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

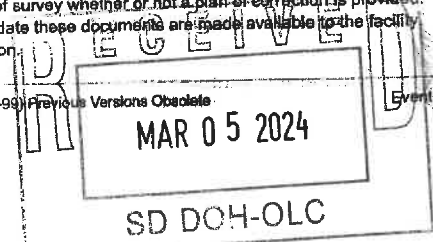
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435043	A. BUILDING ______ B. WING ______	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET SPEARFISH, SD 57783

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/5/24 through 2/7/24. Spearfish Canyon Healthcare was found not in compliance with the following requirements: F558, F576, F584, F600, F658, and F880.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure the following: *Four of four Resident Council members' (22, 28, 32, and 47) preference to have menu information posted was accommodated. *One of one sampled resident (33) had not received his requested food choice at meals. Findings include: 1. Group interview on 2/6/24 between 11:00 a.m. and noon with Resident Council members 22, 28, 32, and 47 regarding the facility's food service program revealed: *Resident menus were not posted. *The Resident Council members referred to above made food choices each day from a paper menu provided that listed the following days meal option information. -Families of some residents who were unable to	F 558	Corrective Action The TV in the dining room is for digital signage. It has been fixed and turned on to have a scrolling daily menu throughout the day. The TV in the main lobby is also for digital signage. It has also been turned on to a have scrolling daily menu throughout the day. Residents have access to other TV's throughout the building (their personal rooms, Birdroom, and Sunroom) to watch their programs. The Menus policy was reviewed. All dietary and nursing staff will be educated on the Menus policy to give residents their selected menu items and if a substitution must be made the resident or family member is in agreeance with the substitution as well as menus have to be displayed in 2 resident areas in the facility, on or before March 15, 2024. Dietary manager/designee be responsible to have the TVs menu loaded each day. Dietary manager/designee will also ensure at the week's end that next week's menu items are available.	March 15, 2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charlotte Kirkhey — TITLE: Administrator — (X6) DATE: 3/5/24

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.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F 558	Continued From page 1 make their own food choices were provided multiple days worth of menus to complete for their family member. *Menu information was supposed to have been posted on the white erasable board at the entrance of the dining room or on a mounted television screen inside the main dining room. *Knowing in advance of upcoming menu information was important to the Resident Council members. -That sometimes dictated whether one of the Resident Council members chose to eat somewhere other than the facility. -Other Resident Council members were unable to remember what they selected for the next days meal after they completed their daily menu. Interviews on 2/6/24 at 3:45 p.m. and again on 2/7/24 at 11:15 a.m. with dietary supervisor E revealed: *He was rehired as the dietary supervisor two days ago after having been the facility's administrator for a year and a half. -Before that time, he was the facility's dietary supervisor. *He confirmed there was no posted menu information for residents to know what was scheduled to be served to them beyond the next days menu. *A television screen in the dining room was designated to display facility-specific information including the weekly menu information. -The computer flash drive that contained the current menu cycle was not available to the kitchen staff to upload on that television so it was turned off. *The erasable whiteboard was used to communicate menu changes. *He was aware of the significance of residents	F 558	Residents will be informed of these updates by overhead speaker and the resident council meeting on or before March 15, 2024. Identification of Others All residents have the potential to be affected. Systematic Changes Administrator/DON/Dietary Director/designee is to provide education on the Menu policy to dietary and nursing staff to ensure all residents receive their selected menu items and to understand they must offer the resident, or family member, an acceptable substitution as well as menus being posted in 2 resident areas in the facility on or before March 15, 2024. Dietary Director/designee is to ensure the next weeks' menu items are available and the digital signage TVs are loaded with the menus.	March 15, 2024

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F 558 Continued From page 2
knowing what their food choices were beyond the next day's menu options.

Review of the revised October 2017 Menus policy: "11. Copies of menus are posted in at least two (2) resident areas, in positions and in print large enough for residents to read them."

2. Interview and observation on 2/5/24 at 5:35 p.m. in the main dining room revealed:
*Resident 33's daughter stated she had been noticing her father had not been getting the food that they requested on his meal tickets.
*Resident 33's supper meal had been served accordingly to what the family requested on his meal ticket.

Observation on 2/6/24 at 12:47 p.m. of resident 33 revealed he:
*Had been served pureed peas instead of the requested pureed capri vegetable mix.
*Had been served chocolate pudding instead of the requested pureed peaches.

Interview on 2/6/24 at 4:35 p.m. with dietary supervisor E regarding the above observation revealed:
*There were pureed peaches in the kitchen.
*He was unsure why the staff had not served resident 33 the pureed peaches.
*They did not have any capri vegetable mix to puree.

Observation on 2/6/24 at 5:33 p.m. of resident 33 revealed he was served pureed peas instead of the requested pureed green beans.

Interview on 2/7/24 at 11:13 a.m. with dietary

F 558

Monitoring

Administrator/DON/Dietary Director/designee will audit 4 residents weekly for 1 month beginning on or before March 15, 2024, to determine if the residents are seeing the scrolling daily menus on the TV screens and if they are receiving their selected menu items or are offered an acceptable substitution. After 1 month, the audits will continue 2 times per month for an additional 1 month. Then monthly until the QAPI committee determines the facility is demonstrating sustained compliance. Any issues identified during these audits will be corrected immediately and re-education will be provided at the time of the audit.

Administrator/designee will audit menu items for 1 week for 1 month on or before March 15, 2024, to determine if the next weeks' menu items are available. After 1 month, the audits will continue 2 times per month for an additional 1 month. Then monthly until the QAPI committee determines the facility is demonstrating sustained compliance. Any issues identified during these audits will be corrected immediately and re-education will be provided at the time of the audit.

