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
	435122	A. BUILDING _____ B. WING _____	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST WILLIAM'S CARE CENTER	103 N VIOLA ST MILBANK, SD 57252

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 06365 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 2/28/22 through 3/1/22. St. William's Care Center was found not in compliance with the following requirements: F582, F609, F610, F625, F636, F656, F758, and F909.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the	F 582		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rene' Thrift	Administrator	3/25/2022

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 582	Continued From page 1 Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Surveyor: 43021 Based on record review and interview, the provider failed to ensure the proper Medicare notices were completed appropriately and provided for one of three sampled residents (34) who had remained in the facility following her discharge from skilled services. Findings include: 1. Review of resident 34's medical record revealed: *Her last day of Medicare part A services was 1/25/22. *She had covered days remaining and continued	F 582	Facility not able to correct prior non-compliance for resident 34 as date of discharge from skilled services was 1/25/22.	

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F 582	Continued From page 2 to reside in the facility. *There was no record of a signed Skilled Nursing Facility Advance Beneficiary Notice. -This standardized notice allows Medicare beneficiaries to make informed decisions about whether to receive certain Medicare services and accept financial responsibility for those services if Medicare does not pay. *The Notice of Medicare Non-coverage form did not include the name and telephone number of the Quality Improvement Organization (QIO) for South Dakota. -This standardized notice informs Medicare beneficiaries when their Medicare covered services are ending and provides an opportunity to request an expedited determination from the QIO. -The form's instructions stated to insert the name and telephone numbers of the QIO. Interview on 3/1/22 at 5:45 p.m. with administrator A regarding the required Medicare notices revealed: *The provider's licensed social worker had retired in 12/21. *She stated the staff were unsure which notices had to be given and by whom.	F 582	ABN forms have been updated with the name and telephone number for the Quality Improvement Organization for South Dakota. The completed notices will continue to be given by the Social Service Designee or the D.O.N in her absence. Results of compliance will be reported at the next QAPI meeting and thereafter for 3 months by the Social Service Designee. The QAPI committee will determine if further monitoring is required. ADDENDUM to F582 dated 4/6/2022 (RT) The D.O.N and the S.S.D received additional training on the completion of the Skilled Nursing Facility Advance Beneficiary Notice by the SW Consultant 3/14/2022. Subsequent training for other staff will be provided by the SSD as the need arises. System change: The Social Service Designee or her designee will maintain a list of the ABNs issued and verify that they were completed accurately and timely. The system change will be monitored by the Social Services Designee or her designee and reported to QAPI committee on a monthly basis for 3 months, The QAPI committee will determine if further monitoring is needed. (RT)	3/28/22
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(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,	F 609		

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F 609	Continued From page 3 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. This REQUIREMENT is not met as evidenced by: Surveyor: 45383 Based on observation, interview, record review, and policy review, the provider failed to ensure two injuries of unknown source had been reported to the South Dakota Department of Health in a timely manner and thoroughly investigated for one of one sampled resident (13) who could not explain how the injuries occurred. Findings include: 1. Observation on 2/27/22 at 5:04 p.m. of resident 13 and record review revealed: *The resident was not able to communicate and had multiple psychological diagnoses that affected her cognitive and mental functioning. *Licensed practical nurse (LPN) MM noted on 1/5/22 multiple small unexplained bruises to	F 609	ADDENDUM to F609 dated 4/8/22 (RT) Utilizing the facility's charting system, reports will be generated to identify other residents with past incidents or injuries that potentially should have been reported and investigate any findings. The SD Department of Health Event Reporting protocol has been reviewed by Administrator, and other key personnel. Facility wide re-training is being scheduled to assure that staff understand the importance of immediate reporting injuries/incidents that are unexplained so that immediate investigation can take place. System change: Staff members with the responsibility of reporting injury of unknown origin will initiate the process within the allotted timeframe as outlined in the Event Reporting protocol and inform the administrator or designee of the report initiation so the followup investigation is completed timely. This will ensure reports are submitted timely and thoroughly investigated. The system change will be monitored by the DON and/or Administrator or designees weekly for the first month. Aggregate data will be given to the QAPI committee to review within 1 month and thereafter for the next 2 quarters. The QAPI committee will determine if further monitoring is required. (RT)	4/20/22

