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
	435062	A. BUILDING _____ B. WING _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALCESTER CARE AND REHAB CENTER, INC	101 CHURCH STREET ALCESTER, SD 57001

(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 3/7/23 through 3/9/23. Alcester Care and Rehab Center, Inc. was found not in compliance with the following requirements: F578, F695, F700, F727, and F880.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the	F 578	Unable to change the outcome of the deficient practice for inaccurate following of resident 4's advanced directives. Administrator, DON, and interdisciplinary team will review and revise as necessary the policy and procedure for advanced directives on 03/16/2023. Unable to educate LPN G due to no longer being employed at facility. All other residents can be affected by this deficient practice. DON or designee will provide education to all staff responsible for following advanced directives appropriately on 03/17/2023 and 03/24/2023. DON or designee will perform audits on all hospital transfers to ensure proper understanding of advanced directives once a week for four weeks and once per month for two more months. DON or designee will present findings from these audits monthly for three months at the QAPI meetings for review until the QAPI committee advises to discontinue monitoring.	03/31/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tiffany Mills	Administrator	03/26/2023

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

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F 578	Continued From page 1	F 578		

time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and policy review the provider failed to ensure one of one sampled resident's (4) advanced directives had been followed. Findings include:

Record review of resident 4's electronic medical record (EMR) revealed:
*She was admitted on 3/5/15.
*Past medical history included:
-Atrial fibrillation
*Her code status was do not resuscitate (DNR) {do not perform cardiopulmonary resuscitation}.
-Had not been updated to indicate DNH (do not hospitalize) and DNI (do not intubate) {inserting a breathing tube}.
*On10/1/22:
- At 11:25 a.m. and unidentified CNA had notified licensed practical nurse (LPN) G that the "resident was not acting right, her skin was clammy and hot to the touch, her checks were flushed, and had labored breathing."
- At 11:26 a.m. resident 4 was assessed by LPN G and the assessment revealed:
-Blood pressure of 106/62 (normal blood pressure is 120/80).

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F 578	Continued From page 2 -Temperature of 98.7 (normal temperature is 98.6) -Respiratory rate of 24 respirations per minute (normal respiratory rate is 12-16 breaths per minute). -The resident had not been complaining of any pain. -Heart rate had been taken by a pulse oximetry and ranged from 90-150 beats per minute (BPM). -Listened with a stethoscope to assess the heart rate (HR) was 146 (BPM) {normal heart rate would be 60-100 BPM} and irregular. -Resident 4 was refusing to answer questions at that time but when asked if she wanted to go to the hospital states, "No I don't want to go." -At 11:30 a.m. a phone call had been placed to the resident's son and a voicemail had been left to call the facility as soon as possible. -At 11:35 a.m. the resident's daughter had been contacted and informed on resident's condition. The resident's daughter requested the resident to be sent to hospital. -At 11:37 a.m. report had been given to the emergency room (ER) at the receiving facility notifying the ER staff that the resident had possible a-fib (atrial fibrillation which is an irregular heart rhythm) and history given. -At 12: 00 p.m. the resident had left the facility by ambulance and was transferred to the hospital. -At 12: 10 p.m. the resident's physician had been notified of the emergent transfer to the hospital. -At 12:15 p.m. nurse manager C and administrator A had been notified of resident 4's transfer to the hospital. Review of the requested copy of resident 4's advance directive revealed: *She had signed a DNR/DNH/DNI order on 8/27/21 and had been signed by her physician on	F 578		

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F 578	Continued From page 3 8/30/21. Interview on 3/9/23 at 11:00 a.m. with director of nursing (DON) B regarding resident 4's advance directive revealed: *She agreed resident 4 should not have been transferred to the hospital. *The nurse who had been taking care of resident 4 was no longer employed at the facility. *Agreed that resident 4's advance directive had not been followed as the resident had requested. Interview on 3/9/23 at 12:00 p.m. with administrator A regarding resident 4's advanced directive revealed: *Nurse manager B had been unavailable for interview as she had been working on the floor. *Staff should have followed the provider's policy. Regarding the residents advanced directive. *She thought that there were other circumstances that regarding this event. No further information had been provided by administrator A before exiting the facility. Review of the provider's undated Advanced Directive policy revealed: *Advanced directives would have been respected in accordance with state law and facility policy. *In accordance with current omnibus budget reconciliation act (OBRA) definitions (to improve the quality of care in nursing homes) and guidelines governing advanced directives, the facility has defined advanced directives as preference regarding treatment options and include, but not limited to: -DNR. -DNH. *The director of nursing or designee would have	F 578		

