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
	435135	A. BUILDING _____ B. WING _____	C 03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT COUNTY HOSPITAL AND NURSING HOME	102 MAJOR ALLEN MARTIN, SD 57551

(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: 40788 A complaint survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 3/15/22 through 3/16/22. Areas surveyed included: resident neglect, unqualified personnel, accidents, and quality of care and treatment. Bennett County Hospital and Nursing Home was found not in compliance with the following requirements: F609, F610, F677, F679, F684, F726, and F835.	F 000	Submission of this Response and Plan of Correction (POC) is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any Employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation! and submission of the Plan of Correction does not constitute and should not be interpreted as an admission or agreement of any kind or the correctness of any conclusions set forth by the facility of the truth of any facts alleged in the statement of deficiencies .	
F 609 SS=G	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, 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	F 609	Accordingly, the Facility has prepared and submitted this Plan of Correction for these deficiencies prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law That mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. Without waving the foregoing statement, the facility states that with respect to: ADON C has resigned and LPN F has been terminated. DON B has been replaced with a new RN / CNP who began serving as DON on April 8, 2022 C N A E left the area before any other action could be taken	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO / Administrator | (X6) DATE: 04/14/2022 ~~04/09/2022~~

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 609	Continued From page 1 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: 40788 Based on observation, interview, record review, policy review, and anonymous complaint, the provider failed to investigate and report one of one incident of verbal abuse towards one of one sampled resident (12). Findings include: 1. Review of a 2/17/22 anonymous complaint to South Dakota Department of Health revealed allegation licensed practical nurse (LPN) F had verbally and emotionally abused resident 12 by taunting her when she repeatedly attempted to get out of her recliner. Observation at random times throughout the survey period of 3/15/22 from 10:30 a.m. through 4:10 p.m. and 3/16/22 from 8:30 a.m. through 4:45 p.m. of resident 12 revealed she: *Sat in a recliner in front of the nurses' station. -Was often reminded by staff not to try to get up out of the recliner on her own because she was at risk for falling. Review of resident 12's care record revealed her 1/17/22 brief interview for mental status (BIMS) score was 3 indicating she had severe cognitive impairment. Interview on 3/16/22 at 1:35 p.m. with director of nursing (DON) B regarding the anonymously reported allegation LPN F had verbally and emotionally abused resident 12 revealed she had	F 609	BCHNH has developed and implemented written policies and procedures that prohibit abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property. This new written policy includes removing any one under investigation from access to residents and from resident care to prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. The facility now has an abuse prevention program that includes the seven required elements of screening, training, prevention, identification, investigation, protection and timely reporting/response. The facility has further revised its policy and procedure on Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response that includes the 2 hour reporting requirement to the Survey agency for both F609 and F610 (regarding events involving allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property and voluntary seclusion) to ensure all allegations of abuse or any incidents of unknown origin are thoroughly investigated, documented, and reported as per regulation. BCHNH employees have been directed to complete an on-line in-service by 04/14/2022 in response to the identified deficiency, for failure to timely report allegations of abuse to the State Survey agency. BCHNH ensured that South Dakota State Long Term Care Ombudsman Program Ombudsman for our area presented an in-service education training on April 6, 2022 to include specific training about resident abuse; examples of abuse; actions to take should they see, hear or suspect possible abuse; understand and comply with the 2 hour reporting requirement for	04/14/2022

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F 609	Continued From page 2 no knowledge of the incident. Interview on 3/16/22 at 1:50 p.m. with assistant director of nursing (ADON) C regarding the above allegation revealed: *She confirmed more than one caregiver who had witnessed the incident and reported it to her. -They alleged LPN F "was mean" and had raised his voice to resident 12 when she attempted to get up on her own out of a recliner positioned in front of the nurses' station. - LPN F had reportedly taunted the resident "go ahead, get up" [out of the recliner] and "if you get up, you're sitting beside me" [at the nurses' station]. *Had thought the allegation constituted verbal and emotional abuse. *She stated this was not the first time caregivers had reported concerns regarding LPN F's interactions with residents. *She had not reported the allegation to administrator A, DON B, the South Dakota Department of Health, local authorities, the resident's physician or the resident's family, but knew she should have. *She knew she should have but had not completed and documented a thorough investigation of the allegation. Interview on 3/16/22 at 3:30 p.m. with administrator A regarding the anonymous allegation revealed: *He stated, "that's hard to understand" why ADON C had done nothing about the allegation and "she knows" what the expectations are when resident abuse/neglect is reported. *He had provided education about his expectations for abuse and neglect to both DON B and ADON C.	F 609	notification of allegations of abuse to the State Survey agency; 65 employees attended training in person or by tele-video. All remaining Employees will be required to read hand-out information on what constitutes resident abuse; examples of abuse; actions to take should they see, hear or suspect possible abuse; understand and comply with the 2 hour reporting requirement for notification of allegations of abuse to the State Survey agency; attest to having read and agree to not commit acts of abuse, and knowingly be subject to disciplinary action, up to and including termination, for failure to comply with facility procedures. All PRN employees will be required to complete this training before working their next shift. Human Resources manager is responsible for - monitoring staff compliance in reading the hand- out material The incident reporting form has been revised to include the required reporting timelines to ensure compliance with timely reporting and the policy and procedure has been updated to include a decision tree form for clearly guiding employees on when incidents should be reported to the state of South Dakota. The Director of Nurses and the Quality Assurance Nurse have been assigned to conduct a monthly review of all facility reported incidents of allegations of abuse and track facility compliance and improvement with timely reporting. Results of the monthly audits will be aggregated and reported to the Quality Assurance and Performance Improvement Committee (QAPI) monthly to identify opportunities for improvement. The CEO/Administrator is responsible for	