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F 609	Continued From page 4 resident 13's left arm. Interview with LPN MM on 3/1/22 at 10:19 a.m. revealed she was unsure of the bruises had been reported. Refer to F610, finding 1. 2. Review of resident 13's record also revealed an unexplained abrasion was noted on 1/14/22 under her right breast. Interview with director of nursing C and LPN/wound nurse NN revealed the source of the abrasion had not been reported. Refer to F610, finding 2.	F 609	(F609) Facility not able to correct prior non-compliance of reporting investigations for resident 13. All staff will be re-educated in recognizing and immediately reporting all allegations of abuse, neglect, exploitation or mistreatment beginning with re-education as of 3/25/2022. This plan will be effective 4/15/22, Compliance with reporting injuries of unknown origin will be monitored weekly by the DON or Administrator. Results of compliance will be reported at the next QAPI meeting and thereafter for 6 months. The QAPI committee will then determine if further monitoring is required.	
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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. This REQUIREMENT is not met as evidenced by:	F 610		

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F 610	Continued From page 5 Surveyor: 45383 Based on observation, interview, record review, and policy review, the provider failed to thoroughly investigate two injuries of unknown source for one of one resident (13). Findings include: 1. Observation on 2/27/22 at 5:04 p.m. of resident 13 revealed she was sitting up in her wheeled high back chair and she did not communicate verbally. Review of resident 13's record revealed: *She was admitted on 12/3/21. *She has multiple psychological diagnoses that affected her cognitive and mental functioning, including delusional disorder, bipolar disorder, schizoaffective disorder, and catatonic state. *She needed extensive transfer assistance using Hoyer lift and two staff. *A progress note on 1/5/22 at 2:41 p.m. by licensed practical nurse MM (LPN) that identified multiple small hematomas (bruises) of "unknown origin (unexplained) to left arm." Interview on 3/1/22 at 8:41 a.m. with director of nursing (DON) C regarding the above incident revealed she was not aware of the bruising and confirmed: *No incident report had been completed. *No investigation had been conducted. Interview on 3/1/22 at 10:19 a.m. with LPN MM regarding her documentation revealed she: *Had reported finding the bruise to the next shift to follow-up on. *Was unsure if an incident report had been completed. *Should have completed an incident report.	F 610	Facility not able to correct prior non-compliance of resident 13 although investigation took place during survey. All allegations of abuse, neglect, exploitation or mistreatment will be thoroughly investigated, including extensive interviewing of all persons involved--this will begin immediately. Following the initial notification of the incidents, the investigation may include but is not limited to, resident, staff, family, visitor interviews and direct observation. The investigator will also consider activities, personal care schedules, off-site appointments/activities that occurred prior to the discovery of an injury and include these findings in the report. Compliance will be monitored by the DON or designee, Administrator or designee and results of compliance reported at the next QAPI meeting and thereafter for 5 months. The QAPI committee will determine if further monitoring is required.	4/15/2022

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F 610	Continued From page 6 2. A progress note on 1/14/22 by an unknown author in resident 13's record revealed an abrasion to resident 13's right breast had been caused by using a lift belt. Interview on 3/1/22 at 8:41 a.m. with DON C revealed: *She had been aware of the abrasion. *She thought staff were using a belt to transfer resident 13 onto a bath chair. *No investigation or further inquiries were made, nor incident report completed. *Staff usually reported to her any harm caused to residents. *The wound nurse would evaluate any skin issues. Interview on 3/1/22 at 9:44 a.m. with LPN/wound nurse NN regarding skin evaluations revealed: *The nurse that identified the skin issue should have documented the findings. *She would follow up with identified skin issues. *Staff would leave her notes. *Significant skin issues should be reported immediately. Interview on 3/1/22 at 12:20 p.m. with administrator A regarding the above incidents revealed she: *Had not been aware of the two incidents. *Would expect staff to complete an incident report. *Would investigate incidents that resulted in resident harm. Review of provider's 1/05 Abuse, Neglect and Misappropriation of Property policy revealed: *"The facility has developed and implemented this	F 610	ADDENDUM to F610 dated 4/6/22 (RT) Utilizing the facility's charting system, reports will be generated to identify if resident 13 or other residents had past incidents or injuries that potentially should have been reported and investigate any findings. The SD Department of Health Event Reporting protocol has been reviewed by Administrator, and other key personnel. Facility wide re-training is being scheduled to assure that staff understand the importance of immediate reporting injuries/incidents that are unexplained so that immediate investigation can take place. System change: Using our current electronic charting system, an internal memo will be generated to nursing staff when there is documentation entered into the system about the presence of an injury which will require an investigation to be initiated. The system change will be monitored by the DON and/or Administrator or designee(s) weekly for the first month. This information will be reported to the QAPI committee within 1 month and thereafter for the next 2 quarters.. The QAPI committee will determine if further monitoring is required. (RT)	