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F 558	Continued From page 3 supervisor E regarding the above observation revealed he: *Had told his staff they needed to be watching what was on the tickets and what was served to the residents more closely. *Had told the staff if they do not see the food that was requested, they need to ask him and he would assist them in finding the requested food. *Agreed that staff should have been asking the resident or family if a substitute was fine before serving the substitute to them. 3. Review of provider's March 2021 revised Accommodation of Needs policy: "2. The resident's individual needs and preferences are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered."	F 558		
F 576 SS=F	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail.	F 576	Corrective Action The front desk receptionist is now responsible for delivering residents' mail Monday through Friday. The Activities Department is now responsible for delivering residents' mail on Saturdays. Job descriptions of the front desk receptionist and the Activities Department have been updated to reflect the duties of mail delivery.	March 15, 2024

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F 576	Continued From page 4 §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on interview, and policy review, the provider failed to ensure mail delivery was available on Saturdays for all 67 residents residing in the facility. Findings include: 1. Interview on 2/6/24 at 9:00 a.m. with resident 19 revealed: *The facility's business office staff delivered resident mail Monday through Friday. -Resident mail was not delivered on Saturdays because there were no business office staff available to deliver it on that day. *There was no delivery of Saturday mail for "as long as I can remember". Interview on 2/6/24 at 9:05 a.m. with assistant	F 576	Identification of Others All residents have the potential to be affected. Systematic Changes The Mail Delivery policy was reviewed. The Administrator will educate the front desk receptionist, the Activities Department, the Business Office Manager, and Assistant Business Office Manager of the Mail Delivery policy and the process change on or before March 15, 2024.	March 15, 2024

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F 576 Continued From page 5

business office manager (BOM) J regarding Saturday resident mail delivery revealed:
*She, BOM I, and receptionist M were responsible for delivering mail to the residents on weekdays.
*Resident mail delivered on Saturdays was "held over" (not given to residents) until the next Monday when she, BOM I, and receptionist M returned to work.
-There was no designated staff person assigned to deliver resident mail on Saturdays.

Interview on 2/7/24 at 8:30 a.m. with administrator A and director of nursing B revealed:
*They were not aware resident mail delivery was not occurring on Saturdays.
*The activities department was responsible for ensuring resident mail was delivered on Saturdays.
-An activities department staff person was scheduled to work seven days a week.

Review of the revised May 2017 Mail and Electronic Communication policy revealed "4. Mail and packages will be delivered to the resident within twenty-four (24) hours of delivery on premises or to the facility's post office box [including Saturday deliveries.]"

F 576

Monitoring

The administrator/designee will audit 4 residents weekly for 1 month beginning on or before March 15, 2024, to determine if the residents are getting their mail Monday through Saturday. After 1 month, the audits will continue 2 times per month for an additional 1 month. Then monthly until the QAPI committee determines the facility is demonstrating sustained compliance. Any issues identified during these audits will be corrected immediately and re-education will be provided at the time of the audit.

F 584 SS=E Safe/Clean/Comfortable/Homelike Environment
CFR(s): 483.10(i)(1)-(7)

F 584

§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

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F 584	Continued From page 6 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review the provider failed to ensure: *One of one hallway (400) was maintained in a home-like environment.	F 584	Corrective Action The unused screw holes in the hallway of 400 will be filled and painted on or before March 15, 2024. The refrigerator will be replaced with a new one by maintenance staff on or before March 15, 2024. The carpet in the Sunroom and throughout the facility was professionally cleaned by Captain Clean finishing on February 22, 2024. The cushions on the loveseat have been cleaned and put on a weekly cleaning schedule. A cover for the loveseat has been ordered as well. The faucet heads on the sinks in the resident rooms will be cleaned on or before March 15, 2024. A new hot water softener will be installed on or before March 15, 2024, by Superior Water. All staff will be trained, and instructions hung by the Kiosks in each hallway, on the TELS Work Order Creation- Standard Operating Procedure Instructions on using the TELS system to report surfaces or furniture needing to be cleaned or repaired on or before March 15, 2024. The housekeeping supervisor will be given a Houskeeping and Laundry Service Cleaning Schedule to follow for preventative maintenance checks on or before March 5, 2024.	March 15, 2024

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F 584	Continued From page 7 *One of one hallway (400) refrigerator was clean. *One of one carpet in the sunroom was maintained and clean. *One of one loveseat cushions in the sunroom was maintained and clean. *The faucet heads on the sinks in 34 out of 34 residents' rooms, on the green unit were maintained and clean. Findings include: 1. Observation on 2/6/24 at 11:32 a.m. of hallway 400 and the sunroom revealed: *There were multiple unused screw holes in the walls. *The refrigerator had dark brown stains on the bottom of the refrigerator and the top shelf on the door. *The carpet in the sunroom had multiple dark stains on it. *The cushions on the loveseat in the sunroom had stains on them. *The faucet heads on the sinks in residents' rooms had white, hard and thick buildup on them. Interview on 2/7/24 at 8:50 a.m. with plant maintenance assistant Z revealed: *He had not noticed the multiple unused screw holes in the walls. -The holes in the walls should have been filled and painted over. *Maintenance was not responsible for the cleaning of the refrigerator. *He confirmed the carpet in the sunroom had multiple stains but was unsure who was responsible for it. *Cleaning of the cushions on the loveseat in the sunroom was completed by housekeeping staff. *He confirmed that maintenance was responsible for the upkeep of the faucet heads in residents'	F 584	Identification of Others All residents have the potential to be affected. Systematic Changes The administrator/DON/designee is to provide education to all staff on the TELS Work Order Creation- Standard Operating Procedure instructions and to put housekeeping and maintenance requests regarding uncleanliness of surfaces or furniture, and surfaces needing to be repaired into the TELS system on or before March 15, 2024. The administrator/designee is to provide education to the housekeeping staff on the Cleaning and Disinfection of Environmental Surfaces policy on or before March 15, 2024. The administrator will educate the housekeeping supervisor to provide a regular schedule of when furniture in the Sunroom and carpeting throughout the facility will be cleaned as well as provide a Housekeeping and Laundry Service Cleaning Schedule on or before March 15, 2024.	March 15, 2024

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F 584 Continued From page 8

room.
-He confirmed the faucet heads were unappealing and needed to be addressed.

Interview on 2/7/24 at 10:15 a.m. with administrator A and director of nursing (DON) B revealed:
*DON B was not aware of the unused screw holes in the 400 hallway.
-The unused screw holes should have been filled and painted over.
*Confirmed that the refrigerator in the 400 hallway was unclean and all staff was resposible for cleaning it.
*They confirmed that the sunroom carpet had multiple stains on it.
-The carpet cleaners were to have been there the next week to clean the carpet.
*They were unaware of the stains on the cushions of the loveseat that was in the sunroom.
-They confirmed that the cushions on the loveseat in the sunroom were not cleanable.
*DON B was not aware of the buildup of white, hard, and thick buildup on the head of the faucet heads in the resident's rooms on the green unit.
-She agreed that the buildup on the faucet heads was unappealing and needed to be addressed.

