVENUE** **REDFIELD, SD 57469**

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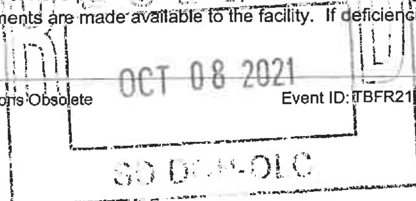
K 000	INITIAL COMMENTS Surveyor: 40506 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 9/15/21. Eastern Star Home of South Dakota, Inc. was found in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deborah L. Bowar	Administrator	10/08/2021

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10670	A. BUILDING: ______ B. WING ______	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR HOME OF SOUTH DAKOTA, INC	**126 W 12TH AVE POST OFFICE BOX 150 REDFIELD, SD 57469**

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S 000	Compliance/Noncompliance Statement Surveyor: 42477 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 9/14/21 through 9/16/21. Eastern Star Home of South Dakota, Inc. was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 42477 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 9/14/21 through 9/16/21. Eastern Star Home of South Dakota, Inc. was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deborah L. Bowar	Administrator	10/07/2021