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F 609	Continued From page 3 Review of the undated Investigating Abuse, Neglect and Exploitation policy revealed: *"2. Any alleged violations involving mistreatment, neglect or abuse must be reported immediately to the DON and Administrator and an investigation will be initiated neglect or abuse must be reported immediately to the DON and Administrator and an investigation will be initiated. *"4. Information and findings will be recorded in the final five day report." *"5. Staff and/or person(s) who witnessed or reported the incident will complete a Detailed Account of Incident."	F 609	Reporting compliance to the board of directors and the DON and Administrator are developing on-going improvement action plans to address any instances of non-compliance with regulatory requirements.	04/14/2022
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	BCHNH has developed and implemented written policies and procedures that prohibit abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property. This new written policy includes removing any employee under investigation from patient care to prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. The facility now has an abuse prevention program that includes the seven required elements of screening, training, prevention, identification, investigation, protection and timely reporting/response. The facility has further revised its policy and procedure on • Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response" that includes the 2 hour reporting requirement to the Survey agency for both F609 and F610 (regarding events involving allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property and voluntary seclusion)	

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F 610	Continued From page 4 Surveyor: 40788 Based on review of an online self-reporting form, anonymous complaint, interview, and policy review, the provider failed to ensure: *Corrective action described in the provider's investigation summary report had been implemented for one of one substantiated case of resident abuse involving certified nurse aide (CNA) E's action toward resident 2. * Two of two sampled residents' (1 and 10) falls had been accurately and appropriately documented and thoroughly investigated with necessary notifications. Findings include: 1. Review and interview on 3/15/22 at 2:15 p.m. with director of nursing (DON) B and assistant director of nursing (ADON) C of the Healthcare Online Self-Reporting form for the 2/22/22 event revealed: *A resident abuse/neglect allegation was substantiated involving CNA E's action toward resident 2. -CNA E reportedly "was rough and had an attitude" when applying a barrier cream to resident 2's bottom. She "slapped it on" and then just slammed the tube to the resident's bedside table. *Conclusionary summary statement of the facility investigation: -"If she [CNA E] returns [to work], [CNA E] will be educated on abuse and neglect policies." *DON B confirmed CNA E, a temp agency worker did return to work 4 to 6 shifts after the incident, but had not received abuse/neglect training because she had previously received that training in December 2021. -DON B agreed that in light of a new incident of abuse re-training should have occurred.	F 610	to ensure all allegations of abuse or any incidents of unknown origin are thoroughly investigated, documented, and reported as per regulation. BCHNH employees have been directed to complete an on-line in-service by 04/14/2022 in response to the identified deficiency, for failure to timely report allegations of abuse to the State Survey agency. BCHNH ensured that South Dakota State Long Term Care Ombudsman Program Ombudsman for our area presented an in-service education training on April 6, 2022 to include specific training about resident abuse; examples of abuse; actions to take should they see, hear or suspect possible abuse; understand and comply with the 2 hour reporting requirement for notification of allegations of abuse to the State Survey agency; 65 employees attended in person or by tele-video. All remaining Employees will be required to read hand-out information on what constitutes resident abuse; examples of abuse; actions to take should they see, hear or suspect possible abuse; understand and comply with the 2 hour reporting requirement for notification of allegations of abuse to the State Survey agency; attest to having read and agree to not commit acts of abuse, and knowingly be subject to disciplinary action, up to and including termination, for failure to comply with facility procedures. Human Resources manager is responsible for - monitoring staff compliance in reading the hand- out material The incident reporting form has been revised to include the required reporting timelines to ensure compliance with timely reporting and the policy and procedure has been updated to include a

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F 610	Continued From page 5 Interview on 3/16/22 at 3:15 p.m. with administrator A revealed he expected that abuse/neglect re-training had occurred regardless of whether or not CNA E had received it before since "clearly it wasn't enough" the first time. Review of the undated Investigation Abuse, Neglect and Exploitation policy revealed "Our facility will not condone resident/patient abuse by anyone, including staff members..." 2. Review of resident 1's care record relevant to an anonymous complaint revealed: *No progress notes that indicated she had fallen on 1/25/22. *The only documented vital signs had been taken close to midnight on that same date. *No post-fall nurse assessments. Review of the emergency department report from resident 1's transfer there on 1/26/22 revealed: "She [resident 1] complained of some right sided rib pain." "Nursing staff not sure of fall." Interviews on 3/15/22 at 3:15 p.m. and on 3/16/22 at 10:10 a.m. with DON B regarding resident 1 revealed: *She confirmed that resident had fallen between 6:30 p.m. and 7:00 p.m. on 1/25/22. -No fall report had been completed. *She had not been notified of that fall until 1/29/22 and completed an incident report at that time. *CNA E reported she found the resident on the bathroom floor in her room with bruising to her coccyx and complaints of right shoulder pain. -She had notified LPN G. *LPN G had denied being advised of that fall.	F 610	Decision tree form for clearly guiding employees on when incidents should be reported to the state of South Dakota. The Director of Nurses and the Quality Assurance Nurse have been assigned to conduct a monthly review of all facility reported incidents of allegations of abuse and track facility compliance and improvement with timely reporting. Results of the monthly audits will be aggregated and reported to the Quality Assurance and Performance Improvement Committee (QAPI) monthly to identify opportunities for improvement. The Administrator is responsible for reporting compliance to the board of directors and the DON and Administrator are developing on-going improvement action plans to address instances of non-compliance with regulatory requirements The date of compliance is 4/14/2022.	04/14/2022