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F 578	Continued From page 4 notified the attending physician of the resident's advance directive so that the appropriate physician orders could have been documented in the resident's medical record and the care plan. *The nurse supervisor would have been required to inform the emergency medical personnel of a resident's advanced directive regarding treatment options and provide such personnel with a copy of such directive when transfer from the facility via ambulance or other means is made.	F 578		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation, interview, and policy review the provider failed to ensure oxygen tubing had been changed per facility policy every two weeks for one of three samples residents (12). Findings include: 1. Review of resident 12's medical record revealed: *The resident had diagnosis of: -Chronic obstructive pulmonary disease (COPD) with (acute) exacerbation. -Chronic diastolic (congestive) heart failure. -Chronic kidney disease, stage 3 unspecified. *She used oxygen to keep saturation above 90%	F 695	Resident 12's oxygen tubing has been changed on 3/21/2023. DON will add oxygen tubing changes to TAR on 03/09/2023 to be changed bimonthly. Administrator, DON, and interdisciplinary team will review and revise as necessary the policy and procedure for changing oxygen tubing on 03/16/2023. DON or designee will provide education to all staff responsible for changing oxygen tubing on 03/17/2023 and 03/24/2023. DON or designee will perform audits on all residents that utilize oxygen weekly per week for four weeks and once per month for two more months. DON or designee will present findings from these audits monthly for three months at QAPI meetings for review until the QAPI committee advises to discontinue monitoring.	03/31/2023

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F 695	Continued From page 5 (normal oxygen saturations are 90%-100%). *She had a physician's order to replace and date humidifier on the oxygen concentrator monthly at bedtime. *She had recent hospitalization for acute COPD exacerbation. Observation and interview on 3/8/23 at 8:53 a.m. of resident 12 in her room revealed: *She was sitting in her recliner watching television. *She was using a nasal canula for oxygen. *An oxygen concentrator was located next to her bed set at two liters. *She was not sure when the tubing had been changed. *The oxygen tubing had tape wrapped around it that was dated 2/6. Interview on 3/9/23 at 9:12 a.m. with nurse manager C regarding resident 12's oxygen tubing revealed: *The tubing should have been changed every other week as scheduled. *The date on the tubing was 2/6. *Some staff would date the tubing when they change it and others would have documented the tubing was changed in the treatment administration record (TAR). *The last documentation on the TAR was 2/6/23. Interview on 3/9/23 at 10:19 a.m. with director of nursing B regarding resident 12's oxygen tubing revealed: *The tubing should have been changed every other week by the nursing staff. *That should have been documented on the TAR when the task was completed. *Her expectation would have been that the	F 695		

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F 695	Continued From page 6 nursing staff would have followed the policy to prevent any problems with infection control. Review of the provider's undated Oxygen policy revealed: "Changing tubing, cannula or mask every other week as scheduled or prn."	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review the provider failed to ensure safety assessments had been completed and documented for three of eight sampled residents (8, 20, and 23) who had half side rails attached	F 700	Resident 8, 20, and 23, will have side rail assessments including risk versus benefit of use, as well as ensuring side rails are appropriate for beds dimensions. All other residents' medical records were reviewed and revised to include side rail assessments on 03/16/2023. Administrator and Maintenance Director created side rail to bed dimensions form to ensure side rails are appropriate for bed dimensions and will be completed before every installation of side rails. All side rails currently installed will have form completed by 03/24/2023. Administrator, DON, Maintenance Director and interdisciplinary team reviewed and revised as necessary the policy and procedure for side rails on 03/16/2023. DON or designee will provide education to Maintenance Supervisor F and all staff responsible for installation of side rails on 03/17/2023 and 03/24/2023. DON or designee will perform audits on bed rails weekly for four weeks and monthly for two more months. DON or designee will present findings from these audits monthly for three months at QAPI meetings for review until the QAPI committee advises to discontinue monitoring.	03/31/2023