Review of providers revised 2023 "Cleaning and Disinfection of Environmental Surfaces" policy reveals:
*3. Devices that are used by staff but not in direct contact with residents shall be cleaned and disinfected regularly by the environmental services staff and as needed by the nursing staff.
*10. Environmental surfaces will be disinfected on a regular basis and when surfaces are visibly soiled.

F 584

Monitoring

The administrator/designee will audit furniture in the Sunroom, carpeting throughout the facility, walls throughout the facility, and refrigerators for 1 month beginning on or before March 15, 2024, to determine cleanliness and good repair. After 1 month, the audits will continue 2 times per month for an additional 1 month. Then monthly until the QAPI committee determines the facility is demonstrating sustained compliance. Any issues identified during these audits will be corrected immediately and re-education will be provided at the time of the audit.

The administrator/designee will audit faucet heads in 4 resident rooms for 1 month beginning on or before March 15, 2024, to determine they are clean and in good repair. After 1 month, the audits will continue 2 times per month for an additional 1 month. Then monthly until the QAPI committee determines the facility is demonstrating sustained compliance. Any issues identified during these audits will be corrected immediately and re-education will be provided at the time of the audit.

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F 584	Continued From page 9 Review of providers revised December 2009 "Cleaning/Repairing Carpeting and Cloth Furnishings" policy revealed: *2. Carpets shall be deep cleaned periodically or more often as needed. *6. Stained or soiled upholstered furniture shall be cleaned in a manner consistent with the type of fabric and stain.	F 584		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the following: *One of one sampled resident (116) was provided timely incontinence care by one of one certified nurse aide (CNA) (P). *Physical therapy recommendations regarding bed mobility for one of one sampled resident (25) were followed by one of one activities director (H) and one of one CNA (N).	F 600	Corrective Action CNA P completed assigned training regarding Skin Care Basics and Urinary Care for CNAs on Healthcare Academy on February 6, 2024, before he started another shift. All nursing staff will be reeducated on Skin Care Basics and Urinary Care on Healthcare Academy on or before March 15, 2024. Resident 116 had a skin assessment completed on February 6, 2024. No issues were identified. At the monthly All Staff meeting education trivia was presented to all staff on the unacceptance of residents wearing two briefs, the importance of paying attention to signs in rooms, and reading the resident Kardex on February 13, 2024. A Performance Improvement Plan will be discussed with CNA P reflecting walking rounds and education on the Abuse/Neglect policy on or before March 15, 2024. All nursing staff will be educated on walking rounds and the Abuse/Neglect policy on or before March 15, 2024.	March 15, 2024

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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

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Findings include:

1. Observation and interview on 2/5/24 at 1:30 p.m. with CNA O assisting resident 116 in the bathroom revealed:
*CNA O was a "float CNA" [assisted other CNAs in different resident living units provide resident care] that day.
-That was her first encounter with resident 116 on that day.
*CNA O commented the resident was wearing two pairs of incontinent briefs underneath his pants.
-He had a bowel movement in the first pair of briefs and the second pair of briefs was dry.
*The resident was unable to verbalize why he was wearing two pairs of briefs.
-He was unable to independently have placed those briefs on himself.

Interview on 2/5/24 at 2:24 p.m. with director of nursing (DON) B revealed CNA O had discussed with her the observation referred to above regarding resident 116.

Interview on 2/5/24 at 2:26 p.m. with CNA P revealed he:
*Overheard the conversation between the surveyor and DON B referred to above.
*Had "forgotten" about resident 116 and not provided him incontinence care since arriving for work at around 6:00 a.m. that day.
-The resident had moved to a different room on that unit last Friday and this was CNA P's first day back to work since that move occurred.

Interview on 2/5/24 at 3:30 p.m. with unit director/licensed practical nurse C regarding the process for shift-to-shift communication regarding

F 600

CNA N and Activities Director H will be reeducated on the Transferring policy and reading the Kardex prior to care to be completed on or before March 15, 2024.

All staff will be reeducated on the Transferring policy and reading the Kardex prior to care to be completed on or before March 15, 2024.

Weight bearing status was verified on resident 25. His care plan and Kardex were updated to reflect the status. A copy of the order was provided to MDS/DON/Nurses station/Communication book and charge sheets regarding resident's weight bearing status.

Identification of Others

All residents have the potential to be affected.

Systematic Changes

DON/designee is to ensure all nursing staff have access and review resident Kardexs on or before March 15, 2024.

DON/designee is to educate all staff on the Abuse/neglect policy, Transferring policy, and walking rounds on or before March 15, 2024.

All nursing staff will review education of Skin Care Basics and Urinary Care on Healthcare Academy on or before March 15, 2024.

Completion date: March 15, 2024

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	435043	A. BUILDING ______ B. WING ______	02/07/2024

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resident care revealed:
*Off-going staff and on-coming staff were expected to complete daily "walking rounds".
-That included walking from room to room with the off-going staff providing the on-coming staff a verbal report regarding each resident residing on that unit.

Interviews on 2/6/24 at 12:15 p.m. and again on 2/7/24 at 3:30 p.m. with DON B and administrator A regarding resident 116 revealed:
*DON B interviewed the overnight staff person responsible for resident 116's care on the evening of 2/4/24 through the morning of 2/5/24. That staff person reported:
-CNA P was given a verbal hand-off report on 2/5/24 around 6:00 a.m. that included resident 116.
-No walking rounds occurred.
-Resident 116's incontinence brief was dry when it was last checked before leaving the overnight shift around 6:00 a.m.
*DON B confirmed CNA P had not checked resident 116's incontinency brief between 6:00 a.m. and 1:30 p.m. on 2/5/24.
-CNA P's failure to have provided resident 116 personal care during that time was careless.
*There was no explanation or reason why resident 116 was wearing two incontinent briefs when he was checked and changed at 1:30 p.m. on 2/5/24.