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F 610	Continued From page 6 *DON B had not interviewed CNA E and LPN G together to determine what had or had not happened on 1/25/22, but should have. 3. Review of resident 10's care record relevant to an anonymous complaint revealed: *No progress notes that indicated she had fallen on 2/21/22. *No documented vital signs (blood pressure, pulse, oxygen saturation, and respirations) between 2/15/22 and 3/2/22. *No post-fall nurse assessments. Review of the 2/21/22 Incident Report completed by LPN F revealed: *Resident 10 was found on the floor near the nurses' station. -Her vital signs were reportedly taken but not documented after the fall. -There were no predisposing environmental, physiological, or situational factors identified on that report that may have contributed to the fall. Interview on 3/16/22 at 10:00 a.m. with DON B revealed: *She agreed that Incident Report and post-fall follow-up had been incomplete. *The resident was at risk for falls. -She often sat in a recliner near the nurses' station and attempted to get out of that recliner by herself. -It was determined her chair alarm had been turned off at the time of the fall. *The nurse was expected to complete a post-fall resident assessment, fully complete an Incident Report, promptly notify the DON, physician, and family, and continue post-fall to monitor the resident's vital signs, assess the resident for physical and cognitive changes, and document	F 610	Resident 10 expired of other non-COVID related Comorbidities on 03/22/2022	

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F 610	Continued From page 7 that information. Interview on 3/16/22 at 3:40 p.m. with administrator A revealed he: *Expected nursing staff had been accountable for accurate, timely, and complete fall documentation. *Had gone through fall investigation expectations with DON B and ADON C previously. Review of the December 2011 Post Falls Assessment and Follow Up Documentation policy revealed: *Notify the physician and family/POA [Power of Attorney] of the fall. *File an Incident Report. *Check on the resident as their condition warrants for the rest of the shift. *Continue with neurological checks per policy if indicated. *Report the incident to the oncoming nurse for further follow-up. *Continue to assess the resident for signs and symptoms of injury related to the fall at least one time per shift for the next 72 hours and document findings.	F 610	The date of compliance is 4/14/2022.	04/14/2022
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Surveyor: 40788 Based on observation and interview, the provider failed to ensure two of seven observed residents	F 677	Corrective Action taken for those residents alleged to have been affected by the deficient practice are: • Resident 3 has a razor ordered to be provided for self-shaving • Resident 5 has a razor ordered to be provided for self-shaving Actions taken to identify other residents that may have been affected by the deficient practice are: • A house sweep was conducted to ensure all residents who are independent have access to razors for shaving as they choose	

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F 677	Continued From page 8 (3 and 5) had been assisted with or provided the means to complete facial hair grooming per their preference. Findings include: 1. Observations and interviews on 3/15/22 at 10:50 a.m. and 3/16/22 at 11:35 a.m. with resident 5 revealed he: *Had admitted to the facility on 3/1/22. *Complained his moustache was too long. *Was able to shave himself, but had no razor of his own. *Had spoken to director of nursing (DON) B on 3/14/22 about having access to a razor to shave himself. -Was still waiting for DON B to follow-up with him about that razor. 2. Observation and interview on 3/16/22 at 9:15 a.m. with resident 3 revealed he: *Had facial hair stubble. *Did not have a personal razor. *Was shaved on his bath days which occurred about two times per week. 3. Interview on 3/16/22 at 11:00 a.m. with medication aide M regarding shaving revealed: *There was one electric razor with disposable heads available to shave male residents. *Shaving occurred on the residents' bath days. -Staff tried to shave residents on their non-bath days if time permitted. *Several residents including residents 3 and 5 were capable of shaving themselves if they had access to a razor. 4. Interview on 3/16/22 at 9:45 a.m. with DON B revealed: *Daily shaving was expected, but she knew that was not consistently happening.	F 677	• Dependent residents who need assistance with shaving were identified and will be shaved on bath days or as needed to maintain grooming per the preference of the resident and razors with disposable heads will be placed in each bath house for convenient access during bathing The measures the facility will take to ensure the problem will be corrected and will not reoccur: • Nursing team educated on grooming policy in an in-service on April 6, 2022 • Master shower schedule reviewed and adjusted as needed so all residents who need assistance with grooming will be shaved on their bath day or as they prefer. • Weekly skin assessments made to match shower schedule • Weekly skin assessments on residents will be completed on the first bath day of each week by a nurse. Quality Assurance plan to monitor facility performance to make sure corrections are achieved: To monitor and maintain ongoing compliance, beginning 4/11/2022, the Director of Nursing or designee will observe residents and will perform audit weekly x 4, bi-weekly x 2, and monthly x 1 • audits will be reported by the DON to the QAPI committee monthly and more audits will be implemented if the QAPI committee determines the need. Any identified areas of concern will be corrected. • Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee and to the Administrator The facility Director of Nursing is responsible for compliance.	

