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
	43A136	A. BUILDING _____ B. WING _____	02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME	2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments 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 2/13/24 through 2/15/24. Michael J Fitzmaurice South Dakota Veterans Home was found in compliance.	E 000	Statement of Compliance: The following represents the plan of correction for alleged deficiencies cited during the survey that was conducted 02/13/24 through 02/15/24. Please accept this plan of correction as Michael J. Fitzmaurice Credible Allegation of Compliance with the completion date of 03/31/24. This plan of correction is completed in good faith as Michael J. Fitzmaurice State Veterans Home's commitment to quality outcomes for the residents. In addition, this plan of correction is completed as it is required by law.	
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 2/13/24 through 2/15/24. Michael J Fitzmaurice South Dakota Veterans Home was found not in compliance with the following requirements: F550, F604, F684, F686, F800, and F880.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550	1. Upon notification from DOH surveyors that resident 46 was being placed at the kitchenette counter long periods of time, DON and ADON took immediate steps by speaking with LPN I, CHM K, and CHM M and provided education on the apprpriate practice. Upon identification that nursing staff failed to provide privacy to resident 29 during the residents foley catheter care, DON and ADON provided immediate verbal education to CHM L on the import-ance of maintaining the resident's dignity and privacy during personal cares. 2. All residents residing in the facility have the potential to be affected in a similar manner. To ensure no other residents were affecyed by these deficient practices, Social Workers rounded on 02/15/24 on all units to ensure residents dignity, resident rights, and psychosocial well-being were being maintained.	03/31/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
CR Johnson	Superintendent	03/18/24

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 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure: *The psychosocial well-being and dignity was maintained for one of four sampled residents (46) during three of three observed meal services. *Privacy for one of two sampled residents (29) was provided during his Foley catheter care. Findings include: 1. Random observations on 2/13/24 between 9:45 a.m. and 12:06 p.m. with resident 46 revealed: *He sat alone facing an empty kitchenette. -His Broda chair (a specialty wheelchair that provided supportive positioning and repositioning ability) was pushed against the kitchenette	F 550	3. All nursing staff will recieve education on dignity, resident rights, and psychosocial well-being via a course assigned in Relias chosen by the DON and Social Worker by 03/31/24. 4. The DON or designee will perform rounding on the units to ensure the dignity, residents rights, and psychosocial well -being are being maintained. Five (5) random audits will be conducted weekly for four (4) weeks, then bi-weekly times four (4) weeks, then monthly times one (1) month. Audits will begin on 03/25/24 with the potential to end on 06/25/24 pending 100% complaince.. Currently, audits are being complted by ADON to ensure safe practice. 5. All plan of correction audit data will be reported by DON or designee during the monthly QAPI meeting and reviewed by the committee each month for three (3) months and recommendations given to assist in ensuring that the facility remains in compliance. If concerns are identified, the QAPI committee will add additional time until 100% compliance is sustained.	

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F 550	Continued From page 2	F 550		

countertop with the wheels of the chair locked.
-His back faced the main dining room.
*A quilt with sensory touch items secured to it was placed on the countertop in front of him.
-He occasionally grazed the items on that quilt with his fingers.
*Other times he was asleep, mumbling, repetitively moving his trunk forward then back or reaching for seasonal decorations just out of his reach.
-When staff walked past the resident they briefly spoke to him, offered him fluids or would move things out of his reach.
*His spouse arrived after noon and sat next to him, interacted with him, and assisted him with his meal.

Observation and interview on 2/13/24 at 10:15 a.m. with certified homemaker M in the main dining room revealed:
*She led a group exercise program in the main dining room.
-All participants including certified homemaker M sat in a circle for that program.
*Resident 46's back faced the group of exercising residents.
-He was not invited to join or assisted to participate in the group exercise program.

Random observations on 2/14/24 between 10:00 a.m. and 2:15 p.m. of resident 46 revealed:
*The resident's morning care routine was completed in his room by certified homemaker K at 10:00 a.m.
*He was then positioned against the countertop facing the empty kitchenette in his Broda chair with the brakes locked.
-The resident sat alone and fed himself breakfast.
*At 12:15 p.m. the resident remained in his Broda

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chair in the manner referred to above.
-His breakfast food was removed.
-Two almost empty drinking cups from breakfast remained in front of him.
-Pieces of bacon and slices of banana from breakfast laid on the resident's lap and on the floor surrounding his Broda chair.
-Residents gathered in the main dining room for the noon meal.
-Resident 46's back was faced toward those residents.
*At 12:42 p.m. he remained positioned against the countertop facing the empty kitchenette and was served lunch.
-He sat alone.
-The area on the floor surrounding his Broda chair remained littered with fallen breakfast food served earlier that day.
*At 1:50 p.m. residents finished their noon meal and left the dining room.
-Resident 46 remained at the countertop with an empty lunch plate in front of him.
-The area on the floor surrounding his Broda chair remained littered with food from his breakfast and noon meals.

Review of resident 46's care plan revised on 2/8/24 revealed:
*"I dine in the main dining room."
-There was no indication he was unable to sit with other residents at a dining room table.

Interviews on 2/14/24 with certified homemaker K at 10:00 a.m. and again at 1:50 p.m. regarding the observations of resident 46 referred to above revealed:
*The resident had previously eaten his meals at a table in the main dining room.
-Staff were instructed to have the resident eat his

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meals at the kitchenette countertop after he had begun using the Broda chair in October 2023 but she had no idea why.
*She confirmed resident 46 remained in the same position at the countertop facing away from interaction and stimulation since 10:00 a.m. that morning.
*She agreed his dignity was not maintained when:
-He was left staring at an empty kitchenette for hours at a time with minimal interaction or stimulation.
-Bits and pieces of mealtime foods that had fallen onto his clothes were not removed and the area around his Broda chair littered with that same food was not cleaned up.

Interview on 2/14/24 at 2:30 p.m. with licensed practical nurse (LPN) I regarding resident 46 revealed:
*"He stays there [pushed against the countertop of the kitchenette with the Broda chair brakes locked] most of the day."
-That was a customary practice for the resident since at least October 2023.
*It was easier to "keep an eye on him" so he would not try to stand up on his own and potentially fall.

