STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A038	A. BUILDING _____ B. WING _____	08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTCHMAN LIVING CENTER	503 WEST PINE PHILIP, SD 57567

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/28/23 through 8/30/23. Scotchman Living Center was found not in compliance with the following requirements: F609 and F658.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609	Administrator or designee will ensure all incidents will be investigated and reported according to Regulation 483.12; all alleged violation involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of property is reported within 2 (two) hours after the allegation is made. The Administrator or designee communicated the skin injury to the Department of Health on August 29, 2023 and it was accepted. The Administrator or designee will resubmit the DOH investigation to include explanations of possible causes and the interventions put in place to prevent a reoccurrence of the injury. The Director of Nursing or designee will educate all nursing staff at the next staff meeting on September 27, 2023, to ensure they understand the policy to report and investigate all resident incidents, including those of unknown sources. Any staff not in attendance at the meeting are required to review the information presented at the meeting and will sign and date when it was reviewed. The Director of Nursing or designee will monitor random skin assessments, wound care assessments, and incident reports weekly for 3 (three) months, then monthly for 3 (three) months to ensure all incidents are properly investigated and reported according to regulation. This includes incident reporting as required to the Department of Health. The Director of Nursing or designee will report the findings to the Quality Assurance Team for 6 (six) months for further recommendations.	09/29/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Maureen Cadwell *Maureen Cadwell*	CEO	09/25/2023

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

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SCOTCHMAN LIVING CENTER	503 WEST PINE PHILIP, SD 57567

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F 609	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the 8/29/23 Required Healthcare Facility Event Reporting form, and policy review, the provider failed to investigate and report in a timely manner an injury of unknown origin for one of one sampled resident (32). Findings include: 1. Observation and interview on 8/29/23 at 11:15 a.m. with certified nurse aide (CNA) E and CNA F and resident 32 in her room revealed: *The resident was lying in bed. -There were bilateral side rails on her bed, one fall mat on the floor next to one side of her bed, and a second fall mat on the floor at the foot of her bed. *A sign near the head of her bed indicated she was at risk for falls. *CNAs E and F transferred the resident with a mechanical lift from her bed to her wheelchair. -The staff stated the wheelchair was new to the resident. *The resident's left hand was wrapped with a gauze dressing. -A portion of the skin that was visible on her left thumb appeared black-colored and dry-looking. *CNA F confirmed the resident had injured her left hand a few weeks earlier but was not certain what happened to have caused that injury. *The resident stated she had been injured after falling out of an airplane. *Staff placed the resident's left arm in a sling after she was transferred to her wheelchair. -The resident had a stroke in the past and was unable to control the movement of that arm. Review of resident 32's medical record revealed the following nurse progress notes:	F 609		

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F 609	Continued From page 2 *On 8/12/23 at 6:21 a.m.: "Around 5:30 AM 8/12/23 resident rolled out of their bed. Resident was found laying on fall mat with pillow under head. Resident was assisted back into bed, injury assessment done, and vitals taken." "No new injuries found. Fluid pockets found on left hand." *On 8/12/23 at noon: "Resident's vital signs and LOC [level of consciousness] seem to be WNL [within normal limits] s/p [status post] fall earlier this morning. Large bruise found on L [left] elbow and resident does c/o [complain of] pain at this site. No other bruising or signs of injury on head or elsewhere noted. Of note, there are 3 large fluid pocket/blisters on L outer thumb as well as one small fluid blister on outer 5th digit." Review of the physician's 8/15/23 progress note regarding resident 32's left-hand skin injury revealed: *"They [nursing home staff] are not sure how that happened [the hand injury] just on her left hand which is a side that is affected from her stroke. Not sure if she laid on the hand or got pinched in between something." *"Multiple blisters [on the] left hand most likely secondary to some sort of friction injury on her affected stroke side..." Observation and interview on 8/29/23 at 10:30 a.m. with registered nurse (RN) D in resident 32's room revealed: *There were multiple areas of impaired skin integrity that varied in size and shape that were observed after RN D removed the dressing from the resident's left hand. *The areas observed were: -On the top of the resident's hand near her knuckles and near where her hand and wrist met. -On either side of the base of the palm of her	F 609		