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F 677	Continued From page 9 *Had not followed-up on resident 5's request for a razor. 5. Interview on 3/16/22 at 1:15 p.m. with assistant director of nursing (ADON) C revealed shaving was expected to occur daily as a part of the residents' morning routine. 6. Interview on 3/16/22 at 3:35 p.m. with administrator A revealed: *His office was located in the attached hospital, but he usually "rounded" two times per week at the nursing home with the environmental services staff. -Was unaware male grooming had been a problem. 7. Review of the May 2018 Certified Nurse Aide job description Specific Requirements revealed: 3. d. Personal care functions that included grooming (shampoo, nail care, and shaving). An Activities of Daily Living policy that would reflect shaving and resident preference was requested on 3/16/22 at 12:45 p.m. from ADON C, the provider had no such policy.	F 677	The date of compliance is 4/14/2022.	04/14/2022
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of	F 679	Corrective Actions taken to identify other residents that may have been affected by the deficient practice are:	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 10 each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Surveyor: 40788 Based on observation, interview, record review, review of Resident Council minutes, and policy review, the provider failed to: *Identify three of five sampled residents' (4, 5, and 6) interests, preferences, and abilities to involve them in an activity program that supported their physical, mental, and psycho-social well-being. *Fully implement an activity program based on resident assessments and preferences for five of five sampled residents (1, 3, 4, 5, and 6) in a census of 29. Findings include: 1. Observation on 3/15/22 at 10:45 a.m. revealed: *Three residents seated in recliners in front of the nurses' station, one resident in a wheelchair seated nearby them, and four residents leaving the activity room after Catholic rosary. -The remaining twenty-one residents had been in their rooms. *There was no posted activity calendar. Review of the 3/11/22 Resident Council minutes revealed "Residents main concern was no activities being done on a daily basis. They get bored easily." 2. Review of resident 1's care plan revised on 2/21/22 revealed she enjoyed western movies, country music, filling the bird feeder, bingo, participating in regularly scheduled activities and helping other residents to do the same.	F 679	An activities calendar with activities that meet the need of residents has been created and posted in each resident's room and in the public areas. The activities program is designed to provide ongoing resident-centered activities programming to support residents in their choice of activities that have been designed to meet the individual interests of the residents while encouraging both independence and interaction in the community. Activities will be meaningful and incorporate the resident's interests, hobbies and cultural preferences. Activities will be individualized and customized based upon the individual's previous lifestyle, preferences and comforts. Care plan interventions and planned activities will be updated based on observed resident outcomes to better meet each resident's needs. Care plan meetings are scheduled on a routine basis for assessing needs of residents and include the activities manager. Training for all staff was completed on 04/06/2022 by the activities coordinator on the activities program to include the fact that our facility-wide goal includes staff participation from all departments feasible; specifically an activity does not need to be led / directed by a member of the Activities Department. The activities program will also include a variety of community-based activities, such as local Lakota drum concerts, and regular church services that afford a resident the opportunity to pursue lifelong interests, spirituality as well as meet their goal, needs and strengths. A binder with an activities sheet for each resident has been created and will be located at the nurses station to allow all members of the staff to record activities they participate in with residents to facilitate recording such activities for staff who do not have access to chart such activities in the electronic record.	

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	435135	A. BUILDING _____ B. WING _____	C 03/16/2022

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F 679	Continued From page 11 Interview on 3/15/22 at 1:20 p.m. with resident 1 regarding activities revealed she: *Read books in her room that she had gotten from the activity room. *Had colored pencils her family supplied that she used to color. *Wanted activities that stimulated her mind and allowed her to socialize with others. -Was uncertain of the last time she participated in an organized activity. *Had not known if there was a posted activity calendar. 3. Review of resident 3's care record revealed: *A care plan revised on 2/21/22 identified his activity preferences included watching favorite television programs, attending Catholic church, smoke breaks, and visiting. *Activity documentation for the thirty days prior to 3/15/22 indicated he participated in a kickball activity twice, Catholic rosary once, a coffee social once, a one-on-one activity, and a "You Tube" activity. Interview on 3/16/22 at 9:15 a.m. with resident 3 regarding activities revealed he: *Had become "addicted" to television. *Enjoyed Wii bowling, but the last time it was offered was "a long time ago." *Wanted to communicate by email with his brother, but the computer in the activity room had no Internet service. -Administrator A said he would have to purchase his own computer to have Internet access, but resident 3 could not afford that. *Was glad church services had restarted. 4. Review of resident 6's care record revealed: *No activity care plan.	F 679	The activities coordinator will be responsible for ensuring the activities program is implemented and that each resident has activities to meet their needs and choices. SSD K will interview residents 1,3,4,5,6 and will update their care plans to reflect individual preferences, interests and hobbies. SSD K will interview all other residents and will update their care plans to reflect individual preferences, interests and hobbies. She will continue to update all resident care plans at their quarterly care plan review. To monitor and maintain ongoing compliance, the activities coordinator will audit 5 residents activity sheets on each hall per week for one month , bi weekly for one month, and then monthly for two months for staff involvement and participation and will report the aggregated findings to the QAPI committee each month. The COO will randomly attend 2 team care plan meetings per month and will report the results to the QAPI committee monthly. The date of compliance is 4/14/2022.	04/14/2022 04/14/2022 04/14/2022