Interview on 2/14/24 at 3:10 p.m. with director of nursing (DON) B regarding resident 46's mealtime observations on 2/13/24 and on 2/14/24 referred to above revealed:
*She was not aware the resident was positioned away from the main dining room at the kitchenette counter during meals and left alone for periods in that position.
-His psychosocial well-being and his dignity were disregarded during those meal services.

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F 550	Continued From page 5 Interview on 2/15/24 at 2:45 p.m. with superintendent A, social work staff F and G regarding the observations referred to above revealed they: *Were not aware that observations like those referred to above were occurring. -Agreed the resident's psychosocial well-being and his dignity was overlooked by the staff. 2. Observation and interview on 2/13/24 at 3:50 p.m. with certified homemaker L in resident 29's room revealed: *She lifted his pant leg and emptied the urine from his urine collection bag into a collection device. *His door was left open and his care was visible to anyone walking by his room. -His privacy was not maintained. Review of the undated Resident Rights policy revealed: *"1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: -a. a dignified existence; -b. be treated with respect, kindness, and dignity;" -"d. be free from corporal punishment or involuntary seclusion, and physical or chemical restraints not required to treat the resident's symptoms;" -"t. privacy and confidentiality;" Refer to F604 and F684.	F 550		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect	F 604	1. Upon notification from DOH surveyors t that resident 46 was being placed at the kitchenette counter for long periods of time with BRODA wheelchair brakes locked, the DON and ADON immediately provided education	03/31/24

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F 604	Continued From page 6 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 indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to identify one of four sampled residents (46) seated in a wheelchair was restrained with locked brakes pushed against a countertop. Findings include: 1. Random observations on 2/13/24 between 9:45 a.m. and 12:06 p.m. with resident 46 revealed:	F 604	to LPN I, CHM K, CHM M, CHM L, DPT E, and Activities Director on the noted deficient practice. 2. All residents in the facility have the potential to be affected in a similar manner. To ensure that no other residents were affected by these deficient practices, all care plans and provider orders were reviewed to ensure that the use of restraints were indicated and the least restrictive alternative was being used. 3. All nursing staff will be assigned the "Obtaining a Restraint Free Environment" course in Relias to be completed by 03/31/24. 4. DON or designee will perform chart audits to ensure provider orders are up to date, care plans are accurate, consent was obtained, and restraints are being used appropriately if indicated. The DON or designee will complte five (5) random audits weekly for four (4) weeks, then bi-weekly for four (4) weeks, then monthly for one (1) month demonstrating that expectations are being met. Audits will begin on 03/25/24 with the potential to end on 06/25/24 pending 100% complaince. Currently, audits are being completed on all units by ADON to ensure safe practice. 5. All plan of correction audit data will be reported by the DON or designee during the monthly QAPI meeting and reviewed by the committee each monthly for three (3) months and recommendations given to assist in ensuring the facility remains in complaince. If concerns are identified, the QAPI committee will add addtional time until 100% compliance is sustained.	

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F 604	Continued From page 7	F 604		

*He sat alone facing an empty kitchenette.
-His Broda chair (a specialty wheelchair that provided supportive positioning and repositioning ability) was pushed against the kitchenette countertop and his wheels were locked.
-There was no lap belt in the chair.
*A quilt with sensory touch items secured to it was placed on the countertop in front of him.
-He occasionally grazed the items on that quilt with his fingers.
*Other times he was asleep, mumbling, repetitively moving his trunk forward then back or reaching for seasonal decorations just out of his reach.
-When staff walked past the resident they briefly spoke to him, offered him fluids or moved things out of his reach.

Random observations on 2/14/24 between 10:00 a.m. and 2:15 p.m. of resident 46 revealed:
*He sat alone facing an empty kitchenette.
-His Broda chair was pushed against the kitchenette countertop and his wheels were locked.
-There was no lap belt in the chair.
*He fed himself finger foods for breakfast and the noon meal.

Review of resident 46's electronic medical record (EMR) revealed:
*His diagnoses included: early onset Alzheimer's dementia and hypertension.
-His cognition was severely impaired and he required assistance of one or more staff to complete his activities of daily living.
*Two physician orders dated 10/23/23:
-"May lock wheelchair until anti-tippers are placed."
-"Wheelchair lap belt for safety continuous use."

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F 604	Continued From page 8 Review of resident 46's paper medical record revealed: *A physical therapy consultation was completed on 11/20/23 to determine the appropriateness of the resident using a Broda chair versus the wheelchair he was using at the time. -Subjective: "...Inconsistent reports of what 'fall' out of chair that veteran sustained. Facility cannot have him in the seat belt while up in the chair [previous wheelchair] due to being a restraint free facility. " -Recommendations: "Look for different backrest w/ [with] contour at laterals to maintain safety & not restrain." *The wheelchair the resident was using was left with the physical therapy provider at the conclusion of that consultation and he had begun using the Broda chair. Review of resident 46's care plan updated on 12/19/23 revealed: *He was at high risk for falling. -Used a Broda chair. -Used a lap belt to remind him to stay seated. -"My wheelchair can be locked until anti-tippers are placed." *There was no documentation that the resident should have been pushed against the countertop kitchenette while in his Broda chair. Interview on 2/14/24 at 2:30 p.m. with licensed practical nurse (LPN) I regarding resident 46 revealed: *"He stays there [pushed against the countertop of the kitchenette with his chair brakes locked] most of the day." -That practice was a regular occurrence since at least October 2023.	F 604		

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F 604	Continued From page 9	F 604		

*It was easier to "keep an eye on him" so he would not try to stand up on his own and potentially fall."

Interview on 2/14/24 at 3:10 p.m. with director of nursing (DON) B regarding resident 46 revealed she:
*Observed the resident seated at the kitchenette counter during the meal services but had not considered pushing him against the counter with his chair brakes locked as a restraint.
-There was a physician's order to lock the chair brakes.

Interview on 2/15/24 at 8:55 a.m. with doctor of physical therapy (DPT) E regarding resident 46 revealed:
*In November 2023, the physical therapy department completed a wheelchair evaluation for the resident.
*It was determined the Broda chair was an appropriate seating option for the resident because it:
-Provided bilateral lateral supports for improved positioning and the seat depth was better able to accommodate his leg length.
-Decreased the resident's tendency towards sliding out of the chair.
*With appropriate supervision, there was no need to push the resident against the kitchenette countertop and lock the brakes of the Broda chair.