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F 610	Continued From page 7 policy and procedure, which includes the following components: screening, training, prevention, identification, investigation, protection, and reporting/response." *"Identification- staff will identify events, such as suspicious bruising of resident, occurrence, patterns, and trends that may constitute abuse; and will determine the direction of the investigation." *"Investigation- alleged violations will be investigated and will be reported to proper authorities by the administrator, director of nursing and /or social worker, or their representative."	F 610		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.	F 625		

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F 625	Continued From page 8 §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Surveyor: 45383 Based on interview, record review, and policy review, the provider failed to ensure notification of the bed hold policy had been provided to one of one sampled resident (10) upon transfer to the hospital. Findings include: 1. Review of resident 10's record revealed: *She had been transferred and admitted to the hospital on 12/17/21 and was admitted on 12/17/21 with diagnoses of pneumonia and congestive heart failure. *There was no documentation that notice of the bed hold policy was provided at the time of transfer to the hospital. *She had been discharged from the hospital on 12/19/21 back to the facility. Interview on 3/1/22 at 8:35 a.m. with director of nursing (DON) C regarding bed hold notification revealed she: *Thought bed hold notification was only required if a resident left on a temporary leave. *Confirmed a bed hold notice had not been given to resident 10 upon transfer to the hospital. Review of the provider's undated Bed Hold policy revealed: *Private pay resident's bed shall be held by the provider for the agreed length of time. The bed	F 625	The facility is not able to correct prior non-compliance for providing a bed hold policy for resident 10. The facility will provide the bed hold policy to those residents transferring to the hospital by either nursing staff or the Social Service Designee. Compliance will be monitored by the Social Service Designee and/or DON and results of compliance reported at the next QAPI meeting and thereafter for 3 months. The QAPI committee will then determine if further monitoring is required. ADDENDUM to F625 dated 4/6/22 (RT) System change: The functions within our electronic charting system were adjusted during the survey to include the printing of a notification of bedhold when documentation is printed for a hospital transfer. When possible, a signature will be obtained from the resident or a responsible party at the time of the transfer. Monitoring of the system changes will be completed by the the Social Services Designee or designee,and will include a list of who was transferred and when documentation has been reviewed, signed and returned to the facility. (RT)	4/15/2022

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F 625	Continued From page 9 hold rate is $115.00 per day. *Medicaid resident's bed shall be held for five consecutive days for each separate and distinct medically necessary hospital stay.	F 625		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information	F 636		

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F 636	Continued From page 10 regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Surveyor: 45683 Based on observation, interview, and record review, the provider failed to assess fall prevention devices for one of one sampled resident (33) during the comprehensive assessment. Findings include: 1. Observations and interview with resident 33 on 2/28/22 revealed: *At 9:53 a.m., she was seated in her recliner with pull string clipped to her shirt that was attached to	F 636	For resident 33, the use of a personal alarm will be assessed and added to her care plan as indicated.	