2. Observation and interview on 2/5/24 at 3:08 p.m. with activities director H and CNA N transferring resident 25 from his wheelchair to his bed with a Hoyer mechanical lift revealed:
*One side of his bed was pushed against the south wall.
-On that wall directly above the center of the bed

F 600

Monitoring

DON/designee will audit 4 residents 2 times per week for 1 month beginning on or before March 15, 2024, to determine 1 brief is being used, incontinence cares are being performed timely, and positioning or transfers are performed per the residents Kardex. Audits will continue 2 times per month for 1 month. Then monthly until the QAPI committee determines the facility is demonstrating sustained compliance. Any issues identified during these audits will be corrected immediately and re-education will be provided at the time of the audit.

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was a sign that read: "Pillow between knees when rolling."
*After lowering the resident to his bed using the lift, activities director H and CNA N rolled the resident without using a pillow between his knees on his right then his left side to remove the Hoyer lift sling from underneath his body.
-The resident cried out in pain each time he was rolled onto his side.
*CNA N thought the resident had a left leg fracture but was not aware of any specific precautions that were expected to be followed when he was physically moved.
-She was hired about a week ago and had only cared for the resident one other time.
*Activities director H (also a CNA) referred her to the resident's Kardex (a resource that provided an overview of an individual resident's care needs) for resident-specific care information.
*Activities director H and CNA N confirmed seeing the sign on the wall referred to above regarding the resident's care needs but "it just didn't register" [to have followed those instructions].

Review of resident 25's electronic medical record revealed he:
*Was admitted to the facility on 1/22/24 after he was hospitalized with a left intertrochanteric femur fracture (a specific type of hip fracture).
-Elected not to have surgery on that fracture while he was hospitalized but after his admission to the facility decided he wanted to have surgery.
-Was waiting on medical clearance from a pulmonologist and orthopedic surgery before that surgery was able to be scheduled.
*Had no physician orders related to his weight bearing status or specific care instructions for staff to have followed related to his fracture.

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Review of his care plan revised on 2/5/24 revealed:
*The resident had declined the use of a knee immobilizer to his left lower extremity but used a pillow between his knees when rolling in bed for all care.
-There was no mention of his current weight bearing status or how the resident was expected to have been transferred in and out of bed.

Interview on 2/5/24 at 3:17 p.m. with unit director/licensed practical nurse D regarding resident 25 revealed:
*He admitted to the facility with comfort care orders but had since decided to proceed with rehabilitation and surgical treatment of the hip fracture.
*Staff were expected to use a pillow between his legs to prevent him from crossing his legs.

Interview on 2/6/24 at 8:40 a.m. with physical therapist L regarding resident 25 revealed:
*She placed the sign above his bed regarding the use of a pillow between his legs when he was rolled in bed during care.
-It was purposely hung "where the activity [bed mobility] occurs" to ensure staff had read and followed her instructions.
*The purpose of using a pillow was for the resident's comfort and to keep his left hip in a neutral position to prevent undue stress.

Interview on 2/7/24 at 8:45 a.m. and review of resident 25's care plan with administrator A and DON B revealed:
*It was last week when the resident started transferring out of his bed and into a wheelchair.
*Director of rehabilitation K and the resident's

F 600 Continued From page 14 F 600

medical provider discussed the physical restrictions related to his hip fracture.
-The therapy department was responsible for but had not updated the resident's care plan to reflect his weight-bearing status or how the resident was expected to have been transferred in and out of his bed.
*Care plan content was linked to the resident's individualized Kardex for staff to have know-how to care for resident 25's hip fracture.
*Activities director H and CNA N failed to follow physical therapist L's instructions regarding how to safely and comfortably remove the lift sling from beneath resident 25 causing him undue stress and discomfort.

Interview and review of the 2/2/24 "Requested Change in Care Plan" on 2/7/24 at 9:45 a.m. with director of rehabilitation K regarding resident 25 revealed:
*Orders from the resident's medical provider:
"Staff to assist out of bed with Hoyer lift, at least daily. NWB [non-weight bearing] L LE [left lower extremity]."
-A copy of that communication was to be routed to the following facility staff: the Minimum Data Set Coordinator, director of nursing, the nurses' station and placed in a staff communication book, and charge nurse sheets.
*Director of rehabilitation K was out sick and the process referred to above had not occurred.

Review of the September 2022 Identifying Neglect policy revealed:
*"5. Neglect includes cases where the facility's indifference to or disregard for resident care, comfort or safety results in (or could have resulted in) physical harm, pain, mental anguish or emotional distress."

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F 600	Continued From page 15 *"9. Examples of failures to provide care and services to the resident that result in neglect include:" "f. Failure of staff to implement resident interventions, even when residents are assessed and interventions are identified in the care plan;"	F 600		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure one of one licensed practical nurse (LPN) (X) had removed and cleaned the nebulizer mask and the medicine reservoir when the treatment was completed for one of one sampled resident (33). Findings include: 1. Observation and Interview on 2/5/24 at 4:40 p.m. in resident 33's room revealed: *LPN X was administering the resident's nebulizer treatment. *After the setup of the nebulizer, LPN X had asked the resident's daughter if she would prefer the LPN to have come back and remove the nebulizer mask or if the daughter would remove the nebulizer mask and the daughter stated she would remove the nebulizer mask. *The daughter stated she had visited her father in the evenings and his nebulizer mask was still on and the liquid in the medication reservoir was gone.	F 658	Corrective Action Med Aide X and LPN/Unit Manager D will be educated on not allowing family members to remove and clean nebulizer equipment unless they have been properly trained, and it is care planned, as well as reviewing the Administering Medications through a Small Volume (Handheld) Nebulizer policy on or before March 15, 2024. Nebulizer cleaning will be put on the resident TARS on or before March 15, 2024. Resident 33's family will be trained to remove and clean nebulizer mask and equipment and will review the policy Administering Medications through a Small Volume (Handheld) Nebulizer. The care plan will be updated to reflect the training on or before March 15, 2024. All nursing staff will review and be educated on the Administering Medications through a Small Volume (Handheld) Nebulizer policy and ensuring only trained individuals can administer, or clean the Nebulizer, per the care plan, on or before March 15, 2024.	March 15, 2024

