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
	43A103	A. BUILDING ______ B. WING ______	12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KADOKA NURSING HOME	605 MAPLE ST W KADOKA, SD 57543

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 12/18/23 through 12/20/23. Kadoka Nursing Home was found not in compliance with the following requirements: F658, F758, F761, F811, F812, and F919.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled residents (27) physician's order (PO) for weight monitoring and physician notification of weight changes outside the specified parameters was followed. Findings include: 1. Observation and interview on 12/18/23 at 11:31 a.m. and again on 12/19/23 at 3:00 p.m. with resident 27 revealed he: *Was admitted in August 2023 and his diagnoses included a stroke history, heart disease, diabetes, and a brain bleed. -Was wearing compression socks to help maintain his blood flow and reduce leg swelling. -Weighed less than he had in the recent past. Review of resident 27's electronic medical record (EMR) revealed:	F 658	Resident #27 order changed to weekly weight on 12/27/23. Nursing staff are to monitor weights daily/weekly/monthly and report to provider a 5-pound weight loss/gain in 1 week or as ordered. DON/ADON or designee will educate all nursing staff the updated policy to document a note with a 5-pound weight loss/gain or as ordered and notification to provider, to utilize the maintenance repair form for broken scale immediately, and to use the backup portable or portable scale on 1/25/24. Weight policy revised 12/27/23. The weight sheet will be revised to reflect a 5-pound gain/loss and to report to the provider and nursing staff will be educated on 1/25/24. All resident weight orders and care plans have been reviewed by MDS Coordinator and updated with the new policy guidelines on 1/10/24. DON/ADON or designee will monitor and track weight sheets 5 times per week for 3 weeks, then randomly 3 times weekly for 3 weeks, then once weekly for 2 weeks and report to Quality Assurance Process Improvement. DON/ADON or designee will monitor and track notification/documentation notes to provider 5 times weekly for 3 weeks, then 3 times weekly for 3 weeks, then once weekly for 2 weeks and report to Quality Assurance Process Improvement for further recommendations.	2/3/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maureen Cardwell TITLE: administrator (X6) DATE: 01/17/2024

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 658	Continued From page 1 *A 9/4/23 PO that included the following instructions: -Weigh the resident daily. -Notify the cardiologist if the resident has a three lb (pound) weight gain overnight or a five lb weight gain in one week. *An 11/28/23 Nutritional Assessment indicated the resident's weight was 288.8 lbs. -That was an increase of 17.2 lbs in 30 days and a 13.8 lb increase since his admission date. Interview on 12/19/23 at 9:30 a.m. with registered nurse G regarding resident 27 revealed: *He was administered a daily diuretic medication (a medicine that helps reduce fluid build-up in the body) for heart failure. *His weight was taken and documented daily. *A physician was notified if the resident's weight fluctuated outside the parameters outlined in the PO referred to above. -Nurse communication with the physician regarding those weight changes was documented in the resident's EMR. *She had not: -Ever had to notify a physician for a weigh gain outside of the parameters referred to in the above PO. -Been aware of any nurse who needed to contact a physician regarding the resident's weight having been outside of those physician-ordered parameters. Interview on 12/19/23 at 1:30 p.m. with director of nursing (DON) B revealed: *Resident 27's weight was taken no later than 9:00 a.m. each day and documented on the Daily Weight Sheet form. *The nurse was responsible for the following: -Signing the bottom of the Daily Weight Sheet	F 658		