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F 609	Continued From page 3 hand and on the center of her wrist just below the palm. -On her thumb, index and "pinky" fingers. *The areas were dark red or black colored, dry looking in appearance, and none of the areas were fluid-filled. *RN D confirmed those areas on the left hand had initially presented as two to three fluid-filled blisters when they were first observed after the resident's 8/12/23 fall. *She had not known the cause of those blisters but thought the resident had "a reaction" to something. Interview on 8/30/23 at 3:15 p.m. with director of nursing (DON) B regarding resident 32's post-fall injury referred to above revealed: *It was presumed the left-hand blisters referred to above had occurred as a result of the 8/12/23 fall. -That was when those blisters had first been noticed by the staff. *The development of blisters was not a common injury associated with falls. -Bruising and skin tears were more often seen with falls. *Resident 32's 8/12/23 injury of unknown origin should have been reported to the South Dakota Department of Health-Office of Licensure and Certification (SD DOH-OLC) within 24 hours of its occurrence. -That notification had not been made until 8/29/23. *It was DON B's responsibility to ensure that notification occurred in a timely manner. Review at that same time of the Required Healthcare Facility Event Reporting form submitted by the provider on 8/29/23 to the SD DOH-OLC regarding the injury of unknown origin	F 609		

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F 609	Continued From page 4 referred to above revealed DON B agreed: *The information documented by the provider in the Explanation of Event section and the Conclusionary Summary Statement of the Facility Investigation section of that form were the same. -The Investigation section of that form had not included any information explaining possible causes for that hand injury or what interventions had been put in place to prevent a re-occurrence of that injury. *There was no documentation to support the following: -The resident's environment had been assessed after the fall for possible causes of that injury such as the side rails on her bed, her new wheelchair, the mechanical lift, or the arm sling she had worn. -Interviews with other staff members regarding what may have caused or contributed to those injuries. -Potential causes of the hand injury referred to in the physician's 8/15/23 progress note were not investigated. *DON B agreed it was her responsibility to ensure a thorough, documented investigation was completed following the unwitnessed fall that had resulted in resident 32's injuries of unknown origin. Review of the revised April 2023 Abuse policy revealed: *Injuries of unknown origin that had not resulted in serious bodily injury to a resident were expected to have been reported to the SD DOH-OLC no later than 24 hours following the event. *The completed investigation of that event was to have been submitted to the SD DOH-OLC within five working days.	F 609		

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F 609	Continued From page 5 -The report was expected to have included pertinent information such as the steps the facility had taken to protect the resident and a description of preventative measures that had been implemented to try to prevent a recurrence of that event.	F 609		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the following: *Care-specific details regarding one of one sampled resident's (32) skin condition and skin treatment had been documented in that resident's medical record. *One of one registered nurse (RN) C had not implemented a discontinued physician-ordered skin treatment for one of one sampled resident (32). *One of one sampled resident's (32) physician had been notified of her worsening skin condition. Findings include: 1. Observation and interview on 8/29/23 at 10:30 a.m. with RN D in resident 32's room revealed: *There were multiple areas of impaired skin integrity that varied in size and shape that were observed after RN D removed the dressing on the resident's left hand. *The areas observed were:	F 658	The Director of Nursing or designee in consultation with the medical director will review, revise, create necessary policies for Documentation, Notifying a Provider and Medication and Treatment Orders. The Director of Nursing will ensure resident 32's skin issue is resolved, documented, and the provider was notified on September 13, 2023. The Director of Nursing or designee will educate all nursing staff at the next staff meeting on September 27, 2023 on the revised or new policies regarding proper documentation, following a provider order, and notifying providers. The Director of Nursing or designee will monitor random residents on treatment orders to ensure they are being followed as ordered, skin assessments to ensure they are being documented as appropriate and provider notifications have been completed as necessary, weekly for 3 (three) months, then monthly for 3 (three) months. The Director of Nursing or designee will report findings to the Quality Assurance Team for 6 (six) months for further recommendations.	09/29/2023