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F 636	Continued From page 11 a chair alarm. The alarm activated when she adjusted positions. *At 10:42 a.m., she was seated in a wheelchair in the hallway by the dining room with a pull string attached to the back of her shirt that was attached to chair alarm. *At 3:42 p.m., she was seated in her recliner while the chair alarm was sounding. At that time, -She told the nurse who responded to the alarm that she needed to use the bathroom. -The call light cord was laying on the floor out of reach for the resident. -Interview with her, when asked about the alarm, revealed the alarm "bothered" her. Review of the annual minimum data set (MDS) dated 11/15/21 and the quarterly MDS dated 2/8/22 revealed alarms had been coded as "not used." Review of resident 33's care plan dated 11/17/21 revealed: *"I need my aides to: -Use an alarm on my bed to help remind me that I need help to get up. -Use the following assistive devices to be able to better help me: walker, wheelchair, stand-up lift, side rails to improve mobility in bed, frequently check on me." Interview on 3/1/22 at 10:32 a.m. with MDS coordinator E revealed she: *Acknowledged the MDS section for alarms had been marked with zeros to signify not in use. *Would look for documentation in the care plan and nurses notes to accurately code the MDS. *Would only code an alarm if there had been documented use. *Missed coding resident 33's alarm on the MDS.	F 636	Prior to implementing a personal alarm or pressure sensitive pad as a "supportive device", an assessment will be completed and for those residents who currently use supportive devices, the assessment will be scheduled with the next scheduled MDS and thereafter each quarter. Compliance will be monitored by the MDS coordinator, and results of compliance reported at the next QAPI meeting and thereafter for 3 months. The QAPI committee will determine if further monitoring is required. ADDENDUM to F636 dated 6/9/2022 (RT) Other residents using supportive devices will be identified and verified that an assessment has been completed through an audit. Audit data will include the type of supportive device, how long it has been in place, purpose of the device, any changes (medical, physical, mental, etc) that may warrant continued use or gradual reduction of the supportive device and when it will be reassessed. (RT)	4/20/22

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F 636	Continued From page 12 Interviews on 3/1/22 at 11:35 a.m. and 12:43 p.m. with registered nurse/care plan coordinator R revealed: *She was aware resident 33 had a chair alarm. *Assessments had not been completed for chair alarms. *There was a quarterly "supportive device" assessment in the electronic medical record that they will start using for alarms.	F 636		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		

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F 656	Continued From page 13 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Surveyor: 06365 Based on observation, interview, record review, and policy review, the facility failed to develop and revise person-centered care plans for one of fourteen sampled residents (21) reviewed for care plans. Findings include: 1. Observation and interview with resident 21 on 2/27/22 at 1:15 p.m. revealed : *A see-through white mesh banner with a stop sign in the center of it was attached by magnets between 4-5 feet high on the outside of the door frame to her room. *Her "biggest issue" is with a resident that "frequently attempts to enter my room and will take things saying she needs them." *The mesh banner "doesn't always work" because that resident "sometimes walks in [to the room] with [the banner] in her hands." Observation and interview with resident 21 on 2/27/22 at 3:45 p.m. revealed:	F 656	For resident 21, the care plan will be revised to specifically address how to keep her personal belongings and provide a clean, safe environment. The facility will develop and revise care plans using person centered concepts and tools. Compliance will be monitored by the Care Plan Coordinator, and results of compliance reported at the next QAPI meeting and thereafter for 3 months. The QAPI committee will determine if further monitoring is required.	4/20/22

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F 656	Continued From page 14 *A large pile of papers, tissues, magazines, books, and other miscellaneous papers was on the floor to the right side of the reclining chair she was sitting in. *The bottom of the pile measured about 3 feet by 3 feet and it was almost as tall as the armrest of her chair. *She did not need the staff to help her sort it; she "can do it" herself but "just haven't done it yet." Review of social service progress notes revealed: *On 5/7/21, "she has piles of stuff that she doesn't like to part with. Sometimes the wandering residents upset her. [Resident name] has a reacher or grabber to help her reach items." *On 7/29/21, "[resident name] tends to have a cluttered room with stacks of papers, magazines, and disposable kitchen items. She does get upset with residents that wander and when staff suggest getting rid of some of her piles." *On 10/25/21, "[resident name] does tend to keep stacks of old magazines, newspapers, and disposable kitchen products and she doesn't want staff to mess with them - she occasionally will send some home with her son." Review of the 1/17/22 Minimum Data Set assessment revealed: *Resident 21 had no visual, mental, or mood limitations. *It was "very important" for her to: -"Take care of her personal belonging or things." -"Have books, newspapers, and magazines to read." *She was independent transferring between surfaces and used a wheelchair for moving about.	F 656	ADDENDUM to F656 (RT) System change: Person Centered tools will be given to residents/family members prior to the assessment period so the information can be incorporated into the care plans. Any concerns identified will be discussed with the resident and/or family along with development of interventions which will be placed on the care plans. Audits will monitor the following: date person centered tools provided to resident and/or family; date completed/returned to the facility; inclusion of information on the care plan. (RT)	

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F 656	Continued From page 15	F 656		

Review of her care plan revealed:
*Taking care of her personal belongings was not addressed.
*Activities, dated 12/28/21 and 1/17/22, included the preference "to spend time in my room" with "one-on-one" staff conversation or "solo activities" of word puzzles or reading the newspaper and magazines.