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F 700	Continued From page 7 onto their beds. Findings include: 1. Observation on 3/7/23 at 11:50 a.m. of resident 20's room revealed he had one half side rail on the left side of his bed. Review of resident 20's medical record revealed: *He had been admitted on 7/13/22. *His 10/4/22 Brief Interview of Mental Status (BIMS) revealed no cognitive impairment. *His last revised care plan was dated 1/18/23 revealed he used one-half side rail to encourage independence with turning and re-positioning in his bed. *There had been no documentation that a side rail safety assessment for his one-half side rail had been completed. 2. Observation on 3/7/23 at 12:44 p.m. of resident 8's room revealed she had bilateral half side rails on her bed. Review of resident 8's medical record revealed: *She had been admitted on 4/1/22. *Her BIMS completed on 9/17/22 revealed severe cognitive impairment. *Her last revised care plan dated 2/11/23 revealed she used the bilateral half side rails to encourage independence with turning and re-positioning in bed. *There had been no documentation that a side rail safety assessment had completed. 3. Observation on 3/7/23 at 12:50 p.m. of resident 23's room revealed she had a half side rail on the right side of her bed: Review of resident 23's medical record revealed: *She had been admitted on 10/8/20.	F 700		

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F 700	Continued From page 8 *Her BIMS completed on 10/4/22 revealed severe impairment. *Her last revised care plan dated 1/19/23 revealed she used one-half side rail to encourage independence with turning and repositioning in bed. *There had been no documentation that a side rail safety assessment had been completed. Interview on 3/9/23 at 10:23 a.m. with maintenance supervisor F revealed: *He did safety assessments for the resident beds in the facility. *Staff did move beds around so they were hard to track. *He confirmed he had not completed side rail safety assessments for residents 8, 20, and 23. Interview on 3/9/23 at 1:13 p.m. with administrator A revealed: *She expected side rail safety assessments to have been completed on all beds with side rails. *She confirmed side rail safety assessments had not been completed for residents 8, 20, and 23. Review of the providers revised 12/1/2021 Side Rail policy revealed: "...4. Side rail use is evaluated by a facility assessment to address if this would be a safet option for the resident. 5. Alternative options for side rails for safety and/or definition of mattress borders including pool noodles around the mattress border, scoop mattresses, etc, should be utilized if appropriate."	F 700		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3)	F 727	All residents have the potential to be affected by not utilizing the service of a registered nurse 8 hours a day, 7 days a week.	03/31/2023

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F 727	Continued From page 9 §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and staff schedule review the provider failed to ensure a registered nurse (RN) had been scheduled for eight hours of coverage for two of four weekends in February 2023. Findings include: 1. Interview and staff schedule review on 3/9/23 at 11:00 a.m. with director of nursing (DON) B revealed she: *Had worked full time Monday through Friday completing Minimum Data Set (MDS). *Was available to staff by phone twenty-fours hours per day seven days per week. 2. Interview and staff schedule review on 3/09/23 at 12:43 p.m. with administrator A regarding RN coverage revealed: *She had been aware that they did not have eight hours per day of RN coverage seven days per week. *She was attempting to hire an RN.	F 727	Discussion for other system changes included collaboration with the LTC Public Health Advisor. Administrator and DON reviewed nursing schedule to include full-time overnight RN to work every weekend. DON/MDS Coordinator to work Monday-Friday 8-hour days to obtain full RN coverage. Administrator will continue with help wanted ads for a full-time day RN need. Administrator will educate all nurses on RN rules and regulations on 03/17/2023 and 3/24/2023. Administrator or designee will perform audits on RN coverage weekly for 4 weeks and monthly for two months. Administrator or designee will present the audit monthly for three months at QAPI meetings for review until the QAPI committee advises to discontinue monitoring.	
F 880	Infection Prevention & Control	F 880	The Administrator, DON, Infection Control Nurse, and/or designee in consolation with	03/31/2023