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F 658	Continued From page 6 -On the top of the resident's hand near her knuckles and near where the top of her hand and wrist had met. -On either side of the base of the palm of her hand and at the center of her wrist just below the palm. -On her thumb, index and "pinky" fingers. *The individual areas varied in size and shape: -Round, slightly larger than the eraser at the end of a pencil to quarter size. -Approximately one-inch square. -Oval-shaped and about one and a half inches by a half-inch. *Each of those areas varied in color from dark red to black in color and were dry-looking. *RN D confirmed those areas referred to above on the resident's left hand had initially presented as two to three fluid-filled blisters when they were first observed after the resident's 8/12/23 fall. Review of resident 32's medical record documentation between 8/12/23 and 8/30/23 related to her left-hand skin condition referred to above included the following: *Three progress notes: -On 8/12/23 at 6:21 a.m. the resident had been found on the floor lying on a fall mat beside her bed. An injury assessment had been completed and "fluid pockets found on [the] left hand." -On 8/12/23 at 12:00 noon "there are 3 large pockets/blisters on L [left] outer thumb as well as one small fluid blister on [the] outer 5th digit [finger]." -On 8/14/23 at 4:03 p.m. the left hand dressing had been removed from the resident's hand and "several fluid filled blisters" had been observed. "One to her pinky finger, one at the base of her thumb two to her inner hand. Not open at this time."	F 658		

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F 658	Continued From page 7 *An 8/15/23 physician's progress note that indicated the resident had multiple fluid-filled blisters to her left hand. *Two weekly skin assessments: -On 8/16/23: "Resident has scattered bruising throughout her entire body. Several large blister on her left hand/wrist that is wrapped in Kerlex. [Kerlix]" -On 8/23/23: On the palm of the resident's left hand "Two large sanguineous (clear fluid) filled blisters. Little finger with blister as well. Applied iodine and put dressing over hand to protect site." *One monthly resident summary: -Skin Summary documentation on 8/18/23: The resident's skin was "normal" and "intact." Comments included "blisters to left hand." *No additional documentation related to the status of resident 32's left hand had been documented since 8/23/23. 2. Review of resident 32's August 2023 Treatment Administration Record (TAR) revealed: -A physician's skin treatment order for "Iodine to L hand blisters, then wrap with Kerlex [Kerlix] one time day." That order had been started on 8/15/23 and was discontinued on 8/16/23. -An updated physician's skin treatment order initiated on 8/16/23 to "Monitor L hand blisters, then wrap with Kerlex [Kerlix] one time a day." *RN C signed the TAR on 8/23/23 indicating she had completed resident 32's physician-ordered skin treatment that day. -The resident's weekly skin assessment completed on that same date by RN C revealed she had "applied iodine and put dressing over hand to protect site." -RN C had implemented a physician-ordered skin treatment for resident 32 that had been discontinued on 8/16/23.	F 658		

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F 658	Continued From page 8 Observation of resident 32's unwrapped left hand and interview at that same time with director of nursing (DON) B on 8/30/23 at 3:30 p.m. revealed she: *Agreed the condition of the resident's hand was "much worse" since the last time she had observed it. *Between the time of the last documented left hand skin assessment on 8/23/23 and today's skin observation: -The number of affected areas on the resident's left hand had increased from three located on two parts of her hand to approximately ten separate areas affecting multiple fingers, the top and palm of her hand and the top and inside of her wrist. -The blisters had opened, the skin was dry-looking, and the black-colored areas might have been necrotic or dead skin. *DON B expected: -Resident 32's skin assessments should have been comprehensive and included wound characteristics such as: wound edges, undermining and/or tunneling, drainage type, drainage amount, drainage odor, signs and symptoms of infection, the skin surrounding the wound, edema, pulses, temperature, texture, turgor, and color. -The nursing staff used that assessment information to document in their progress notes the resident's skin condition and any changes observed following the resident's daily skin treatments. -RN C had not implemented the discontinued physician ordered skin care treatment for resident 32. -The nursing staff had notified the resident's physician of her worsened skin condition.	F 658		

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F 658	Continued From page 9 Review of the 12/21/20 Charting and Documentation policy revealed: *Policy Statement: "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record." *Policy Interpretation and Implementation: -Information expected to have been documented in the resident's medical record included the following: "treatments or services performed; changes in the resident's condition, and events; and incidents or accidents involving the resident." *"7.c. Documentation of procedures and treatments will include care-specific details, including the assessment data and/or any unusual findings obtained during the procedure/treatment;"	F 658		