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F 679	Continued From page 12 *Activity documentation for the thirty days prior to 3/15/22 indicated he participated in six one-on-one activities including an outdoor activity and bingo. Interview on 3/16/22 at 11:15 a.m. with resident 6 regarding activities revealed he liked to do "anything." Interview on 3/16/22 at 11:25 a.m. with social services director (SSD) K regarding resident 6 revealed he mostly stayed in his room and also ate his meals there. 5. Review of resident 4's care record revealed: *No activity care plan. *Activity documentation for the thirty days prior to 3/15/22 indicated he participated in a quilting design program, Catholic rosary once, Lakota drumming activity, watched a movie, and participated in two one-on-one activities. Interview on 3/16/22 at 11:20 a.m. with resident 4 regarding activities revealed he: *Was a "farm boy", enjoyed watching the Andy Griffith show, walking the halls, and spiritual programming. -"Give me a can of beer once in awhile and I'll be happy." 6. Review of resident 5's care record revealed: *He had been on the COVID-19 isolation unit since his admission on 3/1/22. -That restriction was lifted on 3/13/22. *No activity care plan. *Activity documentation since his admission indicated he had participated in a single one-on-one activity.	F 679		

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F 679	Continued From page 13 Interview on 3/16/22 at 11:30 a.m. with resident 5 regarding activities revealed he liked to play pool. 7. Interviews on 3/15/22 at 12:30 p.m. and 1:45 p.m. with SSD K regarding resident activities revealed: *There was currently no activity director. -Activity assistant L transported residents to appointments and was unable to carry out activity programming. *There had been few resident activities "for some time". *No activity calendar for the month of March 2022 was posted. *At approximately 3:00 p.m. she "found" a March activity calendar. -On 3/15/22, those activities reflected Catholic mass, Scheduled exercise, and Bingo. -For 3/16/22, activities reflected Scheduled exercise, Snack time, Newspaper, and 1-1's. =Catholic mass occurred on 3/15/22. 8. Interview on 3/16/22 at 1:00 p.m. with director of nursing (DON) B and assistant director of nursing (ADON) C regarding activities revealed: *Resident activity needs had not been met "for months" and residents were "getting bored." -Most resident activities had been one-on-one and involved only select residents. *No one had been identified to take responsibility for the activities program in the absence of an activity director. -Activity assistant L received direction from DON B and ADON C regarding activity programming, but she was not consistently available to carry out activity programming. *DON B was responsible for activities staff supervision.	F 679		

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F 679	Continued From page 14 9. Interview on 3/16/22 at 4:00 p.m. with administrator A regarding activities revealed: *The activity director position was in the process of being filled. *Currently "there is not an [activities] program." *He was aware of concerns with activity programming under the previous activity director. -That director had not been held accountable for the responsibilities of his position. 10. Review of the 5/12/21 Activity policy revealed: *"The purpose is that the facility identifies each resident's interests and needs and involves the resident in an ongoing program of activities that is designed to appeal to his or her interests and to enhance the resident's highest practicable level of physical, mental, and psychosocial well-being." *"Resident engagement should be a facility-wide goal with staff participation from all departments feasible." *"Care planning involves identification of the resident's interests, preferences, and abilities; and any issues, concerns, problems, or needs affecting the resident's involvement/engagement in activities." *"A monthly calendar will be provided to each resident listing the types of activities that can be participated in a group setting."	F 679	The date of compliance is 4/14/2022.	04/14/2022
F 684 SS=G	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 that residents receive treatment and care in accordance with professional standards of	F 684	Facility has created a new notifications policy to ensure that residents who are COVID positive are thoroughly assessed with reflected documentation for signs/symptoms ofCOVID-19 or change in condition, and that providers and family are notified within 2 hours or as appropriate based on severity or change in condition. Facility has created a new notifications policy to ensure that Providers and families receive timely notification if orders are not able to be fulfilled as noted, that all falls are thoroughly investigated and documented and reported as needed, that	

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F 684	Continued From page 15 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Surveyor: 40788 Based on observation, interview, anonymous complaint review, and policy review, the provider failed for one of one sampled resident (1) to ensure: *She had been thoroughly assessed for signs/symptoms of COVID-19. *She and her family as well as the writer of the order for the resident's transfer to a higher level of care had a delay in transfer notification occur in a timely manner. *A fall she had, had been documented and thoroughly investigated. *She had received physician ordered care for treatment of a rash. *She had weekly skin assessments completed and documented. Findings include: 1. Review of resident 1's care record revealed: *She had tested positive for COVID-19 on 1/21/22 and was transferred to a higher level of care of COVID-19 related treatment on 1/26/22. *COVID-19 nurse assessments between 1/21/22 and 1/26/22: -1/21/22 at 3:07 p.m.: "Is positive for COVID at this time." -1/21/22 at 10:35 p.m.: "This resident is COVID positive and has a non productive cough noted. She admitted to having sore throat she is SOB [short of breath] when ambulating and is without oxygen on. She is in isolation." -1/22/22 at 9:14 p.m.: "Is COVID positive, in quarantine. Lung sounds very diminished. Bowel	F 684	Orders are carried out timely and skin assessments occur per professional standards, notification is given to providers and families, and that any need for emergency treatment is addressed. Notice will be given within 2 hours or as appropriate based on severity or change in condition. COVID Assessments will be completed on every resident during outbreak periods one time per staff shift. During non-outbreak periods residents will be COVID assessed one time per day. COVID positive residents will be assessed once per shift or more frequently based on their condition, acuity, symptoms, or change in condition. Assessment will include SAO2, Temperature, Vital Signs and evaluation of other common COVID symptoms such as new fatigue, muscle or body aches, headache, sore throat, loss of taste and/or smell, or new dizziness. Acute care DON provided education and training for all staff about their roles and responsibilities to ensure residents receive care and services as per their needs and on these new policies. This training occurred 04/06/2022 Director of Nursing will review 5 random COVID positive resident records to ensure proper COVID assessments per week and will report aggregated results to the QAPI committee monthly for further recommendation. Director of Nursing is responsible for compliance The date of compliance is 4/14/2022. Resident 1 recovered from COVID illness and complications and returned to the facility on 03/2/2022	04/14/2022