Interview on 2/28/22 at 3:01 p.m. with housekeeping assistants OO and PP revealed:
*They were afraid to "move her chair" for cleaning the floor for fear of "making the pile fall over."
*Resident 21 would "not let us help her sort it out."
*They had reported the concern to their supervisor.

Interview on 3/1/22 at 9:51 a.m. with activity supervisor (AS) G and HS K revealed:
*AS G said resident 21 "will not let us touch her pile." HS K agreed, and she had tried to help sort it.
*AS G said she would "check if she could receive counseling" for the hoarding behavior.
*HS K said she would "try to offer a tote on wheels so they can clean around her chair" while allowing her access to her belongings.

Interview on 3/1/22 at 2:05 p.m. with registered nurse (RN)/care plan coordinator (CPC) R revealed:
*Agreement that resident 21's "stuff is very important to her."
*She will address that on her care plan.

Review of the provider's interdisciplinary team plan of care policy and procedure, reviewed on "03/21," revealed the resident and "his/her family

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F 656	Continued From page 16 member or responsible person" "will be involved in the development and review of his/her plan of care."	F 656		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		

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F 758	Continued From page 17 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Surveyor: 06365 Based on observation, interview, and record review, the facility failed to document a rationale for the PRN [as needed] order of a psychotropic medication for longer than 14 days for one of five residents (4) reviewed for unnecessary medications. Findings include: 1. Observations of resident 4 revealed: *On 2/27/22 at 5:15 p.m., she got up from the dining room table where she was seated multiple times and had to be redirected to sit back down by registered nurse (RN) HH. *On 2/28/22 at 11:20 a.m., she was seated at the dining room table and repetitively took the salt and pepper shakers out of the condiment holder in the center of the table, slid or skipped them around on the placemat in front of her, and put them back into the condiment holder. *On 2/28/22 at 3:30 p.m. and on 3/1/22 at 10:30 a.m., she wandered into the lounge area where surveyors were located.	F 758	Resident 4 had a prn order that has been discontinued per physician order. At this time, her behaviors do not compromise her or staff safety. The facility will implement an automatic stop order policy for PRN psychoactive medications after14 days. If the physician deems it appropriate to extend the prn order, a rationale will be documented in the residents medical record. Compliance will be monitored by the DON and results of compliance reported at the next QAPI meeting and thereafter for 3 months. The QAPI committee will determine if further monitoring is required.	4/15/22

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F 758	Continued From page 18 Review of the current physician orders for resident 4 revealed orders dated: *9/17/20 for Seroquel (generic name of quetiapine) 50 milligrams (mg) 1 tablet by mouth daily PRN for agitation to be given "for behaviors that compromise patient or staff safety." *9/28/22 for Seroquel 50 mg 1 tablet by mouth daily at "supper" for "behavioral disorders associated with dementia." Review of the medication regimen review (MRR) revealed registered pharmacist (RPh) F noted: *On 9/17/20, resident 4 was recovering from an incident with injury that required hospitalization, and the Seroquel order "was changed back to 50 mg again instead of 100 mg." There was no reference to the PRN Seroquel order. *On 10/15/20, "the quetiapine has been reviewed and per [physicians names'] recommendation we are going to state [sic] at 50 mg and she seems to be doing fine with that dose." There was no reference to the Seroquel PRN order still in place beyond the 14 day limitation. *Between 11/10/20 and 2/8/22, there were no references to the Seroquel PRN order still in place beyond the 14-day limitation. Review of the Care Area Assessments for psychotropic medication use revealed Minimum Data Set coordinator E noted: *On 9/23/20: -Seroquel was "being used to help control behavioral symptoms associated with Alzheimer's disease and vascular dementia." -Seroquel use "started on 12/24/19" with reference to dosage changes associated with her hospitalization from "9/11/20 - 9/15/20." -The order for Seroquel PRN without noting how often it was used.	F 758	ADDENDUM to F758 dated 4/8/22 (RT) A change in the electronic charting system has included addition of a prompt to discontinue PRN psychoactive medication after 14 days unless the provider deems it is appropriate for the PRN order to be extended beyond that time frame. If this would be the case, he or she will document their rationale in the resident's medical record and indicate the duration for the PRN order. (RT) The DON will audit the information above on a monthly basis, reporting it to the QAPI committee for the next 3 months, the QAPI committee will determine if further monitoring is needed.	