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

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 8/28/23 through 8/30/23. Scotchman Living Center was found in compliance.	E 000		

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

Maureen Cadwell *Maureen Cadwell* | CEO | 09/19/2023

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	43A038	A. BUILDING **01 - MAIN BUILIDING 01** B. WING _____	**08/28/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTCHMAN LIVING CENTER	**503 WEST PINE** **PHILIP, SD 57567**

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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 8/28/23. Scotchman Living Center was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K363 and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or	K 363	The rubber floor wedge was removed from room 310 (Resident Activities). Maintenance Director or designee will educate staff on the requirement that the corridor doors remain closed in an event of a fire. Maintenance Director or designee will observe the doors of room 310 and other corridor doors to ensure they are not propped open by any device. Maintenence Director of designee will report findings to Quality Assurance Team monthly for 3 (three) months.	09/29/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Maureen Cadwell *Maureen Cadwell*	CEO	09/19/2023

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	43A038	A. BUILDING **01 - MAIN BUILIDING 01** B. WING _____	**08/28/2023**

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SCOTCHMAN LIVING CENTER	**503 WEST PINE** **PHILIP, SD 57567**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 1 pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to ensure one randomly observed room door (room 310 Resident Activities Room) was maintained to allow the door to function to resist the passage of smoke into the corridor. Findings include: 1. Observation on 8/28/23 at 2:30 p.m. revealed the corridor door for room 310 (Resident Activities Room) was held open with a rubber floor wedge. Interview with the maintenance technician at the time of the observation revealed that the provider's staff had been instructed in the past by the plant operations director to not place items against corridor doors to hold a door open. Interview with the maintenance technician at the time of the observation confirmed that finding. The deficiency could affect 100% of the occupants of the smoke compartment.	K 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A038	A. BUILDING **01 - MAIN BUILIDING 01** B. WING _____	**08/28/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTCHMAN LIVING CENTER	**503 WEST PINE** **PHILIP, SD 57567**

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K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: A. Based on observation and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (resident was left in the corridor during the fire drill). Findings include: 1. Observation on 8/28/23 at 2:45 p.m. revealed the fire alarm was sounded to initiate a drill for a simulated fire in the Resident Care Manager's office room 321. During the course of the fire drill, a resident with a walker entered the smoke compartment where the drill was in progress. The resident was not removed from the corridor and moved to a place of refuge until the 'All Clear' was sounded by the staff. Interview with the maintenance technician at the time of the observations confirmed those findings. The deficiency had the potential to affect 100% of the occupants. B. Based on document review and interview, the	K 712	A. Maintenance Director or designee will ensure all staff understand the fire procedures by providing training to all staff at Nursing Home Staff meeting on September 27, 2023. B. Maintenance Director or designee will work with the monitoring agency on the process for the call back. Maintenance Director or designee will train maintenance staff on the process for the call back on alarms on September 22, 2023. Maintenance Director or designee will track the fire alarm call backs for 3 (three) months. Maintenance Director or designee will report the findings to the Quality Assurance Team for 3 (three) month.	09/29/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A038	A. BUILDING **01 - MAIN BUILIDING 01** B. WING _____	**08/28/2023**

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K 712	Continued From page 3 provider failed to ensure the monitoring agency received the fire alarm signal. The fire drill reports had not indicated a call back to the monitoring agency noting the person receiving the signal and at what time it had been received. Findings include: 1. Document review on 8/28/23 at 3:00 p.m. revealed the provider's fire drill reports had not indicated a call-back confirmation to the monitoring agency documenting the name of the staff person receiving the fire alarm signal and the time it was received by the monitoring agency. Interview with the maintenance technician at the time of the document review confirmed those findings. The deficiency had the potential to affect 100% of the occupants..	K 712		

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
	10661	A. BUILDING: _____ B. WING _____	08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTCHMAN LIVING CENTER	503 W PINE POST OFFICE BOX 790 PHILIP, SD 57567

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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 8/28/23 through 8/30/23. Scotchman Living Center 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 8/28/23 through 8/30/23. Scotchman Living Center was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maureen Cadwell | TITLE: CEO | (X6) DATE: 09/19/2023