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F 684	Continued From page 16 sounds are normal active. No fever noted. Skin is pale. Has been sleeping a lot today. Food and fluid intake is poor. Temperature-97.4, Pulse-94, Oxygen-85% on 2 liters. Oxygen was increased to 3 liters. Sats [oxygen saturations] went up to 93%. Will continue to observe." -There were no documented COVID assessments on 1/23/22. -1/24/22 at 4:22 a.m.: "Resident remains in COVID isolation." -1/24/22 at 12:53 p.m.: "Resident remains in COVID isolation noted with diminished lung sounds BIL [bilaterally], involuntary tremors and O2 [oxygen] saturations @74% on room air. Resident reminded and encouraged to keep O2 via NC [nasal cannula] on. SN [skilled nurse] place O2 on resident and sat [saturations] increased to 93%." -1/25/22 at 12:46 a.m.: "Continues to be in isolation for positive COVID." -1/25/22 at 4:19 p.m.: "This resident is on oxygen 4 liters via nc [nasal cannula] d/t [due to] isolation for COVID positive. She is SOB at rest with labored breathing noted. Poor appetite noted. She took her meds and tolerated them well. Afebrile [without a temperature]. -1/26/22 at 12:46 a.m.: "Continues to be in isolation for positive COVID test." -1/26/22 at 9:43 a.m. and 4:09 p.m.: Comprehensive COVID assessments were completed. *Documented vital signs between 1/21/22 and 1/26/22: -Respirations were documented on 1/24/22, 1/25/22, and 1/26/22. -Temperatures were documented on 1/24/22, 1/25/22, and 1/26/22. -Blood pressures were documented on 1/24/22, 1/25/22, and 1/26/22.	F 684	Director of Nursing or designee will review 5 random resident records to ensure proper audits of fall investigations, timely order implementation, skin assessments, and proper provider notifications for one month , bi weekly for one month, and then monthly for two months and will report aggregated results to the QAPI committee monthly for further recommendation. Date of compliance is 04/14/2022	04/14/2022

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F 684	Continued From page 17 -Oxygen saturations were documented daily. Interview on 3/15/22 at 1:45 p.m. with licensed practical nurse (LPN) F regarding nurse COVID assessments revealed: *Vital signs including pulse, respirations, temperature, blood pressure, and oxygen saturations are taken daily by the certified nurse aide. -He may or may not ask for or refer to that information in his COVID assessment of the resident. *The nurses' COVID assessment is a "visual" assessment that he described as "eye balling or looking at them and making a judgement call." Interview on 3/15/22 at 2:30 p.m. with DON B and ADON C regarding COVID-19 nurse assessments revealed: *Nurse assessments were expected to be completed twice daily for residents with COVID. -That assessment should consider the vital sign information obtained by the certified nurse aide or medication aide, lung sounds taken by the nurse, and a visual description of the resident's condition (breathing, skin color/temperature, food/fluid intake). *They agreed most of the COVID assessments referred to above "did not constitute an assessment" of the resident's condition. 2. Continued review of resident 1's care record revealed: *A late entry nurse note on 1/26/22 at 9:43 a.m.: -The nurse had been summoned emergently to the resident's room and she was found to be in respiratory distress. Her O2 saturation was 74% on room air. Her lung sounds had wheezes and rales and her lower left lobe was very diminished.	F 684		

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F 684	Continued From page 18 Her skin was pale and her face was swollen. A medical provider from the attached hospital/clinic arrived within minutes and ordered transfer to a higher level of care to receive treatment unable to be provided in the nursing home. --That could occur either in the attached emergency department or the attached hospital. *The hospital contacted DON B stating an anti-viral medication would be administered at 1:30 p.m. -At 3:00 p.m. and again at 3:30 p.m. the ADON C contacted the hospital and was told the emergency department had been busy. *At 4:09 p.m. resident 1 remained SOB on 4 liters of oxygen with O2 saturations between 88-90%. Her oxygen level dropped with the least of movement. She had a non-productive cough. Crackles were noted bilaterally to the anterior lungs. She was weak, lethargic and fatigued. Review of the 1/26/22 Bennett County Emergency Department admission note revealed: *Resident 1 arrived there at 8:15 p.m. *Her oxygen saturation was 75% on room air on presentation. -She was hypoxic with O2 84% on nasal cannula which increased to 92% on 6 liters with a non-rebreather mask applied. Review of the 1/26/22 Bennett County Hospital admission note revealed: *Resident 1 had transferred there from the emergency department and had been diagnosed with COVID pneumonia. -She remained hospitalized until her return to the nursing home on 1/31/22. Interview on 3/15/22 at 3:00 p.m. with physician assistant D revealed:	F 684		