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F 658	Continued From page 16 *She understood the medicine was gone when the machine had made a different sound and the smoke in the nebulizer mask was gone. -The nebulizer treatment would have taken about 10 minutes. -She would have cleaned the nebulizer mask and the medicine reservoir. -She had not had any formal training or any discussion that covered knowing when the treatment was completed or how to clean the nebulizer mask or medicine reservoir. Observation on 2/6/24 at 4:00 p.m. in resident 33's room revealed: *LPN X was administering the resident's nebulizer treatment. *After the setup of the nebulizer, LPN X had asked the resident's daughter if she would prefer the LPN to have come back and remove the nebulizer mask or if the daughter would remove the nebulizer mask and the daughter asked the nurse to come back and remove the nebulizer mask. Interview on 2/6/24 at 4:07 with LPN X regarding the above observation revealed she: *Had been allowing the family to remove the mask after the nebulizer treatment was done. *Had taught the family to listen for a different sound when the nebulizer treatment was done and the smoke inside the nebulizer mask would have been gone, and it would have taken between 8 to 12 minutes to complete the treatment. *Had been going back to the resident's room after the family had removed the nebulizer mask and cleaned the nebulizer mask and the medicine reservoir. *Had discussed with her unit manager that she	F 658	Identification of Others All residents have the potential to be affected. Systematic Changes DON/designee will educate all nursing staff on policy, Administering Medications through a Small Volume (Handheld) Nebulizer, and that only those who are properly trained can remove and clean a nebulizer mask and equipment, and care plan are updated appropriately, on or before March 15, 2024. Monitoring DON/designee will audit 4 residents 2 times per week for 1 month beginning on or before March 15, 2024, to determine if resident Nebulizer mask and equipment is being removed and cleaned per properly trained individuals and the care plans are updated appropriately. The audits will continue 2 times per month for 1 month. Then monthly until the QAPI committee determines the facility is demonstrating sustained compliance. Any issues identified during these audits will be corrected immediately and re-education will be provided at the time of the audit.	March 15, 2024

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F 658	Continued From page 17 had been working with the resident's family. Interview on 2/7/24 at 1:16 p.m. with unit manager D regarding the above observation revealed she: *Felt resident 33's family had been particular with some of their requests for their father and that had included the nebulizer treatments. *Had verbally taught the daughter and son when the nebulizer treatments were finished and how to remove the nebulizer mask. *Had not put any documentation in the resident's chart of any formal training with the family. *Had not put a cleaning schedule into the treatment administration record (TAR) for staff to follow regarding the nebulizer mask or the medicine reservoir. Interview on 2/7/24 at 1:55 p.m. with director of nursing (DON) B revealed she: *Expected LPN X to have removed and cleaned the nebulizer mask and the nebulizer medication reservoir. *Had not expected the resident's family to have removed and cleaned the nebulizer mask and the reservoir cup. Review of provider's revised October 2010 Administering Mediations through a Small Volume (Handheld) Nebulizer Policy revealed: 24. "When treatment is complete, turn off nebulizer and disconnect T-piece, mouth piece and medicine cup." 27. "Rinse and disinfect the nebulizer equipment according to facility protocol."	F 658		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

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F 880	Continued From page 18 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880	Corrective Action CNA/bath aide O will be given individual education, complete in-service, and return demonstration to DON/designee on or before March 15, 2024. All bath aides will be given education, complete in-service, and return demonstration to DON/designee on or before March 15, 2024. Basins will be provided to residents 25 and 54 to keep their urine collection bags from laying on the floor when their bed has to be in a low position on or before March 15, 2024. Traveling therapist T, CNA N, and Activities Director H will be educated that urine collection bags cannot touch the floor, they need to be attached to a bed or wheelchair. And, if the bed has to be in a low position a basin must be in place to prevent the urine collection bag from being on the floor on or before March 15, 2024. All direct care staff will be educated on Catheter Care policy and Infection Control policy on or before March 15, 2024.	March 15, 2024

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F 880	Continued From page 19 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure infection prevention and control practices were implemented to ensure the following: *One of two bath aides (O) had demonstrated effective cleaning of the whirlpool (WP) tub, air jets, and bath seat, in one of two sampled multi-use resident WP bathrooms. *Urine collection bags for three of six sampled residents (13, 25, and 54) were kept off of the floor and covered with a protection bag (dignity bag used to hold and protect urine collection	F 880	Identification of Others All residents have the potential to be affected. Systematic Changes Root cause analysis was conducted. The 5 whys of cleaning the whirlpool tubs were obtained and include staff not knowing the accurate steps in order of procedure per manufacturer guidelines, staff not having visualization of procedure, staff rushing process, staff not using labeled disinfectants, and disinfectant not readily available. The 5 whys of urine collection bags being on the floor were obtained and include proper education to direct care staff, lack of knowledge of where dignity bags are located, lack of area to hook urine collection bags, lack of staff knowledge of basin process, and staff being in a hurry.	March 15, 2024

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bags).
Findings include:

1. Observation and interview on 2/07/24 at 11:45 a.m. with bath aide O in the Clarkson hallway multi-resident use WP bathroom revealed:
*She had already cleaned the WP tub but was willing to demonstrate her cleaning methods.
*She would spray down the tub, including the chair, with an unlabeled spray bottle that was hanging off a linen cart in the main resident bath area.
-Stated the bottle contained a sanitizing solution but could not recall the name of the solution.
*After spraying the inside surfaces of the WP tub, she let those areas soak in the spray solution for about 10 minutes.
-She was unable to recall exactly how long the sanitizing spray should soak before wiping it off.
-She would then wipe down the inner sides of the tub and the surface of the chair seat with a clean cloth.
-She would then rinse the tub with clean water.
-She would flush the WP air jets with a sanitizer solution after every second resident's bath.
*She would scrub and sanitize the underside of the WP seat about two times in every five days of her giving baths.
-Stated, "Probably not as often as I should."
-Sometimes she would use a brush to scrub the tub surfaces, but not always.
*She could not recall the provider's protocol for cleaning and disinfecting of the WP bathtub and bathroom.
-She had been shown several different ways of cleaning the WP room with several different bath aides.
-Stated she felt she was being very thorough in how she cleaned the WP tub.