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F 658	Continued From page 2 form each day indicating the weight information was reviewed. -Determining if resident 27's weight for the current day was three lbs greater than his weight that was documented for the previous day or if the current days weight was five lbs greater than his weight documented one week prior. -Notifying the physician of weight fluctuations outside of the parameters in the 9/4/23 PO. -Documenting the outcome of the physician notification in the resident's EMR. Continued interview with DON B and review of resident 27's 11/19/23 through 12/17/23 Daily Weight Sheet forms and his EMR revealed she confirmed: *There were no documented weights on 11/19/23, 11/30/23, 12/7/23, 12/13/23, and 12/16/23. *Overnight weight gains of greater than 3 lbs occurred on the following days: -Between 11/18/23 (273 lbs) and 11/20/23 (282 lbs). -Between 11/20/23 (282 lbs) and 11/21/23 (288 lbs). -Between 11/28/23 (283.6 lbs) and 11/29/23 (287.8 lbs). -Between 12/4/23 (280.4 lbs) and 12/5/23 (285.6 lbs). -No nurse progress notes between 11/19/23 and 12/17/23 regarding the weight changes referred to above had been communicated to the physician. Review of the undated Physician's Orders policy revealed "[Physician's] orders are verified and coordinated by a nurse."	F 658		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758	Resident #26 orders for Ativan 0.5mg by mouth every 6 hours PRN was discontinued on 12/19/23.	2/3/24

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F 758	Continued From page 3 §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758	F 758 Continued from previous page Order for injectable Ativan PRN for seizure activity was discontinued 12/15/23. DON/ADON/SSD or designee will continue to track psychotropic medications and gradual dose reductions through Telehealth visits and also with the monthly pharmacist chart review. ADON/SSD will continue to utilize and update the psychotropic medication tracking form monthly or as indicated with new medication orders/changes. DON/ADON or designee will monitor and track all resident psychotropic medications and physician orders every 2 weeks for 3 months for all 14-day renewals and evaluations and report to Quality Assurance Process Improvement for further recommendations.	

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F 758	Continued From page 4 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT Is not met as evidenced by: Based on review of the Consultant Pharmacist Review reports for 2023, record review, interview, and policy review, the provider failed to ensure a physician's order (PO) included a specific duration of time for an as needed (PRN) psychotropic medication for one of one sampled resident (26) who received a PRN psychotropic medication. Findings include: 1. Review of resident 26's electronic medical record (EMR) revealed: *Two POs for PRN Ativan (psychotropic medication). -One had instructions for administration with seizure activity and the other had instructions for administration with agitation. -The PO for "Ativan 0.5 mg every 6 hours PRN for agitation" was started on 6/19/23. *Consultant Pharmacist Review 2023 monthly notes completed by pharmacist D that reviewed the resident's EMR for identification of medication irregularities revealed: -Only the PRN PO for Ativan administered with seizure activity had been reviewed. -There was no documentation of the PRN PO for Ativan administered for agitation. *Medication administration records from 6/19/23 through 12/19/23 revealed the PRN Ativan for	F 758		

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F 758	Continued From page 5	F 758		

agitation was administered three times in November 2023.

Interview on 12/19/23 at 3:49 p.m.with pharmacist D regarding resident 26's PRN Ativan for agitation revealed he:
*Had monitored the resident's use of PRN Ativan administered for seizure activity but had not monitored the use of the PRN Ativan administered for agitation.
-That was "an oversight" on his part.
*Had known PRN orders for the use of psychotropic medications were limited to 14 days unless the physician documented a rationale to extend the use of that medication.
-Should have requested a standing order for re-evaluation of the use of that medication every 14 days, requested the medication had been administered on a scheduled basis, or requested the medication had been discontinued.

Interview on 12/20/23 at 9:21 a.m. with director of nursing B regarding resident 26's PRN Ativan administered for agitation revealed:
*The resident's admission orders included multiple PRN Ativan orders for agitation.
-She had thought all those POs had been discontinued.

Review of the July 2022 Psychotropic Medication Use policy revealed "12. a. PRN orders for psychotropic medications are limited to 14 days."

Review of the undated Physician's Orders policy revealed:
*"6. The ADON/SSD [assistant director of nursing/social services designee] will print and verify the physician's orders at least every 60 days to provide a clean (recap) copy."