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F 758	Continued From page 19 -Before the hospitalization, "she was wandering many times daily, sometimes at risk of getting to a potentially unsafe place and/or intruding on the privacy or activities of others. She has a history of sometimes trying to help other residents, which has sometimes been upsetting to them (she is a retired nurse). She has also tended to rummage and hoard items in her room, as well as make delusional statements at times." *On 9/14/21: -The Seroquel PRN order is referenced but did not indicate an assessment of how often it had been used. -Resident 4's behaviors included wandering "on a daily basis during the assessment time frame, which sometimes included going into other residents' rooms...and was sometimes at risk for getting to a potentially unsafe places such as an exit door. She makes delusional statements, at times, re: [about] believing her baby dolls are her children." Interview on 3/1/22 at 3:39 p.m. with director of nursing C revealed she was not aware there was a PRN order for Seroquel. Interview on 3/2/22 at 8:35 a.m. with RPh F revealed: *She did not include a review of the PRN order in her MRR. That order "slipped by me." *The rationale for use of Seroquel was related to her "elopements" (exiting the facility). *She would review whether the PRN order was still needed "during my visit next week."	F 758		
F 909 SS=D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all	F 909		

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F 909	Continued From page 20 bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Surveyor: 06365 Based on observation, interview, and record review, the provider failed to identify the need for preventive maintenance of the bed rail for one of sixteen sampled residents (96) with bed rails. Findings include: 1. Observation and interview on 2/28/22 at 12:06 p.m. with resident 96 revealed: *He was seated in a living room style chair in his room. A four-wheeled walker with a seat was positioned in front of him. *His head was turned with his chin down towards his chest and his right ear towards his right shoulder. *He reported he had moved in recently after falling from dizziness and hurt his hip, which was still sore. *His bed was lower to the floor than a standard height and there was a one-half side rail attached to it. *The side rail was very wobbly upon testing its function. The resident said it "gets pulled up every night," but "[I] don't use it." Review of the baseline care plan signed by resident 96 on 2/24/22 revealed: *He was admitted on that date. *He had a fall before admission. *He needed the assistance of one person for	F 909	For resident 96, the bed rail maintenance was completed during survey. Prior to admission, an inspection of resident room will occur by the maintenance director and/or maintenance staff. Compliance will be monitored by the maintenance director and results of compliance reported at the next QAPI meeting and thereafter for 3 months. The QAPI committee will determine if further monitoring is required. ADDENDUM to F909 dated 4/9/2022 (RT) In addition to the preventative maintenance for siderails that occurs at least annually, the maintenance department is notified of new admissions and the rooms they will be occupying. They will inspect the bed, mattress, and side rails, and any other equipment/safety related issues prior to admission and submit the checklist to the Administrator or designee prior to admission. (RT)	3/28/22

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F 909	Continued From page 21	F 909		

most activities of daily living with a wheelchair, walker that family would bring in for him, and one-half side rails.
*The resident was alert and cognitively intact with no vision impairments.

Review of a side rail assessment in resident 96's electronic medical record dated 2/24/22 at 2:54 a.m. revealed:
*He was "sometimes confused" at night, and "sometimes" awake at night.
*Had no "history of falls at night."
*He was "not able to ambulate" and was "able to use call light."
*The reason for side rail use was noted as "resident wants side rails" and "reason for request" was "request of resident."
*The "team recommends" using the side rails "at all times in bed" for "bed mobility."

Review of nursing progress notes revealed:
*On 2/25/22 and 2/26/22, the resident needed no assistance with moving in bed or with transfers between surfaces.
*On 27/22 and 2/28/22, the resident needed one-person assistance with those.

Interview on 3/1/22 8:53 a.m. with maintenance assistant (MA) S and observation of the side rail at that time revealed:
*There was a primary maintenance (PM) schedule for checking side rails and maintenance repairs would be done "when a work order is put into the system."
*The certified nursing assistants "normally submit the work orders."
*MA S agreed resident 96's side rail "should have been put in as a work order."