F 880

Administrator and DON contacted the South Dakota Quality Improvement Organization on February 28, 2024. The discussion included the root cause analysis of why we thought the whirlpool tubs were not getting cleaned properly. Suggestions that were discussed were to laminate signs in each tub room describing the process of cleaning the tubs and reeducating bath aides to include the manufacturer guidelines.

The root cause analysis of why catheter bags were laying on the floor was also discussed. The discussion started with the facility having purchased new urine collection bags with already manufactured covers. Suggestions were discussed to include having basins readily available for the urine collection bags. Direct care staff will be educated to keep the urine collection bags from hitting the floor and to use a basin if the bed is in a low position to keep the urine collection bag from laying on the floor.

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*She had not identified the cleaning of any other WP room surfaces other than the inside surfaces of the WP bathtub.
*She agreed infectious materials like bacteria, viruses, and fungi, could remain in the tub, on the seat, and in the WP jets if they were not thoroughly cleaned, scrubbed, and sanitized between each resident.

Interview on 2/07/24 at 3:29 p.m. with director of nursing (DON) B and administrator A regarding the cleaning and sanitizing of the WP bathtub and bathroom revealed it was their expectation for the WP tub, jets, seat, and surrounding surfaces to be thoroughly cleaned, scrubbed, and sanitized between each resident use and according to their policy.

Review of the provider's February 2023 'Bath, Shower/Tub' policy revealed:
*"Steps in the Procedure."
-"9. Be sure the tub or shower is clean."
-"35. Clean the bath tub with a disinfectant solution."
*There were no instructions or policy provided on how to clean and sanitize the WP bathtub or bathroom surfaces.

Review of the provider's 2023 'Infection Prevention and Control Program' policy revealed:
*"11. Prevention of Infection. a. (3) educating staff and ensuring that they adhere to proper techniques and procedures;"

2. Observation on 2/05/24 at 3:50 p.m. of resident 54 while in her room revealed her urinary catheter drainage bag was attached to the side of a small garbage can with the lower half of the urine collection bag lying on the floor unprotected.

F 880

Monitoring

Administrator/DON/designee will audit 4 residents 2 to 3 times weekly over all shifts for 1 month beginning on or before March 15, 2024, to determine if whirlpool tubs are being cleaned appropriately and urine collection bags are not on the floor. After 1 month, the audits will continue 2 times per month for an additional 2 months. Then monthly until the QAPI committee determines the facility is demonstrating sustained compliance. Any issues identified during these audits will be corrected immediately and re-education will be provided at the time of the audit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435043	A. BUILDING ____ B. WING ____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET SPEARFISH, SD 57783

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 22	F 880		

Further observations on 2/06/24 at 8:35 a.m. and at 2:00 p.m. of resident 54, while sitting in her wheelchair and while lying in her bed, revealed the lower half of the urine collection bag lying on the floor unprotected.

Observation and interview on 2/06/24 at 2:05 PM with CNA S, while emptying resident 54's urine collection bag revealed:
*Following the emptying of the collection bag, CNA S placed the urine collection bag into a dignity protection bag and hung it so the bag was not touching the floor.
*She thought the therapist had placed the resident in bed following therapy and had left the bag uncovered and touching the floor.
-She stated that sometimes people would get into a hurry and would not put the urinary collection bag into the dignity protector bag.
*Stated the urine collection bags should be protected with a dignity bag at all times to prevent contamination of the collection bag.

Interview on 2/06/24 at 2:18 p.m. with therapist T revealed:
*She was a traveling occupational therapist and had been at this facility since September of 2023.
*She had assisted resident 54 into bed following her therapy after lunch.
*The facility orientation that was provided to her had consisted of computer navigation and the layout of the facility.
-She was trained by her travel company on infection control practices.
*Stated the dignity protector bags were usually kept on the wheelchairs for when the resident was in a wheelchair.
*Confirmed the unprotected urinary collection bag

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F 880	Continued From page 23	F 880		

probably should not have been touching the floor and agreed it posed a potential infection control risk.

3. Observation on 2/5/24 at 2:38 p.m. of resident 13 revealed:
*She was asleep in a recliner chair in her room.
-Her uncovered urine collection bag lay on the floor beside her chair.

4. Observation and interview on 2/05/24 at 3:00 p.m. with activities director H and CNA N in resident 25's room revealed:
*Staff prepared to transfer the resident from his wheelchair to his bed using a Hoyer mechanical lift.
*CNA N:
-Laid the resident's uncovered urine collection bag onto the floor after removing it from his wheelchair frame.
-Assisted activities director H to secure the mechanical lift sling that was beneath the resident's body to the Hoyer lift.
-Picked the uncovered urine collection bag up from off the floor and attached it to the resident's bed frame.
-Completed the Hoyer transfer of resident 25 with activities director H.
*Activities director H and CNA N agreed the resident's uncovered urine collection bag should not have been laid on the uncleaned floor.
-Resident 25's urine collection bag was expected to have been inside of a dignity protection bag.

Interview on 2/7/24 at 8:45 a.m. with administrator A and director of nursing B regarding the uncovered urine collection bags referred to above revealed:

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F 880	Continued From page 24 *Urine collection bags were expected to be kept inside of dignity protection bags and off of the floor. -Uncovered urine collection bags laid onto or that touched the floor were an infection control risk. Review of the revised August 2022 Urinary Catheter Care policy revealed "Infection Control 2. Be sure the catheter tubing and drainage bag are kept off the floor."	F 880		

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

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FORM APPROVED
OMB NO. 0938-0391

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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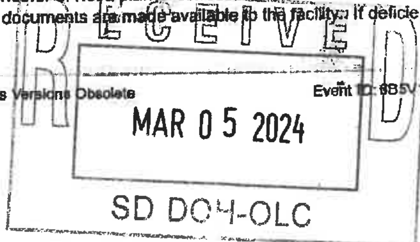
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 2/5/24 through 2/7/24. Spearfish Canyon Healthcare was found not in compliance with the following requirements: E006, E032, and E036.	E 000		
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented,	E 006	Corrective Action Facility assessment will be updated and completed on or before March 15, 2024. Emergency Preparedness Planning and Resource Manual will be updated and completed on or before March 15, 2023. Identification of Others All residents have the potential to be affected. Systematic Changes Administrator/Maintenance Director will ensure the Facility Assessment is in the Disaster Emergency Response Procedure Manual and the Emergency Preparedness Planning and Resource Manual is updated on or before March 15, 2024.	March 15, 2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charlotte Anthony
TITLE: Administrator
(X6) DATE: 3/5/24

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



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E 006	Continued From page 1 facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on interview and review of an undated Disaster and Emergency Response Procedure Manual (DERPM), the provider failed to include a facility-based and community-based risk	E 006	Monitoring Administrator/Maintenance Director will report to the QAPI committee monthly that the Facility Assessment and Emergency Preparedness Planning and Resource Manual is up to date through next review.	