Follow-up interview on 2/15/24 at 3:15 p.m. with superintendent A, DON B, assistant director of nursing (ADON) C, and DPT E regarding resident 46 revealed:
*The 10/23/23 physician's order regarding locking the wheelchair brakes until anti-tippers arrived

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F 604	Continued From page 10 was invalid. -DPT E explained the anti-tippers were intended for use with the wheelchair the resident previously used and not for the Broda chair. *The 10/23/23 physician's order regarding the use of a lap belt was invalid. -There was no lap belt used with the Broda chair. *Superintendent A, DON B, and ADON C were not aware of that information. *They agreed to push resident 46 in front of the kitchenette counter with the Broda chair wheels locked was a restraint. Review of the 11/7/22 Physical and Chemical Restraints policy revealed: *"It is the policy of the MJF SD [Michael J Fitzmaurice South Dakota] Veterans Home that every resident has the right to be free from any physical restraint imposed or psychoactive drug administered for purposes of discipline or convenience and not required to treat the resident's medical symptoms." *"2. There must be a physician's order for the purpose of use and safety of devices and restraints." *"3. The physician's order will identify the type of restraint/posture/safety device to be used and what time it may be applied." Refer to F684	F 604		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684	1. Upon notification from DOH surveyors that resident 46 was being placed at the kitchen counter for long periods of time without repositioning and that peri-care was done incorrectly, DON and ADON immediately educated LPN I, CHM O, CHM K, and CHM N on q2h repositioning and proper and timely peri-care.	03/15/24

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F 684	Continued From page 11 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure: *One of one four residents (46) at risk for skin breakdown was repositioned according to the protocol of the facility. *One of four sampled residents (46) received proper and timely peri-care following a bowel movement. Findings include: 1. Random observations on 2/13/24 between 9:45 a.m. and 12:06 p.m. with resident 46 revealed he: *Sat in a Broda chair (a specialty wheelchair that provided supportive positioning and repositioning ability) at a countertop facing a kitchenette. -The brakes on that chair were locked. *A quilt with sensory touch items secured to it was placed on the countertop in front of him. -He occasionally grazed the items on that quilt with his fingers. *Other times he was asleep, mumbling, repetitively moving his trunk forward then back or reaching for seasonal decorations just out of his reach. -When staff walked past the resident they briefly spoke to him, offered him fluids or would move things out of his reach. Interview on 2/14/24 at 8:55 a.m. with doctor of physical therapy (DPT) E regarding resident 46 revealed: *The resident was not able to reposition himself	F 684	2. All residents residing in the facility have the potential to be affected in a similar manner. To ensure no other residents were affected by these deficient practices, DON and ADON educated the household coordinators and nurses on repositioning and peri-care procedures to ensure the CNA's are following provider orders and care plans correctly. 3. A change was made to the repositioning documentation in the EMR software program, American Data. The "Repositioning" button was changed from purple (as needed charting) to green (required charting). The change will alert staff that repositioning is required and will ensure that repositioning is consistently performed per provider orders and care plan. All nursing staff will complete the "Catheter and Perineal Care" and "Wheelchair Repositioning" skills competency. 4. The DON or designee will perform five (5) random audits weekly times four (4) weeks, then bi-weekly times four (4) weeks, then monthly times one (1) month. Audits will begin on 03/25/24 with the potential to end o6/25/24 pending 100% compliance has been achieved. 5. All plan of correction audit data will be reported by the DON or designee during the monthly QAPI meeting and reviewed by the QAPI committee each month times 3 months and recommendations given to assist in ensuring cthat the facility remains in complaince. If coincerns are identified, the QAPI committee will add additonal time until 100% compliance is sustained.	

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	43A136	A. BUILDING _____ B. WING _____	02/15/2024

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without staff assistance.
-He was non-ambulatory and required caregivers to anticipate and meet his needs.
*He was expected to have been repositioned no less than every two hours.

Random observations on 2/14/24 between 10:00 a.m. and 2:15 p.m. of resident 46 revealed he:
*Sat in that Broda chair positioned at the countertop facing a kitchenette.
-The brakes on that chair were locked.
*Fed himself finger foods at breakfast and for the noon meal.

Observation and interview on 2/14/24 with certified homemaker K at 12:48 p.m. and again at 2:15 p.m. regarding resident 46 revealed:
*She confirmed resident 46 remained in the same position at the countertop since 10:00 a.m. that morning when she positioned him there.
-He should have been repositioned out of the Broda chair more than once during that time.
*Shift change occurred a little after 2:00 p.m. at which time certified homemaker K left work and oncoming staff repositioned the resident to his bed and changed his soiled incontinence brief.
-That was over four hours without checking or changing his incontinent brief or being repositioned.

Interview on 2/14/24 at 2:30 p.m. with licensed practical nurse (LPN) I regarding resident 46 revealed:
*"He stays there [pushed against the countertop of the kitchenette with the Broda chair brakes locked] most of the day."
-That was a customary practice for the resident since at least October 2023.
*It was easier to "keep an eye on him" so he

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would not try to stand up on his own and potentially fall.
*It was important the resident was routinely repositioned to prevent skin breakdown.
-That had not occurred on that date.

Review of resident 46's care plan revised on 2/8/24 revealed:
*"I need help repositioning. I use a Broda chair for safety and repositioning because I need assistance with mobility and am unable to reposition without help."
*"I have the potential to fall down and hurt myself. I am on purposeful hourly rounding."
*"I have the potential to have a skin injury."
-Repositioning interventions were not identified as an approach to reduce the resident's risk for skin injury.

Interview on 2/14/24 at 3:10 p.m. with director of nursing (DON) B regarding the observations of resident 46 referred to above revealed:
*She confirmed the resident was unable to make his needs known and relied on caregivers to anticipate and meet his care needs.
*She expected the resident to have been repositioned no less than every two hours but more frequently if that was indicated.
-The observations referred to above had not supported routine repositioning for resident 46 occurred.