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F 909	Continued From page 22 Interview on 3/1/22 at 10:30 a.m. with maintenance director J and review of the PM schedule revealed: *All beds and side rails are checked annually in November. *Maintenance staff check rooms for maintenance needs after a resident moved out but that had not included beds and side rails. *He confirmed that would be added to the room check tasks. Interview on 3/1/22 at 3:39 p.m. with director of nursing C revealed no additional information.	F 909		

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

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E 000	Initial Comments Surveyor: 06365 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 2/27/22 through 3/1/22. St. William's Care Center was found not in compliance with the following requirement: E0001.	E 000		
E 001 SS=E	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and	E 001		

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

Rene' Thrift | Administrator | 3/25/22

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435122	A. BUILDING _____ B. WING _____	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST WILLIAM'S CARE CENTER	103 N VIOLA ST MILBANK, SD 57252

(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 001	Continued From page 1 local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Surveyor: 45383 Based on interview and record review, the provider failed to establish a complete emergency preparedness program that included policies and procedures, a communication plan, and contact information. Findings include: 1. Interview on 3/1/22 at 11:30 a.m. with administrator A and review of provider's emergency preparedness program revealed: *They did not have a complete emergency preparedness program. *They had not: -Addressed patient population. -Addressed collaboration. -Addressed policies and procedures for risk assessment. -Addressed policies and procedures for sewage and waste disposal. -Addressed policies and procedures for	E 001	The following documents have been added to the Emergency Preparedness Program Manual: St. William's Facility Assessment which addresses patient population; memoranda's of understanding for transportation services, water services, sewage and waste disposal services, and alternate evacuation sites which addresses collaboration. The following policies/procedures were placed in the binder: Disruption of service which addresses sewage and waste disposal Risk assessment Fire Plan which addresses fire alarms Severe Weather Emergencies which addresses emergency pretesting requirements. A current disaster call list has been added to the binder which addresses the communication plan that includes names and contact information for emergency officials. Staff will be re-educated on the Emergency Preparedness Program beginning with Department Heads by 4/15/2022.	6/15/2022 4/20/2022 (RT)

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
	435122	A. BUILDING _____ B. WING _____	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST WILLIAM'S CARE CENTER	103 N VIOLA ST MILBANK, SD 57252

(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 001	Continued From page 2 volunteers. -Addressed policies and procedures for fire alarms. -Implemented emergency preparation and training program. -Maintained emergency pretesting requirements. -Developed a communication plan that had included names and contact information for emergency officials.	E 001	ADDENDUM dated 4/6/2022 (RT) The Safety Committee will review portions of the emergency preparedness plan each month, reviewing it in its entirety annually. The Administrator will review the emergency preparedness manual annually updating contracts with local agencies annually. The Policy Committee will review policies annually and submit updates for filing in manual. Compliance will be monitored by the Administrator and reported to the QAPI committee monthly. (RT)	

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
	435122	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST WILLIAM'S CARE CENTER	**103 N VIOLA ST** **MILBANK, SD 57252**

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K 000	INITIAL COMMENTS Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/1/22. St. William's Care Center 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: Rene' Thrift
TITLE: Administrator
(X6) DATE: 3/25/2022

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.

APR 1-1-2022

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
	10649	A. BUILDING: _____ B. WING _____	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST WILLIAM'S CARE CENTER	103 N VIOLA ST MILBANK, SD 57252