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F 684	Continued From page 19 *He assessed resident 1 on 1/26/22 between 8:30 a.m. and 9:00 a.m. *Wrote orders for her to receive a COVID treatment that was unable to be provided in the nursing home. -That could occur in either the attached hospital or emergency department. *Had not been notified by nursing home staff there were barriers to promptly carrying out his order. *A direct admission to the attached hospital was an option for the resident to expedite her care if the emergency department had been too busy to admit her. Interview on 3/15/22 at 3:20 p.m. with ADON C revealed she: *"Dropped the ball." *Called the emergency department "at least three times" to determine why the resident not able to receive her ordered care but had not thought to update the medical provider to expedite that emergency room transfer or receive an order for a direct admission to the hospital for treatment. 3. Review of resident 1's care record relevant to an anonymous complaint revealed: *No progress notes that indicated she had fallen on 1/25/22. *The only documented vital signs had been taken close to midnight on that same date. *No post-fall nurse assessments. Review of the emergency department report from resident 1's transfer there on 1/26/22 revealed: "She [resident 1] complained of some right sided rib pain. Nursing staff not sure of fall." Interviews on 3/15/22 at 3:15 p.m. and on 3/16/22	F 684		

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F 684	Continued From page 20 at 10:10 a.m. with DON B regarding resident 1 revealed: *She confirmed the resident had fallen between 6:30 p.m. and 7:00 p.m. on 1/25/22. -No incident report had been completed. *She had not been notified of that fall until 1/29/22 and completed an incident report at that time. *CNA E reported she found the resident on the bathroom floor in her room with bruising to her coccyx and complaints of right should pain. -She had notified LPN G of the fall. *LPN G denied being advised of that fall. *DON B had not interviewed CNA E and LPN G together to determine what had or had not happened on 1/25/22, but should have. 4. Review of resident 1's January 2022 medication order summary revealed: *An 11/1/21 order for Clobetasol Propionate Ointment 0.05% applied to the vaginal folds topically two times a day for rash -That was a topical steroid used for swelling and itch due to a skin rash or irritation. 5. Review of resident 1's care record revealed: no skin assessments between 11/25/21 and 2/8/22. 6. Review of the 1/31/22 Patient Transfer Form revealed: *Resident 1 was discharged from Bennett County Hospital and returned to the nursing home on 1/31/22. *Her Foley catheter had been removed on 1/31/22. -"Pelvic region/scrotal area yeast present w/ [with] blanchable red improved w/ Nystatin powder." 7. Interview on 3/15/22 at 3:30 p.m. with DON B regarding resident 1 revealed:	F 684		

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F 684	Continued From page 21 *Resident 1's family member advised her there had been multiple medication cups containing medicated cream for her peri-area found her room. *That cream had been left for the resident to apply herself without staff supervision. -Her ability to safely and independently apply that cream had not ever been assessed by nursing staff, but should have been. *Weekly skin assessments were expected to be completed for all residents, but had not. 8. Interview on 3/16/22 at 3:00 p.m. with administrator A regarding resident 1 revealed: *He expected that resident had received a higher level of care within fifteen minutes of that physician's order. *ADON C should have been in communication with the medical provider regarding delay in care immediately. -It was not until the resident's family member had arrived on site that the transfer had occurred. *He confirmed the resident received insufficient oxygen in the nursing home on 1/26/22. -An oxygen valve had not been correctly placed by ADON C on the oxygen tank. -The resident's family member recognized the problem and addressed it. *He was aware the resident presented to the emergency room with a saturated brief. *A Foley catheter was inserted in the emergency room because her genital area was red and swollen. *He stated the combination of the wet brief and the improper use of the medicated vaginal cream likely contributed to the condition of her peri-area at the time of her emergency room presentation. 9. Review of the revised 9/22/20 Pandemic	F 684	ADON C has resigned and LPN F has been terminated. DON B has been replaced with a new RN / CNP who began serving as DON on 04/08/2022	

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	435135	A. BUILDING _____ B. WING _____	C 03/16/2022

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F 684	Continued From page 22 Resident Screen COVID-19 policy revealed: "1. All residents will be assessed at least once per 24 hr [hour] period for the following signs/symptoms of COVID-19 and results documented on COVID-19 Assessment tool in each resident's electronic medical record (EMR). Assessments will include temperature, pulse, respirations, blood pressure, and SaO2 [oxygen saturation] checks, and lung sounds." 10. Review of the December 2011 Post Falls Assessment and Follow Up Documentation policy revealed: *Notify the physician and family/POA of the fall. *File an Incident Report. *Check on the resident as their condition warrants for the rest of the shift. *Continue with neurological checks per policy if indicated. *Report the incident to the oncoming nurse for further follow-up. *Continue to assess the resident for signs and symptoms of injury related to the fall at least one time per shift for the next 72 hours and document findings. 11. Review of the revised November 2015 Pressure Sores: Skin Assessment and Prevention policy revealed: "2. A skin assessment will be completed on admit and weekly by a licensed nurse on all residents." 12. A policy regarding communication between providers and physician and family notifications was requested on 3/16/22 at 10:50 a.m. from ADON C, the provider offered no such policies.	F 684	Date of compliance is 04/14/2022	04/14/2022
F 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c)	F 726	The date of compliance is 4/14/2022.	04/14/2022