Review of the 5/23/23 Repositioning policy revealed:
*General Guidelines:
-"3. Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning."
*Interventions:

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F 684	Continued From page 14 -"5. Residents who are in a chair [wheelchair] should be on an every one hour [q1 hour] repositioning schedule." 2. Observation on 2/14/24 at 2:20 p.m. of resident 46 while in his room during a mechanical lift transfer and personal care performed by certified homemaker N and homemaker O revealed: *He was transferred from his Broda-style reclining wheelchair onto his bed using a mechanical lift. *His pants and shirt had multiple areas of dried food particles adhered to the fabric. -Certified homemaker N brushed off the food particles from his shirt onto the sheet of his bed then onto the floor. -His pants were removed and placed into a soiled laundry container. *During the removal of the mechanical lift sling and his incontinence brief: -His lower abdominal skin fold had an approximate four-inch horizontal, thin, red indentation from where the fastened brief was creased. -His posterior skin had multiple, dark red, indentation marks, that varied in size and shape, extending from about four inches above his knees to his upper buttocks. -His incontinent brief was saturated with urine and contained an unformed, partially dried, bowel movement (BM). -That BM was adhered to the inner skin folds of his buttocks and anal area. *Certified homemaker N cleansed the resident's genital area and buttock folds while homemaker O stood on the opposite side of the bed supporting the resident in a side-lying position. -During that time, resident 46 had swung his legs off the opposite side of the bed. -Certified homemaker N and homemaker O had	F 684		

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not attempted to reposition the resident's legs.
*Certified homemaker N was not observed cleansing the BM off the resident's skin that surrounded his anal area.
*When homemaker N was asked to allow viewing of the anal area it was visually confirmed BM was remaining around the anal area.
-Homemaker N had not viewed that area while lifting his buttock fold.
-She then applied barrier cream to the resident's buttock folds and applied a clean incontinent brief.
-The call light was placed within the residents reach, the garbage was removed from the resident's room and the homemakers left the room after performing hand hygiene.

Interview on 2/14/24 at 2:40 p.m. with certified homemaker N regarding the above observation revealed she:
*Was not aware BM remained on the resident's anal area.
-Stated she was in a hurry to cleanse the resident's perineal area because she was worried he would roll out of the bed.
-Had not offered an explanation as to why his legs were not repositioned back onto the bed.
*Had not returned to the room to complete the cleansing of the resident's anal area.

Interview on 2/14/24 at 3:10 p.m. with director of nursing (DON) B regarding the above observation revealed:
*She expected resident 46's incontinent brief to have been checked and his body repositioned at least every two hours.
*Stated she was "mortified" and that was not how she expected his care to have been provided.

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F 684	Continued From page 16 Observation and interview on 2/14/24 at 3:30 p.m. with DON B and homemaker O while resident 46 was laying in his bed revealed: *He was turned onto his side, his incontinent brief removed, and DON B agreed the skin to his backside continued to have tan-colored indentations to his upper thighs and buttocks area and that BM remained around his anal area. -Homemaker O had to repeatedly cleanse the resident's anal area to remove the BM. *Homemaker O informed DON B the resident had a small open area and pointed to an approximate 0.2 cm red circular area on the resident's inner right buttock near his anal opening. -DON B stated that was not an open area, but was a reddened area. *Barrier cream was applied to the area by homemaker O and a new incontinent brief was applied. Review of resident 46's nurses notes that were dated 2/14/24 at 5:23 p.m. and entered by DON B revealed "GENERAL SKIN CONDITION: skin issues noted SKIN PROBLEMS: abrasion [sp] vs. pressure wound. LOCATION: R buttock, sacral area D[d]imensions of wound (LxWxD) [length by width by depth]: Approx 0.5 x 0.2 cm[centimeters]. SKIN TREATMENT: Area cleansed well, barrier cream applied ACTION: continue to observe R[r]epositioned." Review of the provider's October 2021 Perineal Care policy revealed: *"10. For a male resident:" -"h. Wash and rinse the rectal area thoroughly, including the area under the scrotum, the anus, and the buttocks."	F 684		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686	1. After identification that resident 27 did	03/15/24

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F 686	Continued From page 17 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to: *Ensure the paper copy of the standardized protocol for stage II pressure ulcer interventions was followed according to policy for one of two sampled residents (27) with a stage II facility acquired pressure ulcer (a skin injury incurred while residing at the facility). *Implement the use of a pressure-reducing device to mitigate the risk for one of two sampled residents (27) who developed a stage II facility acquired pressure ulcer. Findings include: 1. Observations on 2/13/24 at 11:00 a.m. and again at 12:05 p.m. of resident 27 revealed he: *Participated in group exercise seated in his wheelchair. *Ate lunch in the main dining room seated in his wheelchair. -There was a pressure reducing cushion on the	F 686	not have the proper pressure relieving source for his recliner, the resident care coordinator (RN) received a provider order for a pressure relieving and Physical Therapy applied it to Resident 27's recliner. 2. All residents in the facility have the potential to be affected in a similar manner. To ensure that no other residents were affected by these deficient practices, DON and ADON reviewed current provider orders and care plans to ensure that all residents with pressure relieving mattresses also had proper pressure relieving cushions in their wheelchairs and recliners. 3. The Pressure Ulcer Prevention and Reporting Policy was updated on 02/26/24 to include that if a pressure relieving device is needed and ordered, the provider order will include bed, wheelchair, and recliner. The policy be uploaded to Relias for all nursing staff to review. 4. The DON or designee will perform five (5) random audits ensuring all residents at risk for pressure ulcers have the appropriate pressure relieving device ordered, care planned and in place. Audits will occurr weekly times four (4) weeks, then bi-weekly times four (4) weeks, then monthly times one month. Audits will begin on 03/25/24 with the potential to end on 06/25/24 pending 100% compliance. 5. All plan of correction audit data will be reported by the DON or designee during the monthly QAPI meeting and reviewed by the QAPI committee each month for three (3) months and recommendations given to ensure the facility remains in	