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F 758	Continued From page 6 *"7. The physician will review the recap." "The physician, then, will sign and date the recap, stating that it is correct." *"8. The charge nurse will review the recap of orders, enacting all new orders, then noting the recap by signing 'noted', signing, and dating it when the process is completed."	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy	F 761	The refrigerator was secured with a new lock on 12/19/23 until refrigerator lock was repaired/replaced on 12/28/23. Policy number 119D "medication Refrigerator" is in place. Nursing staff will be educated by DON/ADON or designee on 1/25/24 to notify DON/ADON or COO if refrigerator lock or any lock securing medications is discovered broken immediately and to follow the medication refrigerator policy number 119D. DON/ADON or COO will notify maintenance for repair or replacement of lock(s) to ensure proper security of medications. Nursing staff will be educated on the proper labeling, storage and security of medications and only authorized personnel have access to the keys and to ensure compartments/cabinets/refrigerator are locked and medications are securely stored on 1/25/24. Policy number 95A Medication Labeling and Storage revised on 1/16/24. Nursing staff will continue to ensure that medications requiring a log count are counted and verified each shift and logged. Policy number 97 "Medications/Narcotics" reviewed and will be educated to nursing staff on 1/25/24.	2/3/24

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F 761	Continued From page 7	F 761	F761 Continued from previous page.	

review, the provider failed to ensure:
*Medications in one of one medication refrigerator were securely stored.
*One of one sampled residents (20) had her prescription insulin medication accurately labeled.
Findings include:

1. Observation on 12/18/23 at 2:36 p.m. of the medication refrigerator revealed:
*It was unlocked on a counter in an alcove near where the north/south and east/west residential hallways intersected.
*Inside of the refrigerator was the following:
-One syringe of Ativan (psychotropic medication) in a clear plastic container secured by a zip tie.
-Multiple stacked boxes of residents' insulin.
-A tuberculin vial.
*Staff entered and exited that alcove to access residents' paper charts and to use a handwashing sink.

Interview on 12/18/23 at 2:54 p.m. with registered nurse (RN) G regarding the medication refrigerator revealed:
*It was unsecured.
-The key used to lock it had not worked "for a few months".
-"I would have to think someone reported this issue" to management.
*The medications in the refrigerator were accessible to anyone who entered that alcove.
-Missing medications would not have been noticed until shift change when they were counted by the nursing staff.

Interview on 12/19/23 at 1:30 p.m. with director of nursing (DON) B regarding the unsecured medication refrigerator revealed she:
*Was unsure how long the refrigerator key had

DON/ADON or designee will monitor and track that refrigerator and medication cabinet/drawers are locked 5 times weekly for 3 weeks, then randomly 3 times weekly for 3 weeks, then 1 time weekly for 2 weeks and report to Quality Assurance Process Improvement meeting for further recommendations.

Nursing staff will be re-educated by DON/ADON or designee on the 5 rights of medication administration (person, med, dose, time, route) and the 3 safety checks when administering medications (comparing physician order and medication label) 3 times before andduring preparation/administration of medications on 1/25/24.

Nursing staff will be re-educated by DON/ADON or designee that if a discrepancy is noted or an order has changed, they are to place a "SEE MAR" sticker on the label of the medication. This is also to alert nursing staff of the discrepancy between the label and the physician order. Staff to follow policy number 95A "medication Labeling and Storage on 1/25/24.

Nursing staff will be re-educated by DON/ADON or designee to clarify the order if unclear before preparing/administering the medication on 1/25/24.

DON/ADON or designee will monitor and track new physician orders for medication changes for all residents 3 times weekly for 1 month then once weekly for 1 month and report to Quality Assurance Process Improvement.

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F 761	Continued From page 8 not worked. -Had known the key worked at the end of the preceding week. *Expected nursing staff to notify her or another member of the management team upon discovering that the refrigerator key was not working. -The refrigerator could have been secured by another means until a new key was made or the lock was replaced. 2. Observation and interview on 12/19/23 at 11:30 a.m. with RN G during a medication administration pass revealed: *She referred to resident 20's medication administration record (MAR) for the physician's order (PO) and instructions regarding the administration of her insulin (Lantus) medication. -That order was for ten units of Lantus to have been injected subcutaneously daily for diabetes. *She removed the prescription labeled Lantus insulin pen from the medication cart. -Without comparing the instructions on the prescription label to the MAR she prepared and primed the insulin pen. -Dialed the number of units of insulin to administer to ten. -Locked the medication cart and turned towards the resident's room to administer that insulin dose. *RN G was asked by the surveyor to read the prescription label on the insulin pen. -It instructed five units of Lantus to be injected subcutaneously daily. *She had not noticed the discrepancy between the amount of insulin on the MAR that was to have been administered compared to the amount of insulin on the prescription label that was to have been administered.	F 761	F761 Continued from previous page. DON/ADON or designee will monitor and track that the "SEE MAR" sticker is placed on label to alert nurses of discrepancy between the label and physician order 3 times weekly for 1 month then 1 time weekly for 1 month and report to Quality Assurance Process Improvement for further recommendations.	