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F 726	Continued From page 23 §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 40788 Based on current employee list and interview, the provider failed to ensure three of three sampled nurse aides (NA) (H, I, and J) had demonstrated and documented competency in the skills and techniques necessary to care for and provide for	F 726	ADON C has resigned and LPN F has been terminated. DON B has been replaced with a new RN / CNP who began serving as DON on 04/08/2022 Competencies of staff are being evaluated and performed by the DON, or designee and by Bennett County Rural Health Clinic CNP , DNP, FNP-BC To ensure our Policy and Procedures are being followed and to ensure regulatory compliance. Competencies on NA H and NA I were completed by DON or Designee. NA J is out on personal leave and will be retrained and will be become certified when she returns. NA H and NA I became enrolled in the facility Certified Nursing Assistant Program on 3/29/2022 Human Resources manager will perform audits of all new hires to ensure competencies reviews, skills performance and education checklist will be completed for all NAs under the direction of a licensed nurse prior to any direct contact with a resident and to ensure that they enroll in an approved CNA program within 30 days of being hired, and HR manager will report results to the QAPI committee monthly for three months and extend based on QAPI committee review and recommendation. The Director of Nursing will be responsible for compliance. The date of compliance is 4/14/2022.	04/14/2022 04/14/2022 04/14/2022

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F 726	Continued From page 24 resident needs. Findings include: Review of the provider's 3/15/22 employee list revealed NA H's hire date was 9/15/21, NA I's hire date was 12/8/21, and NA J's hire date was 1/24/22. Interview on 3/16/22 at 9:00 a.m. with NA J revealed: *Her NA training consisted of one day of job shadowing another staff person. *She was limited in the types of care she was able to provide residents until she had completed her certified nurse aide training and certification. Interview on 3/16/22 at 1:50 p.m. with director of nursing B revealed: *A skills performance checklist was expected to be completed for all NAs under the direction of a licensed nurse prior to any direct contact with a resident. *It was her responsibility to ensure those checklists had been completed. -No skills performance checklists had been completed for NAs H, I, and J. -She knew NAs were performing resident care outside the scope of their limited role including feeding residents. Interview on 3/16/22 at 3:25 p.m. with administrator A regarding NA training revealed he: *Expected DON B had completed skills performance checklists with all NAs prior to any direct contact with residents. *Stated that expectation had most recently been re-iterated to DON B in February 2022. A nurse aide job description was requested on 3/16/22 at 12:45 p.m. from assistant director of	F 726		

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F 726	Continued From page 25 nursing C. A certified nurse aide job description was provided.	F 726	The date of compliance is 4/14/2022. ADON C has resigned and LPN F has been terminated.	04/14/2022
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 40788 Based on observation, interview, record review, anonymous complaint and online reporting review, and policy review, the provider failed to ensure the facility was operated and administered by administrator A, director of nursing (DON) B, and assistant director of nursing (ADON) C in a manner that ensured the safety and overall well-being of all twenty-nine residents in the facility. Findings include: 1. Observations, interviews, record reviews, anonymous complaint and online reporting review, and policy reviews from 3/15/22 at 10:30 a.m. through 4:10 p.m. and 3/16/22 from 8:30 a.m. through 4:45 p.m. revealed administrator A had not ensured safe management and overall well-being of all the residents who lived in the facility. Confidential interviews on 3/16/22 between 8:55 a.m. and 9:45 a.m. with three staff who requested to remain anonymous revealed: *One staff stated administrator A had been in the	F 835	DON B has been replaced with a new RN / CNP who began serving as DON on 04/08/2022 C N A E left the area before any other action could be taken The CEO/Administrator, COO, DON or designee and QAPI nurse (when working) will meet every week day in the Nursing Home to convene a resident safety and well-being huddle to attain and maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The meeting will also include the DON or designee (when working) from the adjacent Hospital and will follow the existing meeting agenda. A sign-in sheet will be kept for recoding attendance. The QAPI nurse or designee will interview 2 random staff members each week for two months to ensure that there has been follow up by facility leadership of staff or resident concerns. These audits will be reported to the QAPI committee for review and further recommendation. The CEO/Administrator will be responsible for compliance. The date of compliance is 4/14/2022.	04/14/2022

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F 835	Continued From page 26	F 835		

nursing home three times since June 2020.
-His office was located in the attached hospital.
*A second staff recalled having seen him once during that same time frame.
*The third staff member stated she:
-Had recently contacted administrator A about a staffing issue and was told she "could handle it" since she had done that before.
-"Rarely "saw administrator A in the nursing home.
-DON B and ADON C spent most of their time in the nursing home in their office with the door closed.

Interview on 3/16/22 at 4:15 p.m. with administrator A revealed he:
*Was aware of most staff concerns and resident care issues identified during the current survey.
*Provided ongoing education and training with DON B and ADON C to ensure their understanding of his expectations regarding the operation of the nursing home.
-There were problems with their accountability.
*Spent time in the nursing home two to three times per week rounding with "the engineer "and meeting with DON B and ADON C.
-"Talked to some residents" when he was in the nursing home, but stated "I need to spend more time there."

Review of the 9/11/19 Administrator job description revealed: "The Administrator provides leadership, direction, and administration of all aspects of the hospital, nursing home, and affiliated ventures."

Review of the May 2018 Director of Nursing job description revealed: "Perform day to day activities that will assist the Administrator of the facility in accordance with current federal, state

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F 835	Continued From page 27 and local standards, guidelines and regulations governing our facility and as may be directed by the Administrator to assure that our facility is maintained in an orderly manner." Review of the December 2021 Assistant Director of Nursing Job Description revealed: "The Assistant Director of Nursing is responsible for the nursing team and quality of patient service in coordination and/or absence of the Director of Nursing." Refer to F609, F610, F677, F679, F684, and F726.	F 835	The date of compliance is 4/14/2022	04/14/2022