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F 880 SS=F	Continued From page 10 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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	F 880	the medical director will and review and revise as necessary policies and procedures for whirlpool tub cleaning. DON or designee will provide education to all staff about their roles and responsibilities for proper whirlpool tub cleaning and whirlpool room cleaning on 03/17/2023 and 03/24/2023. CNA E will be re-educated about proper procedure for whirlpool tub cleaning on 03/17/2023. All other staff responsible for that role will also be re-educated. Administrator and Maintenance Director will create a new system for towels to ensure they are covered appropriately for infection control purposes on 03/24/2023. Maintenance Director will put new safety strap on whirlpool chair on 03/21/2023. DON or designee will audit proper whirlpool tub cleaning two times weekly per week for four weeks and once per month for two more months. DON or designee will present the audit findings at the monthly QAPI meetings for review until the QAPI committee advises to discontinue monitoring. All residents have the potential to be affected by whirlpool disinfecting and failure to update COVID-19 response plan. The Administrator, DON, Infection Control Nurse and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures to update COVID-19 response plan. Administrator or designee will provide education to all staff about the updated COVID-19 protocols on 03/17/2023 and 03/26/2023.	

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F 880	Continued From page 11 resident; including but not limited to: (A) The type and duration of the isolation, 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: A. Based on observation, interview, and policy review, the provider failed to ensure appropriate disinfection after resident use for of one of one whirlpool and furnishings in the one of one tub room by one of one certified nursing assistant (CNA) E. Findings include: 1. Observations on 3/7/23 at 11:19 a.m. and 3:59 p.m. of the whirlpool room revealed: *The door to the room was open. A sign on the	F 880	Administrator will educate Nurse H and Nurse D in regard to residents only wearing surgical masks due to not being fit tested for an N95. Administrator will sign Infection Control nurse up to the listserv emails from Great Plains Quality Innovation Network for infection control changes. Discussion for other system changes included collaboration with the South Dakota Quality Improvement Organization with the Administrator on 03/22/2023. Included in this discussion was the need for completion of a risk cause analysis for proper whirlpool cleaning. Administrator or designee will audit proper COVID-19 protocols once per week for four weeks and once per month for two more months. If no outbreak occurs, audit process will be extended by three months to ensure proper procedure is being followed. Administrator or designee will present the audit monthly for three months at QAPI meetings for review until the QAPI committee advises to discontinue monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435062	A. BUILDING _____ B. WING _____	03/09/2023

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F 880	Continued From page 12 door stated to keep the door locked. *A stack of towels was setting on top of a short gray plastic storage cabinet against the right wall inside the room. The towels were out in the open and uncovered. *A reception-style chair was positioned against the right wall beside the storage cabinet with towels laid out on the seating surface of the chair. The towels were flattened in the center and appeared as if someone had been sitting on them. *Water was pooled on the floor in the center of the room and around the whirlpool located on the left side of the room. *The safety strap on the whirlpool lift chair was lying in the pool of water. The length of the strap had frayed edges. Observation and interview on 3/8/23 at 10:06 a.m. with certified nursing assistant (CNA) E revealed: *She had started working for the provider two weeks ago. *Her orientation to the role of bath CNA included how to sanitize the whirlpool tub and the location of lotions and shampoos for individual residents stored in a tall gray plastic storage cabinet. *Laundry supplied the stack of towels that were setting on top of the short gray plastic storage cabinet, and she was unable to find another location in the whirlpool room to store them *Most residents undressed and dressed in the whirlpool room, and some would sit in the reception chair while undressing and dressing. *She would change the towels on the seat of the reception chair between residents. *She demonstrated the steps to disinfectant the whirlpool tub between residents, as follows: -Sprayed the inside of the tub with an unlabeled	F 880		