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F 761	Continued From page 9 -She was expected to compare them and reconcile any differences before drawing up the insulin for resident 20. Interview on 12/19/23 at 11:45 a.m. with DON B revealed RN G was expected to: *Compare the prescription label of resident 20's insulin against the PO for insulin on her MAR before preparing the medication for administration. *Place a "See MAR" sticker on the prescription label to alert other nursing staff to the discrepancy between the prescription label on the insulin pen and the PO for insulin on the MAR. Review of the undated Compliance of Medications policy revealed "7. Resident's medications must be properly labeled and stored in a locked cabinet at the nurse's station."	F 761		
F 811 SS=D	Feeding Asst/Training/Supervision/Resident CFR(s): 483.60(h)(1)-(3) §483.60(h) Paid feeding assistants- §483.60(h)(1) State approved training course. A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if- (i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and (ii) The use of feeding assistants is consistent with State law. §483.60(h)(2) Supervision. (i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). (ii) In an emergency, a feeding assistant must call	F 811	Dining Assistance Policy created 1/5/24. All staff educated that to provide dining assistance, they need to be a certified nurse aide or have completed an approved nutrition and hydration dining assistance program. The staff was informed not to feed or assist any resident if not certified/licensed to do so. DON/ADON or designee will monitor and track the dining room meals to ensure any assistance provided is from licensed or certified nursing staff randomly 3 times weekly for 1 month then randomly 1 time weekly for 1 month and report to Quality Assurance Process Improvement for further recommendations.	2/3/24

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F 811	Continued From page 10 a supervisory nurse for help. §483.60(h)(3) Resident selection criteria. (i) A facility must ensure that a feeding assistant provides dining assistance only for residents who have no complicated feeding problems. (ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. (iii) The facility must base resident selection on the interdisciplinary team's assessment and the resident's latest assessment and plan of care. Appropriateness for this program should be reflected in the comprehensive care plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the provider failed to ensure one of one dietary manager (DM) (E) had completed a State-approved training program for feeding assistants prior to providing two of two observed residents (20 and 26) feeding assistance during one of one observed meal service. Findings include: 1. Entrance conference interview on 12/18/23 at 10:30 a.m. with chief operating officer (COO) A revealed the facility had no paid feeding assistants. Observation and interview on 12/18/23 at 5:07 p.m. with DM E in the dining room revealed: *She sat at one of the dining room tables in between residents 20 and 26. *Resident 20's meal was served on a three-compartment plate. -The consistency of her food was moist-looking and had been modified to a soft texture. *DM E verbally cued and physically assisted the	F 811		

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(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 811	Continued From page 11 resident to eat her meal. *Resident 26 used a modified spoon to scoop his food and bring it to his mouth to eat. *DM E held a cup to the resident's mouth for him to drink fluids. *She helped feed residents to "support her co-workers." *She was not a certified nurse aide (CNA) and had not been provided any specialized feeding training. -She thought the only requirement for feeding residents was having cardio-pulmonary resuscitation (CPR) certification. Review of resident 20's electronic medical record (EMR) revealed: *An 8/29/23 speech therapy daily treatment note: "Patient continues to present with moderate to severe dysphagia characterized by needing a modified diet, pocketing food, anterior loss with cup and residue within oral cavity." Review of resident 26's EMR revealed: *A 10/3/23 speech therapy daily treatment note: "Patient presents with mild to moderate dysphagia characterized by oral residues, pocketing, deficits from stroke, and no use of left side as well as safety precautions d/t [due to] patient being at an increased risk for aspiration." Interview on 12/19/23 at 1:00 p.m. with COO A revealed: *She had known DM E helped assist residents with their meals without having CNA training or having completed a State-approved training program for feeding assistants. *Neither resident 20 nor resident 26 were appropriate to have been assisted by a feeding assistant based on their diagnoses, the speech	F 811		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A103	A. BUILDING ______ B. WING ______	12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KADOKA NURSING HOME	605 MAPLE ST W KADOKA, SD 57543