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E 006	Continued From page 2 assessment that utilized an all-hazards approach. Findings include: 1. Interview on 2/7/24 at 2:57 p.m. with administrator A, director of nursing (DON) C, and maintenance supervisor F revealed: *There were no facility-based or community-based risk assessments performed. -They were unaware that a facility-based and community-based risk assessment was required. Review of the provider's undated DERPM revealed: *There was no facility-based or community-based risk assessment identified in the procedure manual. -There was no process for completing a facility-based or community-based risk assessment.	E 006		
E 032 SS=F	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.542(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (3) Primary and alternate means for	E 032	Corrective Action Administrator/Maintenance Director/designee will educate all staff on the emergency communication plan of using walkies, cellular phones, Internet, or SOS radio on or before March 15, 2024. Weather/SOS radio will be ordered on or before March 15, 2024, for an alternate means of communication with federal, state, tribal, regional, and local emergency management agencies.	March 15, 2024

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E 032	Continued From page 3 communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on interview and review of an undated Disaster and Emergency Response Procedure Manual (DERPM), the provider failed to include an alternate means of communication with federal, state, tribal, regional, and local emergency management agencies. Findings include: 1. Interview on 2/7/24 at 2:57 p.m. with administrator A, director of nursing (DON) C, and maintenance supervisor F revealed they: *Did not have an alternate means of communication with the above-mentioned agencies. -Were unaware that an alternate means of communication was required. -Relied on telephones to communicate with the above-mentioned agencies. Review of the provider's undated DERPM revealed no alternate means of communication with the above-mentioned agencies was identified.	E 032	Identification of Others All residents have the potential to be affected. Systematic Changes Administrator/Maintenance Director/designee will educate all staff on the alternate communication for the building and the location of an alternate means of communication for disaster planning on or before March 15, 2024. Monitoring Administrator/Maintenance Director/designee will report to the QAPI committee monthly on the location of the radio for alternate means of communication through the next review.	
E 036 SS=F	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d),	E 036		

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	435043	A. BUILDING ______ B. WING ______	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET SPEARFISH, SD 57783

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E 036	Continued From page 4 §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain	E 036	Corrective Action Facility assessment will be updated and completed on or before March 15, 2024. Emergency Preparedness Planning and Resource Manual will be updated and completed on or before March 15, 2023. Identification of Others All residents have the potential to be affected. Systematic Changes Administrator/Maintenance Director will ensure the Facility Assessment is in the Disaster Emergency Response Procedure Manual and the Emergency Preparedness Planning and Resource Manual is updated on or before March 15, 2024. Monitoring Administrator/Maintenance Director will report to the QAPI committee monthly that the Facility Assessment and Emergency Preparedness Planning and Resource Manual is up to date through next review.	March 15, 2024

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E 036	Continued From page 5	E 036		

an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).

*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.
This REQUIREMENT is not met as evidenced by:
Based on interview and review of an undated Disaster and Emergency Response Procedure Manual (DERPM), the provider failed to develop an emergency preparedness training and testing program based on their DERPM.
Findings include:

1. Interview on 2/7/24 at 2:57 p.m. with administrator A, director of nursing (DON) C, and maintenance supervisor F revealed:
*They had not developed a program to test their DERPM.
-There had been recent changes in their

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 036	Continued From page 6 leadership positions which had delayed the development of an emergency preparedness training and testing program. *Administrator A had been hired 6 days ago. -She had not reviewed all the documents and requirements related to emergency preparedness. Review of the provider's undated DERPM revealed no emergency preparedness training and testing program was identified.	E 036		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	435043	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET SPEARFISH, SD 57783

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K 000	INITIAL COMMENTS A recertification survey for compliance with the life safety code (LSC) (2012 existing health care occupancy) was conducted on 2/6/24. Spearfish Canyon Healthcare was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K321 and K923 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet)	K 321	Corrective Action The Maintenance Director/Assistant will be educated on or before March 15, 2024, on keeping the door closed in the maintenance shop. At the monthly All Staff meeting education slides were presented on ensuring doors are not propped open by any item on February 13, 2024.	March 15, 2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charlotte Pinther
TITLE: Administrator
(X6) DATE: 2/29/24

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

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SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET SPEARFISH, SD 57783

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K 321	Continued From page 1 c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain two separate hazardous areas in the basement (The maintenance shop and the oxygen storage area) as required. Findings include: 1. Observation on 2/6/24 at 10:30 a.m. revealed the maintenance shop in the basement was over 100 square feet and had power equipment such as a table saw. The corridor door was equipped with a closer but the door was held open by pressure against a lateral file when the door was fully open. 2. Observation on 2/6/24 at 11:15 a.m. revealed the basement kitchen supplies storage room was over 100 square feet in area and held copious amounts of combustible items such as cardboard boxes. The corridor door was equipped with a closer, but the storage room door was held open with a wood floor wedge. 3. Interview with the maintenance director at the times of the above observations confirmed those findings. The deficiency affected two of numerous requirements for hazardous rooms and had the potential to affect 100% of the occupants of the	K 321	Identification of Others All residents have the potential to be affected. Systematic Changes Administrator/DON/designee will provide education to all staff on ensuring doors are not propped open by any item on or before March 15, 2024. Monitoring Maintenance Director/designee will monitor that doors are not propped open by any device 1 time per week for 1 month beginning on or before March 15, 2024. The audits will continue 2 times per month for 1 month. Then monthly until the QAPI committee determines the facility is demonstrating sustained compliance. Any issues identified during this monitoring will be corrected immediately and re-education will be provided at the time of the monitoring.	March 15, 2024