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F 686	Continued From page 18 seat of his wheelchair. Review of resident 27's electronic medical record (EMR) revealed a 2/8/24 nurse progress note: *An open area to the resident's right buttock was identified. *It was a one centimeter (cm) by one cm open area with a red wound bed. Interviews on 2/13/24 at 3:18 p.m. and again on 2/14/24 at 1:19 p.m. with licensed practical nurse (LPN) I regarding resident 27 revealed: *He had an open area on his right buttock that was identified a few weeks ago. -It was covered with a Mepilex border (a foam-type wound dressing) and was changed after his bi-weekly bath and as needed. *The resident's wheelchair was his primary mobility source. -The cause of his pressure ulcer was due to "chronic sitting." Observation and interview on 2/13/24 at 5:00 p.m. and again on 2/14/24 at 9:30 a.m. with resident 27 in his room revealed: *He sat in his recliner but was able to stand up from the chair on his own when asked to do so. *On the seat of the recliner was a folded, lap-sized blanket laid on top of the following: -A small, black, flat pillow at the front edge of the recliner seat. -A wrinkled blanket behind the black pillow at the back of the recliner seat. *He had a sore on his bottom. -Staff changed a bandage that covered his sore. *He was not aware what had caused the sore. *There was a pressure-reducing mattress on his bed.	F 686	compliance. If concerns are identified, the QAPI committee will add additional time until 100% compliance is sustained.	

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Interview and review of resident 27's February 2024 Treatment Administration Record (TAR) on 2/14/24 at 3:30 p.m. with LPN I revealed the following:
*A nursing order for a skin treatment was started on 2/8/24.
-Change Mepilex with border on the resident's right buttock two times per week on Thursday's and Sunday's and as needed until resolved.
*That nursing order came from a standardized protocol that included skin treatment interventions approved by a medical provider.
-A paper copy of the standardized protocol was kept in the same binder with the residents' Medication Administration Records (MAR) and the TARs.

Review of the paper copy of the standardized protocol referred to above revealed the following skin treatment intervention for a stage II pressure ulcer: "Write an order for Mepilex with border change 3X wk [three times per week] and PRN [as needed]."

Interview on 2/15/24 at 1:05 p.m. with director of nursing (DON) B and assistant director of nursing (ADON) C regarding prevention and treatment of resident 27's stage II pressure ulcer revealed:
*There was a discrepancy between the paper copy of the standardized protocol for treatment of a stage II pressure ulcer (dressing change three times per week) and the stage II pressure ulcer treatment order on resident 27's TAR (dressing change two times per week).
-That was a system failure that neither DON B or ADON C had been aware of until now.
*The resident's dressing was expected to have been changed three times per week not two times per week following the standardized

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protocol approved by the medical provider.
*DON B and ADON C stated the black pillow on resident 27's recliner was a gel cushion.

Observation and interview on 2/15/24 at 1:50 p.m. with DON B, ADON C, and resident 27 in his room revealed:
*When the resident was asked to stand from his recliner, DON B and ADON C confirmed:
-The black pillow was not a gel cushion.
-The folded and wrinkled bedding also on the recliner sheet had not provided resident 27 appropriate pressure relief for his buttocks or mitigated his chance of further pressure ulcer development.
*Resident 27 was agreeable to having a cushion placed in his recliner.
-He stated "That would be more comfortable" than what was on his chair seat now.
*He slept in his recliner and not in his bed at night.
-DON B and ADON C were unaware of resident 27's sleeping preference and that made his need for an appropriate recliner cushion even more critical.

Review of the 11/7/22 Pressure Ulcer Prevention and Treatment policy revealed:
*"It is the policy of the Michael J Fitzmaurice South Dakota Veterans Home that all residents be protected from pressure ulcers and have a protocol in place to treat."
*General Care Issues and Interventions:
-"11. Use pressure-reducing devices."

2. Observation on 2/14/24 at 9:04 a.m. of resident 27 in the Old Glory bathhouse during application of a pressure ulcer dressing by LPN I revealed:
*When the resident shook the surveyor's hand,

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his skin felt dry and rough to the touch.
*He had a thin frame with little fat tissue located on his buttocks.
-His buttock bones were visible while he was standing.
-He had a newly healed pressure ulcer to his right inner buttock with intact pink skin.
-There were dry flakes of loose skin surrounding the newly healed pressure ulcer.
*LPN I placed a Meplex foam boarder dressing on the healed ulcer site.
*Lotion was not applied to the resident's dry skin.

Interview on 2/14/24 at 9:20 a.m. and again at 10:45 a.m. with LPN I regarding resident 27's pressure ulcer skin care revealed:
*LPN I stated he monitored all dressings on a daily basis and changed them according to the ordered dressing change schedule and as needed.
-Skin checks and dressing changes were usually performed following the resident's twice-weekly baths.
*Resident 27's pressure ulcer prevention interventions consisted of:
-Encouraging walking.
-A pressure-relieving mattress.
-A gel cushion in the resident's wheelchair.
*The resident spent a lot of time in his recliner in the evenings but got up a lot and moved around.
*He thought there was a pressure relieving cushion in the recliner seat with towels covering the cushion.
-He agreed towels were not made to have been used as a pressure relieving device.
*He stated sometimes preventative skincare interventions were missed as he was busy performing other tasks and had to care for residents located in two separate hallways.

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F 800 SS=D	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of two sampled residents (57) with a physician ordered renal dialysis diet was implemented. Findings include: 1. Observation and interview on 2/13/24 at 2:57 p.m. with resident 57 revealed he: *Appeared tired, was yawning, and stated he had just returned from renal dialysis. *Had been a resident at the nursing facility for about a month and resided on the Joe Foss hallway. -Had been a resident of the independent living part of the facility but was hospitalized due to a spike in his potassium levels and was transferred back from the hospital into the nursing facility. *Had been receiving renal dialysis for about four years. *Was supposed to be receiving a renal diet, but had not received a renal diet since he was admitted. -Stated, "Yesterday I had a grilled cheese and potato soup. That was what they served me. They are both high in phosphorus." *Felt his diet was very important and would have preferred a renal diet. 2. Observation and interview on 2/13/24 at 4:57	F 800	1. Upon identification that resident 57 was not receiving the renal dialysis diet as ordered, the DON spoke with the Certified Dietary Manager (CDM) to ensure would begin to recieve the renal dialysis diet immediately. 2. All residents in the facility have the potential to be affected in a similar manner. To ensure no other residents were affected by this deficient practice, DON and ADON reviewed provider orders and ensured each resident with a renal dialysis diet order were receiving the appropriate renal dialysis diet. 3. The resident care coordinators (RN) will inform the CDM each time a new renal dialysis diet order is received or when a renal dialysis diet has been updated. The CDM will update the diet card and educate dietary staff of diet. The CDM will also provide education to all dietary staff the location of diet cards and how to properly read diet cards. 4. The DON or designee will perform five (5) random audits during mealtimes to ensure residents are receiving renal dialysis diets. Audits will be completed weekly times four (4) weeks then bi-weekly times four (4) weeks then monthly times one (1) month. Audits will begin 03/25/24 with the potential to end on 06/25/24 pendin 100% compliance. 5. All plan of correction audit data will be reported by the DON during the monthly QAPI meeting and reviewed by the QAPI committee each month times 3 months and recommendations given to assist in ensuring the remains in complaince. If concerns are identified, the QAPI committee will add additional time until 100% complaince is sustained.	03/15/24