(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 811	Continued From page 12 therapy recommendations referred to above, and DM E's lack of specialized training for residents who required feeding assistance. A Feeding Assistance Program policy was requested from COO A on 12/19/23 at 3:00 p.m. She confirmed there was no policy.	F 811		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review the provider failed to ensure: *One of one kitchen was maintained in a clean and sanitary manner. *Food was stored and labeled safely. Findings include:	F 812	Certified Dietary Manager (CDM) and kitchen staff deep cleaned the kitchen 12/18/23 – 12/29/23. The kitchen sanitation policy was reviewed and revised on 1/5/24. The CDM and COO reviewed and revised the cleaning schedule on 12/21/23. The kitchen staff will be re-educated on the cleaning schedule and the "Kitchen Sanitation" policy on 1/23/24. The new water softener was installed on 11/28/23 to improve the extreme water hardness and buildup. The kitchen staff continue to remove buildup in the dish-room. The new dishwasher was installed on 1/4/24. Staff have been educated in draining the 3-compartment sink by draining one sink at a time to prevent the air gap overflowing. CDM and COO will re-educate staff on kitchen sanitation. CDM or designee will monitor and track proper cleaning during scheduled times 3 random times per week for 1 month, then 1 random time weekly for 1 month, and report to Quality Assurance Process Improvement for further recommendations. Food storage labeling with proper dates were inventoried and corrected on 1/5/24. The new dietician surveyed the kitchen on 1/10/24. The Dietician and CDM reviewed kitchen policies and routine. COO/CDM will re-educate kitchen staff on proper food storage and labeling on 1/23/24.	2/3/24

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KADOKA NURSING HOME	605 MAPLE ST W KADOKA, SD 57543

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F 812	Continued From page 13 1. Observation and interview on 12/18/23 at 10:15 a.m. with dietary manager E while in the kitchen revealed: *A large, thick, white, and brown circle under the dishwasher. *The gas stovetop and burners had dried, burnt food particles on it. *The space between the stovetop and the grill had grease build-up and burnt food particles. *Under the stove and the prep table the floor had a thick build-up of dust, grease and visible chunks of food. *The front of the stove had splattered grease covering the surface. *The stovetop was cleaned weekly every Monday. *The kitchen had been deep cleaned two and a half weeks ago. *The floors were mopped nightly. *The cleaning list was to have been posted on the refrigerator and staff were to place a check mark when completing the task. *She had not kept any logs of past cleaning lists. Observation on 12/18/23 at 4:30 p.m. in the kitchen revealed: *The back of the stove had grease build-up, dust, and spider webs on it. *The floor in the back of the stove had thick dust build-up with visible food particles around the stoves floor outlet. *The back of the stove had a layer of thick dust and cobwebs. *Under the three-compartment sink there was a bucket placed on a serving tray, under a drain that had unidentified overflowing white sludge. Interview on 12/19/23 at 9:45 a.m. with chief operating officer A revealed: *She agreed the items above were dirty and	F 812	F 812 Continued from previous page. CDM or designee will monitor proper food storage of dry foods, refrigerated foods, and frozen foods 5 random times per week for 1 month, then 3 random times per week for 1 month and report to Quality Assurance Process Improvement for further recommendations.	