(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 Surveyor: 27198 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/27/22 through 3/1/22. St. William's Care Center was found not in compliance with the following requirement(s): S301.	S 000	Since survey, 18 of 19 employees have been provided the ongoing inservice training for dietary and food-handling to include the 9 required topics, this includes the 1 new employee's orientation program. 1 of 19 employees is on LOA status and will be provided the training upon return. Since survey, one new employee was hired, and the new employee orientation checklist was completed on 3/31/22 and on file in the dietary manager's office. System change: Inservice records will be maintained in the dietary manager employee office along with a checklist outlining who has/has not completed the 9 module topics. ADDENDUM: The Registered Dietician will be involved in the training material for the 9 modules to ensure required information is covered. 05/10/2022 (RT) Each month 1-2 topic(s) will be covered, with make up sessions the remaining 3 months of the 12 month period. New employees will receive orientation on the topics above, and documentation of such maintained in their file in the dietary manager's office. ADDENDUM: The Dietary Manager will provide the training for both the current staff on a yearly basis, and for new employees. 05/10/2022 (RT) The dietary manager will monitor the system change and report monthly results to the QAPI committee for 3 months followed by quarterly reports for the next 6 months. The QAPI committee will determine if further monitoring is required.	4/25/2022
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 43021 Based on interviews, review of employee files, training reports, and job descriptions, and facility policy, the provider failed to ensure 19 of 19 dietary employees (L, M, N, O, P, Q, T, U, V, W, X, Y, Z, AA, BB, CC, EE, FF, GG) had completed the required yearly training on nine of nine topics and failed to document one (EE) of 19 dietary employee's orientation program, including the nine topics: *Food safety. *Handwashing. *Food handling and preparation techniques. *Food-borne illnesses. *Serving and distribution procedures. *Leftover food handling policies. *Time and temperature controls for food	S 301		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rene' Thrift — TITLE: Administrator — (X6) DATE: 4/26/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10649	A. BUILDING: _____ B. WING _____	03/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST WILLIAM'S CARE CENTER	103 N VIOLA ST MILBANK, SD 57252

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S 301	Continued From page 1	S 301		

preparation and service.
*Nutrition and hydration.
*Sanitation requirements.
Findings include:

1. Review of the dietary training reports from 3/1/20 through 1/31/22 revealed there was no annual training documentation for the required training topics identified above.

Interview on 2/28/22 at 3:30 p.m. with dietary manager (DM) H and DM I regarding the required dietary training revealed:
*The dietary training for the topics identified above had not been completed in the last twelve months.
*DM H stated that infection control registered nurse D had conducted a handwashing in-service in the last year for all staff.

Documentation of the handwashing in-service was requested on 2/28/22 at 6:00 p.m. but the provider did not provide it by the end of the survey.

Review of the provider's 2021 training and orientation policy from Becky Dorner & Associates' 2021 Policy and Procedure Manual revealed:
*Dietary staff would be adequately trained to perform assigned duties and were required to participate in regularly scheduled training sessions.
*Upon completion of initial mandatory facility training, each employee would be trained in all food service areas that are related to the job.
*At the bottom of the policy was a printed note stating "See Sample Training/Orientation Form later in this chapter of the manual for recording each new employee's training."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 301	Continued From page 2 Interview on 3/1/22 at 9:28 a.m. with DM H and DM I regarding the Becky Dorner & Associates' 2021 Policy and Procedure Manual confirmed the provider followed those policies and procedures including the training and orientation policy noted above. Review of dietary aide (DA) EE's employee file revealed: *She had been hired on 11/15/21. *There was no form documenting the orientation she had received in the dietary department. *The orientation to the topics identified above was not documented. Interview on 3/1/22 at 10:05 a.m. with DM H and DM I regarding DA EE's orientation revealed: *New dietary employees worked their first ten days shadowing other dietary staff members for training. *There was no form documenting the training received by a new employee in the dietary department. *They were not aware of the need for the training on the topics identified above. Interview on 3/1/22 at 10:43 a.m. with administrator A regarding required dietary training revealed: *Her expectation was the nine topics would be covered during orientation and annually. *She confirmed there was no form documenting the orientation of dietary employees to the dietary department. Interview on 3/1/22 at 11:02 a.m. with DM I revealed the last training on the required topics had been conducted in 2019.	S 301		

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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST WILLIAM'S CARE CENTER	103 N VIOLA ST MILBANK, SD 57252

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S 301	Continued From page 3 Review of the provider's job description for the certified dietary manager position included: *"Assuring policies and procedures are developed and carried out." *"Training dietary staff." *"Planning and presenting in-service programs for members of the dietary department." *"Ensures continued compliance with local, state and federal standards." *"Responsible for knowing, understanding, and conveying local, state and federal standards regarding food service and nursing home dietary requirements to other dietary staff members. *Responsible for their enforcement within the scope of the dietary department."	S 301		
S 000	Compliance/Noncompliance Statement Surveyor: 06365 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 2/27/22 through 3/1/22. St. William's Care Center was found in compliance.	S 000		