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p.m. with dietary aide P in the Joe Foss dining room revealed:
*He was serving the supper meal, and while serving, the resident homemakers told him there was one person who received finger foods, two persons who received pureed foods, and one person who received ground meat.
-All other residents were served the main meal.
*He voiced he had worked at the facility for about three months, had all the resident's food likes and dislikes memorized but depended on the nurse to tell him if a resident was on a special diet.
-He shared he would ask his dietary manager if no one else was available to inform him of any resident special diets.
-He stated there should have been a list of residents and their diet orders located in the back of the food temperature logbook that he could have referred to.

3. Review on 2/13/24 at 5:00 p.m. of the back of the food temperature logbook with dietary aide P revealed a printout of several resident's face sheets along with their dietary orders; resident 57 was not included.
*He was unsure who was responsible for updating the resident's diet order sheets.
-There were no instructions on dietary restrictions or types of dietary restrictions available.
-There was not a renal diet food substitutions list available for the dietary aide.
*He was unable to identify if any of the residents that were served should have received a renal diet.

4. Review of resident 57's electronic medical record revealed:
*An admission date of 1/12/24.
*Diagnoses of end-stage renal disease (ESRD),

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F 800	Continued From page 24 type 2 diabetes mellitus with diabetic chronic kidney disease, and renovascular hypertension. *A 1/12/24 physician order for a dialysis diet with regular consistency liquids. -The physician order stated the resident agreed to make a conscious effort to adhere to the diet ordered. *A 1/16/24 care plan entry that identified he was on a dialysis diet. -The care plan's approaches indicated he would receive the diet of his choosing and education regarding a dialysis diet. -The care plan's goal indicated he would have his nutritional needs met. *Two entries on 1/15/24 and again on 1/21/24 from registered dietitian Q which stated the resident was receiving a dialysis diet and to continue with current nutrition interventions. 5. Observation on 2/15/24 at 11:30 a.m. of resident 57 revealed: *He had just returned from his dialysis appointment and went to the Joe Foss dining room to eat. -He was served the main lunch meal that consisted of a grilled chicken patty on a bun with a side of honey mustard sauce, a dill pickle, french fries, and a tossed salad with dressing. *The resident removed the bun and the honey mustard sauce and set them next to his plate. 6. Interview on 2/15/24 at 11:46 a.m. with dietary aide R in the Joe Foss dining room revealed: *She was unsure if there were any residents on a renal dialysis diet. -Stated, "I just serve the food." *If there were any specialized diets, her dietary manager would have notified her, and the food would have been sent up pre-prepared from the	F 800		

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main kitchen.
*The homemakers would have known of any residents on a renal dialysis diet.

7. Interview on 2/15/24 at 11:47 a.m. with certified homemaker S in the Joe Foss dining room revealed she had moved up to the floor one week ago and as far as she had known there were no residents on a renal dialysis diet.

8. Interview on 2/15/24 at 11:50 a.m. with registered nurse (RN) T on the Joe Foss hall revealed he identified resident 57 as having a renal dialysis diet order, but was unsure if he was being served that type of diet.

9. Interview on 2/15/24 at 2:47 p.m. with dietary manager H regarding renal dialysis diets revealed:
*He was unable to name the two residents on a renal dialysis diet until he looked them up on the computer.
*Those orders were entered into the electronic record called 'Net Menu' once they were received by the dietitian.
-He would verbally tell the cooks and the dietary aides of the specialized diet.
*He expected the household units to let the kitchen know if there were any specialized diets.
-The homemakers could call the kitchen and ask for a specialized diet if one had not been received.
*There was a food substitutions list for renal diets located in the main kitchen.
-The renal dialysis diets were prepared in the main kitchen and sent up to the resident's hall.
*There was no information or instruction available to the kitchen staff regarding the residents who were to receive a physician-ordered renal dialysis

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F 800	Continued From page 26 diet. *The diets in the located in the food temperature log books got updated whenever there was a change in the diet. -He had updated those books recently. *Stated the dietitian was in the facility full-time every week. -He expected the books to have been updated and staff to have been familiar with those resident's who had specialized diets. *Agreed renal dialysis diets were important for the resident. 10. Phone interview on 2/15/24 at 3:15 p.m. with registered dietitian Q regarding the renal dialysis diet for resident 57 revealed: *The resident care coordinators (RCCs) should have been responsible for notifying the kitchen staff, since they were notified of the resident's diet by the physician's. *Residents 57's diet order should have been followed on admission from the independent living part of the facility. -She had not visited resident 57 since his admission into the nursing facility and was not aware he had not been receiving a renal dialysis diet. *It was her expectation for resident 57 to have received a renal dialysis diet. Review of the provider's February 2021 Cura Standard Diet List had listed renal diets as part of the offered diets but it had not included instruction on how the physician-ordered diets were to have been communicated with staff.	F 800		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880	1. A) Upon identification that 1 of 6 whirl-pools were not disinfected properly, the household coordinator (HHC) provided	03/31/24

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F 880	Continued From page 27 §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 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,	F 880	immediate education to CNA J on whirlpool disinfecting procedures. 1. B) Upon Identification that LPN I and CHM L did not follow appropriate use of PPE, the Infection Prevention (IP) nurse provided immediate education on proper and safe PPE use for residents on transmission-based precautions. 1. C) Upon identification that LPN I did not follow appropriate procedural technique, hand hygoiene and glove use during wound care, DON and IP nurse will provide education on wound care policy and procedure. 2. A) All residents have the potential to be affected in a similar manner when infection control practices are not followed by all staff. The HHC's will provide education and competencies to all nursing staff, including agency staff on the whirlpool policy and procedure by 03/31/24. 2. B) All residents have the potential to be affected in a similar manner when infection control practices are not followed by all staff. The IP nurse will provie PPE education/comptency during the all staff meeting on 03/12/24. IP nurse will complete training with staff unable to attend the all staff meeting to ensure all staff have completed PPE education and compretency training by 03/31/24. 2.C) All residents have the potential to be affected in a similar manner when infection control practices are not followed by all staff. Thenurse educator (RN) will complete the following competencies: procedural technique, hand hygiene, and proper glove use during wound care for all nurses, including agency staff by 03/31/24.	