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	43A103	A. BUILDING ______ B. WING ______	12/20/2023

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KADOKA NURSING HOME	605 MAPLE ST W KADOKA, SD 57543

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F 812	Continued From page 14 unsanitary. *Dietary manager E should have kept a log of the past cleaning lists. *The mops used to clean the floor in the kitchen, were hard to get under the stove and prep table. *She was unaware of the bucket that was on a serving tray under the drain of the three-compartment sink. Review of provider's undated "Cleaning Instructions: Ranges" policy revealed "The range will be cleaned after each use. Spills and food particles will be wiped up as they occur." Review of provider's undated "Cleaning Instructions: Floor, Tables and Chairs" policy revealed: *Procedure: -"1. Kitchen floors will be swept and cleaned after each meal. A thorough cleaning using a disinfectant will be done at least twice a week. Major appliances will be moved at least once a month (as appropriate) in order to facilitate cleaning behind and underneath them." Review of provider's undated "Sanitation of Dining and Food Service Areas" policy revealed: *"The food service staff will maintain the sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule." *"The food service manager will record all cleaning and sanitation tasks needed for the department." 2. Observation on 12/18/23 at 10:00 a.m. in the kitchen revealed:	F 812		

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F 812	Continued From page 15 a. Inside the dry food storage room there was the following: *Unsealed and undated opened bags of pretzels, rice, and crackers. *An unlabeled and undated can of coconut flakes. *An unlabeled and undated jar of dried parsley that was opened to the air. *Multiple bags of unlabeled and undated bags of dried pasta that had been removed from their original packaging. b. Inside the chest freezer there was the following: *Opened bags of unlabeled and undated frozen chicken, frozen pork chops, and frozen garlic toast. *A bag of unlabeled and undated frozen hamburger patties that was opened to the air. *Multiple bags of unlabeled and undated frozen vegetables, poultry, breads, and meat that had been removed from their original packaging. c. Inside the refrigerator there was the following: *Undated and unlabeled plastic containers of prepared Jell-O cups and fruit cups with lids. *Undated and unlabeled pitchers of prepared tea. Interview on 12/18/23 at 10:15 a.m. with dietary manager (DM) E regarding the above-mentioned food items revealed: *She confirmed the food items were not dated, labeled, and sealed when they were opened. *She was unsure when the Jell-O cups, fruit cups, and pitchers of tea were prepared. *It was her expectation that staff stored opened food items in sealed containers and label them with open dates. Interview on 12/19/23 at 9:45 a.m. with chief operations officer (COO) A revealed it was her expectation that food packages and containers	F 812		

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F 812	Continued From page 16 would be sealed and have an opened date on them to ensure the quality and freshness of the foods. Review of the provider's undated and untitled Food Storage and Labeling policy revealed: *Previously cooked or prepared foods were to be labeled with a discard date. *Foods that were made with previously cooked foods in-house were to be labeled with the discard date of the previously cooked items. *Leftover foods stored in containers were to have tight-fitting lids and clearly labeled with the date and time the food was first prepared. *If foods were stored in a zip-top plastic bag, the air was to be pushed out of the bag before it was sealed. *All ready-to-eat foods that were prepared in-house were to have been stored for a maximum of 7 days. -After 7 days, those food items were to have been thrown out to prevent bacteria from growing to unsafe levels. Review of the provider's undated and untitled Food Service policy revealed food stored for future serving was dated and stored in sealed containers then discarded based on the shelf life of the individual food item.	F 812		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from-	F 919	Call Light Policy reviewed and revised on 1/5/24. Resident #13 call light clip was repaired on 12/19/23. DON/MDS Coordinator will review and update care plans for all residents to reflect call light accessibility by 2/3/24. Maintenance staff to ensure that clips are available for modification to all resident call lights and was educated on 12/20/24.	2/3/24