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
	435043	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET SPEARFISH, SD 57783

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K 321	Continued From page 2 smoke compartment.	K 321		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored	K 923	Corrective Action The Maintenance Director/Assistant will repair the closer on the wood door to enable self-closing on or before March 15, 2024. The Maintenance Director/Assistant will remove all paint containers in the storage room on or before March 15, 2024. The Maintenance Director/Assistant will remove all oxygen storage containers to a different room. on or before March 15, 2024. The Maintenance Director/Assistant will have all empty oxygen cylinders labeled on or before March 15, 2024. The Maintenance Director has repaired the light in the storage room. Identification of Others All residents have the potential to be affected.	March 15, 2024

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	435043	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/06/2024

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K 923	Continued From page 3 in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to protect medical gas storage as required. Combustible items were stored on racks within five feet of the oxygen cylinders in the basement cylinder storage room. Findings include: 1. Observation on 2/6/24 at 11:00 a.m. revealed the oxygen storage room in the basement was over 100 square feet in area with eight empty liquid oxygen dewars on wheels, forty-five full oxygen e cylinders in racks, and eighteen portable (single-carry) liquid oxygen units. a. The storage room had a wood door equipped with a closer but the door was not self-closing. b. The minimum five feet of separation between combustibles and oxygen storage were not maintained from combustible items such as wood trim and cardboard boxes as required in that area. c. The storage room was not ventilated. d. Oxygen cylinders were not marked or separated full from empty cylinders. e. The room was not smoke-tight due to the unsealed piping and conduit penetrations of the corridor wall. Interview with the maintenance director at the time of the above observations confirmed those findings. The deficiency affected the basement smoke compartment.	K 923	Systematic Changes No oxygen cylinders or paint containers will be stored in the storage room in the basement. Monitoring The Maintenance Director/designee will monitor that there are no oxygen cylinders or paint containers stored in the basement storage room and all empty oxygen cylinders are labeled 1 time per week for 1 month beginning on or before March 15, 2024. The audits will continue 2 times per month for 1 month. Then monthly until the QAPI committee determines the facility is demonstrating sustained compliance. Any issues identified during these monitors will be corrected immediately and re-education will be provided at the time of the monitoring.	March 15, 2024

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
	10686	A. BUILDING: ______ B. WING ______	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET SPEARFISH, SD 57783

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/5/24 through 2/7/24. Spearfish Canyon Healthcare was found not in compliance with the following requirements: S157 and S435.	S 000		
S 157	44:73:02:13 Ventilation Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation in four randomly observed rooms (The basement soiled linen room, kitchen janitor's closet, Century tub room, and the Island tub room). Findings include: 1. Observation on 2/6/24 beginning at 1:10 p.m. revealed the exhaust ventilation for the basement soiled linen room, the kitchen janitor's closet, the Century tub room, and the Island tub room were not functioning. Testing of the grilles with tissue paper at the time of the observations revealed there was no air draw into the ductwork. Interview with the maintenance director on 2/6/24 at the times of the above observations and testing's confirmed those findings. He revealed he was unaware as to why the exhaust ventilation was not working at those locations.	S 157	Corrective Action Exhaust ventilation for the kitchen janitor's closet has been fixed. Exhaust ventilation for the basement soiled linen room, the Century tub room, and the Island tub room requires an outside contractor. Outside contractor will give estimate for repairs on or before March 15, 2024. Identification of Others All residents have the potential to be affected. Systematic Changes Maintenance staff will ensure monthly checks on exhaust fans are completed on or before March 15, 2024.	March 15, 2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charlotte [illegible]
TITLE: Administrator
(X6) DATE: 2/29/24

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
	10686	A. BUILDING: ______ B. WING ______	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 157	Continued From page 1 Those rooms were required to have exhaust ventilation directed to the exterior of the building.	S 157	Monitoring Maintenance Director/designee will monitor that exhaust ventilation is working in 4 locations in the facility 1 time weekly for 1 month beginning on or before March 15, 2024. The audits will continue 2 times per month for 1 month. Then monthly until the QAPI committee determines the facility is demonstrating sustained compliance. Any issues identified during the monitoring will be corrected immediately and re-education will be provided at the time of the monitoring.	
S 435	44:73:12:36 Vacuum Breakers An antisiphon device or backflow preventer shall be installed on any hose bibs and on any fixtures to which hoses or tubing can be attached such as laboratory, janitors' sinks, bedpan flushing attachments, and handheld showers. Each antisiphon devices or backflow preventers shall be installed on all plumbing and equipment where any possibility exists for contamination of the potable water supply. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to maintain anti-siphon devices for hand-held hoses at two randomly observed locations (The 200 wing shower room and the Century tub room shower). Findings include: 1. Observation on 2/6/24 beginning at 11:45 a.m. revealed the 200-wing shower had a hand-held hose without a visible vacuum breaker. Further observation revealed the Century tub room shower had a hand-held hose without a visible vacuum breaker. Interview with the maintenance director on 2/6/24 at the times of the above observations confirmed those findings.	S 435	Corrective Action The Maintenance Director has ordered vacuum breakers and they will be repaired for the 200 wing shower room and the Century tub room on or before March 15, 2024. Identification of Others All residents have the potential to be affected. Systematic Changes Maintenance Director/Assistant will ensure that each handheld shower has a vacuum breaker device on or before March 15, 2024.	March 15, 2024
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide	S 000		

South Dakota Department of Health

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	10686	A. BUILDING: ______ B. WING ______	02/07/2024

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S 000	Continued From page 2 training programs, was conducted from 2/5/24 through 2/7/24. Spearfish Canyon Healthcare was found in compliance.	S 000	Monitoring Maintenance Director/designee will monitor that handheld hoses have a working vacuum breaker device in 1 shower or tub room each week for 1 month beginning on or before March 15, 2024. The audits will continue 2 times per month for 1 month. Then monthly until the QAPI committee determines the facility is demonstrating sustained compliance. Any issues identified during this monitoring will be corrected immediately and re-education will be provided at the time of the monitoring.	