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F 880	Continued From page 28 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: Based on observation, interview, record review, and policy review, the provider failed to ensure infection prevention and control practices were implemented for the following: *Effective whirlpool (WP) tub cleaning by one of one certified homemaker (J) in one of five multi-use resident WP tub rooms after bathing one of one sampled resident (8). *Appropriate mask, face shield, and gown use by one of one licensed practical nurse (LPN) (I) during care for one of four sampled residents (34) on transmission-based precautions (TBP).	F 880	3. A) Using root cause analysis, it was determined that more education on the whirlpool disinfection porcedures should be provided to agency staff during orientation. 3. B) Using root cause analysis, it was determined that staff forgot to utilize the donning and doffing procedural chart that is posted in each isolation room in the event reminders are needed when following the proper procedure for transmission based precautions. 3.C) Using root cause analysis, it was determined that more wound care education should be offered to agency staff during orientation. We have learned the returning from the COVID crisis is challenging. Ongoing changes and revisions to policies and procedures are frequently required to ensure best practices are being used in the care of residents. It is important to verify competency levels of agency staff during orientation to the facility to ensure they have the approriate skills to provide safe care to our residents and have the proper understanding of transmission-based precautions. The IP nurse contacted the South Dakota Quality Improvement Organization on 03/12/24 and received the following response: "Please email the actual 2567 and the original SD DOH correspondence (except don't send the identifier listings). If this is intended to be the usual DPOC QIO recommendation, the process is the QIO reviews the examples cited for the deficiency, and any root cause analysis work conducted concerning F880 along with scheduling a phone visit to discuss the citation, RCA, and mitigation efforts planned. Once I review the original	

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F 880	Continued From page 29 *Appropriate face shield and mask use by one of one certified homemaker (L) during care for one of four residents (52) on TBP. *Appropriate hand hygiene, glove use, and dressing application by one of one LPN (I) during a dressing change for one of two sampled residents (27). Findings include: 1. Observation and interview on 2/13/24 at 10:00 a.m. with certified homemaker J in the WP tub room revealed: *She used the following process to clean the WP tub after bathing resident 8: -While the WP tub filled with water she pressed the disinfectant button on the control panel a few times then added (by her estimation) 1/2 cup of disinfectant solution from the disinfectant container stored beneath the control panel. -Filled the WP tub almost 3/4 full of water, scrubbed the inside of the WP tub and the tub chair while running the air jets. -Planned to scrub the WP tub again after 15 minutes then drain, rinse and dry the tub. -Used that same WP cleaning process between each resident's bath. *WP tub cleaning instructions were posted on the control panel of the tub but she had not referred to them during the above observation. Follow-up interview on 2/13/24 at 10:45 a.m. and review of the posted WP tub cleaning instructions with certified homemaker J revealed: *She was not aware when the disinfectant button on the control panel was pressed, the cleaning solution entered the tub through jets on the bottom of the tub. -The bottom of the tub was expected to have been covered with disinfectant before scrubbing	F 880	correspondence you received from the SD DOH / OLC, I can more clearly determine the extent of the QIO review and your questions." 4. A) The DON or designee will complete three (3) random audits of whirlpool disinfectionover all shifts weekly times four (4) weeksthen bi-weekly times four (4) weeks thenmonthly times two (2) months. Audits will begin 03/25/24 with the potential to end on 07/25/24 pending 100% complaince. All plan of correction audit data will be reported by the DON or designee during the monthly QAPI meeting and reviewed by the QAPI committee each month times four (4) months and recommendations given to ensure the facility remains in complaince. If concerns are identified, the QAPI committee will add additonal time until 100% compliance is sustained. 4. B) The DON or designee will compete three (3) random audits of PPE donning & doffing during transmission-based precautions over all shifts, weekly times four (4) weeks then bi-weekly times 4 weeks then monthly times two (2) months. Audits will begin on 03/25/24 with the potential to end on 07/25/24 pending 100% complaince. All plan of correction audit data will be reported by the DON or designee during the monthly QAPI meeting and reviewed by the QAPI committee each month times four (4) months and recommendations given to ensure the facility remains in complaince. If concerns are identified, the QAPI committee will add additonal time until 100% complaince is sustained. 4. C) The DON or designee will complete 3 random audits of procedural technique, hand hygiene, and glove use during wound	

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F 880	Continued From page 30 the interior of the tub and the tub chair. *The WP tub should not have been filled with water during the cleaning process. *The disinfectant remained on the surface of the tub for 10 minutes before it was drained, rinsed, and dried. *She was not cleaning the tub according to the posted instructions. 2. Observation on 2/13/24 at 12:30 p.m. of resident 34 in the dining room revealed: *He sat with his head down towards his chest and his meal was uneaten. *An unidentified caregiver was taking his vital signs because he had seemed ill. Interview on 2/13/24 at 3:00 p.m. with licensed practical nurse (LPN) I regarding resident 34 revealed: *He assessed the resident after his vital signs were taken at 12:30 p.m. then called the resident's medical provider to discuss his findings. -The medical provider ordered the resident transfer to the local emergency department (ED) for further evaluation and treatment. Interview on 2/13/24 at 5:10 p.m. with LPN I revealed: *He received a report from the ED that resident 34 was returning to the facility via non-emergent ambulance transport. -The resident was diagnosed with COVID-19 while at the ED. Observation and interview on 2/13/24 at 5:30 p.m. with infection preventionist (IP) D outside of resident 34's room revealed: *A personal protective equipment (PPE) cart was	F 880	care over all shifts, weekly times four (4) weeks then bi-weekly times four (4) weeks then monthly times two (2) months. Audits will begin on 03/25/24 with the potential to end on 07/25/24 pending 100% compliance. All plan of correction audit data will be reported by the DON or designee during the monthly QAPI meeting and reviewed by the QAPI committee each month times four (4) months and recommendations given to ensure the facility remains in complaince. If concerns are identified, the QAPI committee will add addtional time until 100% compliance is sustained.	