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F 919	Continued From page 17 §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure an in-room call light system was accessible for one of one sampled resident (13). Findings include: 1. Observation and interview on 12/18/23 at 11:46 a.m. with resident 13 in his room revealed: *He was in bed underneath his bedding wearing a hospital gown. -Individual packets of lip balm and packages of mouth swabs sat on his bedside table. *His television was on, and his call light was lying on top of the bed covers near his feet. -He used his hands to feel on top of his bedding for the call light but was not sure where it was. -He would have tried to get the attention of someone passing by his room if he had needed help. Observation on 12/18/23 at 2:26 p.m. of resident 13 in his room revealed: *He was in bed asleep with the television on. -His call light lay on the floor at the foot of his bed. Interview on 12/18/23 at 2:30 p.m. with certified nurse aide (CNA) I revealed: *Resident 13 was hospitalized about a month ago. -He received end-of-life care and had chosen to remain in bed most of the time. *Staff had been in the resident's room no less than every two hours to reposition, check, and change his incontinence brief.	F 919	F 919 Continue from previous page Nursing staff to notify maintenance if any call light clip is missing or in non-working order immediately and staff will be re-educated by DON/ADON or designee on 1/25/24. DON/ADON or designee will monitor and track resident call light accessibility in 10 random rooms 3 times weekly for 1 month, then randomly 1 time weekly for 1 month and report to Quality Assurance Process Improvement for further recommendations.	

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	43A103	A. BUILDING ____ B. WING ____	12/20/2023

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F 919	Continued From page 18 Observation on 12/18/23 at 3:25 p.m. of resident 13 revealed maintenance manager F stood in the resident's doorway and asked "How are you, [resident 13]?" without noticing the call light was on the floor. Interview on 12/19/23 at 8:05 a.m. with maintenance manager F regarding the 12/18/23 observation referred to above revealed he had not noticed the resident's call light on the floor. Observation and interview on 12/19/23 at 7:40 a.m. of resident 13 revealed he: *Was in bed and would have been "better" if he had coffee. -Was unable to make his needs known because his call light was between his legs below his knees and was unable to be seen or reached by the resident. Interview on 12/19/23 at 10:20 a.m. with CNA J regarding resident 13 revealed she: *Provided care for the resident at 7:30 a.m. that morning. -Had not noticed the resident's call light was not accessible to him. *Thought the call light might have been unintentionally displaced by the resident when he moved around in bed. -Had known other residents whose call light had a clip on it that could be attached to their clothing or bedding so it remained in place. Interview on 12/19/23 at 1:30 p.m. with director of nursing B regarding resident 13's call light revealed: *Staff were in and out of his room at routine intervals to provide end-of-life care. -They were expected to ensure the resident's call	F 919		

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F 919	Continued From page 19 light was accessible anytime they were in his room or passed by and looked into his room. *A modification to the resident's call light should have been made so it remained in place and accessible for the resident to activate. Interview on 12/20/23 at 9:30 a.m. with assistant DON C revealed call light competencies were completed annually for all caregivers and included ensuring residents always had access to a call light. On 12/19/23 at 4:45 p.m. chief operating officer A stated there was no policy that specifically addressed call light accessibility.	F 919		

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A103	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KADOKA NURSING HOME	605 MAPLE ST W KADOKA, SD 57543

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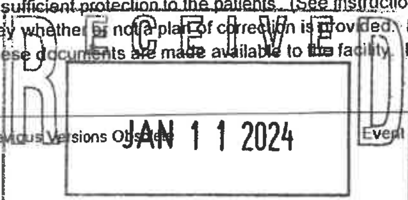
E 000	Initial Comments An emergency preparedness survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 12/18/23 through 12/20/23. Kadoka Nursing Home was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marvin Cadwell

TITLE: CEO/Administrator

(X6) DATE: 1/11/2024

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.



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

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	43A103	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KADOKA NURSING HOME	**605 MAPLE ST W** **KADOKA, SD 57543**

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 12/19/23. Kadoka Nursing Home was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K321 and K911 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maurin Cardwell
TITLE: Administrator
(X6) DATE: 1/11/2024

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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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10637	A. BUILDING: ______ B. WING ______	12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KADOKA NURSING HOME	605 MAPLE ST W POST OFFICE BOX 310 KADOKA, SD 57543

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 12/18/23 through 12/20/23. Kadoka Nursing Home was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 12/18/23 through 12/20/23. Kadoka Nursing Home was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maureen Cadwell | TITLE: Administrator | (X6) DATE: 1/11/2024

STATE FORM | G7KP11 | If continuation sheet 1 of 1