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placed outside of the resident's room.
*He was transported to his room by gurney escorted by ambulance crew members.
*Donning only a pair of gloves, LPN I entered the room, helped move the resident from the gurney to his bed, received report from the crew members, and settled the resident into his bed.
*IP D expected LPN I had performed hand hygiene, donned a gown, an N95 mask, and face shield prior to entering resident 34's room.

3. Observation and interviews on 2/13/24 at 5:15 p.m. and again at 5:45 p.m. with certified homemaker L outside resident 52's room revealed:
*Symptomatic residents were tested for COVID-19 after it was confirmed resident 34 had COVID-19.
-Four residents including resident 52 tested positive for COVID-19.
*Before entering resident 52's room to take his vital signs she performed hand hygiene then:
-Donned a gown and a pair of gloves.
-Placed an N95 mask on top of the surgical mask she was already wearing.
-Donned a face shield.
*Before exiting his room she discarded her gloves and gown and then performed hand hygiene.
*After leaving the room she:
-Placed her face shield on the medication cart without cleaning it.
-Removed her unclean N95 mask but continued to wear the surgical mask that was underneath the N95 mask.
*Her face shield was expected to have been cleaned with a disinfectant wipe after it was used.
*Her surgical mask was expected to have been discarded before donning an N95 mask.

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F 880	Continued From page 32 Telephone interview on 2/15/24 at noon with IP D regarding the observations referred to above revealed: *The instructions posted on the WP tub control panel for the WP cleaning procedure were updated on 1/9/24. -Those instructions were consistent with the Whirlpool and Whirlpool Room Cleaning and Disinfectant policy with the same date. -Certified homemaker J was not following the expected WP cleaning process according to the instructions on the WP tub and the provider's WP cleaning policy. *Correct use and re-use of PPE for COVID-19 positive residents was not followed by certified homemaker L. -Her unclean surgical mask should have been removed and hand hygiene performed before donning a clean N95 mask and entering resident 52's room. -Re-usable face shields were expected to have been cleaned after exiting the room of a resident on TBP. Review of the 3/30/23 Standard Precautions policy revealed: *Standard Precautions include the following practices: -"3.a. Wear mask and eye protection or a face shield to protect mucous membranes of the eyes, nose, and mouth during procedures and resident-care activities that are likely to to generate splashes or sprays of blood, body fluids, secretions and excretions." -"4.a. Wear a gown to protect skin and prevent soiling of clothing during procedures and resident care activities that are likely to generate splashes of sprays of blood, body fluids, secretions, excretions or cause soiling of clothing."	F 880		

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MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME	2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 33	F 880		

*Initiating Transmission-Based Precautions:
-"Transmission-based precautions will be initiated when there is reason to believe that a resident has a communicable infectious disease. Transmission-based precautions may include contact precautions, droplet precautions, or airborne precautions."
4. Observation on 2/14/24 at 9:04 a.m. with resident 27 in the WP tub room during a dressing change performed by LPN I revealed:
*LPN I washed his hands for approximately ten seconds and shut off the water faucet using the back of his wet left hand before drying his hands on a paper towel.
-He pulled a pair of gloves from his uniform pocket and applied them to his hands.
*When he peeled off the protective plastic barrier from the back of a Meplex foam border dressing, he placed his gloved index finger on the interior center of the exposed foam pad of the dressing.
-He then applied that dressing over resident 27's pressure ulcer site.
*He removed his gloves and washed his hands for approximately nine seconds and again turned off the water faucet using the back of his wet hand.

Interview on 2/14/24 at 9:20 a.m. with LPN I regarding the above observations with resident 27 revealed:
*He wore extra large gloves and they were not always available in the room he was working in, so he kept several pairs in his uniform pocket.
-Agreed his uniform pocket was not a clean area as his hands were in and out of his pockets multiple times a day.
*He thought turning off the faucet with the back of his hand was an acceptable practice.
*He had not realized he washed his hands for an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A136	A. BUILDING _____ B. WING _____	02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME	2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 34	F 880		

inappropriate amount of time.
*He had touched the interior center of the dressing pad to keep his gloves from sticking to the dressing's adhesive border.
*Stated he had tried not to do those things but got in a hurry.

Review of the provider's 8/10/23 Wound Care-Dressing Change Policy revealed dressings were to have been opened by pulling the corners of the exterior wrapping outward, touching only the exterior of the dressing.

Review of the provider's undated Handwashing and Hand-Hygiene Policy revealed:
*"Policy Interpretation and Implementation."
-"2. All personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors."
-"3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc [etcetera]) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies."
-"11. Washing Hands. a. Vigorously lather hands with soap and rub them together, creating friction to all services [surfaces], for a minimum of 20 seconds under a moderate stream of running water..."
-"11. c. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel."
-"13. Applying and removing gloves. a. When applying, remove one glove from the dispensing box at a time, touching only the top of the cuff."

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
	43A136	A. BUILDING **02 - 2015 BUILDING** B. WING _____	**02/14/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME	**2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 2/14/24. Michael J Fitzmaurice South Dakota Veterans Home was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

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

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

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10523	A. BUILDING: _____ B. WING _____	02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAEL J FITZMAURICE SOUTH DAKOTA VETERAN	2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities was conducted from 2/13/24 through 2/15/24. Michael J Fitzmaurice South Dakota Veterans 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 2/13/24 through 2/15/24. Michael J Fitzmaurice South Dakota Veterans Home was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

CR Johnson

TITLE: Superintendent

(X6) DATE: 02/26/2024

STATE FORM 6899 935711 If continuation sheet 1 of 1