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F 880	Continued From page 13 spray bottle that she stated contained water mixed with disinfectant. She pointed to a labeled disinfectant gallon jug setting on floor next to the front of the whirlpool. -Brushed the inside of the tub while using the sprayer hose to rinse the tub. -Used a washcloth with disinfectant that she sprayed on it from the unlabeled spray bottle to wipe the outside corner of the tub on the end where the whirlpool lift chair was attached. -Used a towel that was on the floor to mop up some of the water on the floor. *She disinfectant kept working while she went to get the next resident, and that would have given the disinfectant five minutes to continue working. She then left the room to assist another resident to the whirlpool room. *She had not wiped down the whirlpool lift chair or the safety strap on the lift chair. *She had not wiped down the reception chair or changed the towels in the chair before leaving the whirlpool room. Review of the provider policy, "Whirlpool and Bath Chair Disinfecting," dated 11/28/21, revealed the steps for cleaning and disinfecting the whirlpool tub after every bath included: "1. Drain the water from the tub." "2. Press the Shower Button and rinse the inside surfaces with the shower sprayer." "3. Close the drain." "4. Press and hold the Disinfect Button located on the left side of the tub. As the button is held down, the properly mixed cleaning solution is running through the air injection system and out all of the air jets. Release the button after you see solution coming out of all the air jets and you have 1 to 1 1/2 gallons of disinfectant solution in the foot well of the tub."	F 880		

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F 880	Continued From page 14 "5. Using a long-handled brush, thoroughly scrub all interior surfaces of the tub with the solution that remains in the foot of the tub." "6. Disinfect the Penner Transfer [lift chair] by positioning it over the tub. Use the brush to scrub its surfaces with the remaining solution. Allow the proper disinfectant contact time which is 10 minutes as recommended by the disinfectant's manufacturer. Rinse the seat." "7. Remove the plug from the drain." "8. Rinse the tub's interior surfaces thoroughly with the shower sprayer." "9. Spray water from the shower sprayer to rinse out most of the disinfecting solution." "10. Finish rinsing the interior surfaces of the tub with the shower sprayer." Interview on 3/8/23 at 5:00 p.m. with director of nursing (DON) A and nurse manager C revealed: *CNA E was temporarily completing resident baths while their full-time bath CNA was on leave. *The CNA who provided orientation to CNA E was not their full-time bath CNA, and the training given was probably not accurate or complete. *They agreed the whirlpool tub had not been disinfected according to the policy. *They were not aware of the following:: -The exposed stack of uncovered towels. -The use of towels to cover the reception chair and mop the floor. -The frayed edges of the safety strap on the whirlpool lift chair. B. Based on observation, interview, and policy review the provider failed to ensure the facility response plan to COVID-19 was up to date and followed current Center for Disease Control (CDC) guidelines and recommendations for two of two sampled residents (1 and 22) with a	F 880		

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F 880	Continued From page 15 diagnosis of COVID-19. Findings include: 1. Observation on 3/7/23 at 10:17 a.m. with resident 22 in the dining room revealed: *She had been sitting at the dining table with a staff member. -No other residents were in the dining room. -Staff had been wearing a N-95 mask. *She had been in isolation for COVID-19. *Staff had been wheeling her back to her isolation room. -She was wearing a N-95 mask during the wheelchair transport back to her room. 2. Observation on 3/7/23 at 11:00 a.m. with resident 1 while he was in a wheelchair revealed he: *Had been in isolation for COVID-19. *Was independently able to self-propel his wheelchair throughout the facility. *Had been wearing an N-95 mask while outside of his room. Interview on 3/7/23 at 11:00 a.m. with licensed practical nurse (LPN) H regarding COVID-19 positive residents who were in isolation and leaving thier rooms revealed: *Resident 1 had been non-compliant with staying in his room. *He had been diagnosed with COVID-19 on 2/28/23 and received an antiviral treatment. -He could only be out of his room if he had worn an N-95 mask. *Resident 22 had been having a decline in health. -She had been a picky eater. *Administrator A, nurse manager C felt that resident 22 could have come out of her room with an N-95 mask.	F 880		

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F 880	Continued From page 16 Interview on 3/7/23 11:03 a.m. with nurse manager C regarding COVID-19 positive resident's wearing N-95 masks revealed: *They only had one kind of N-95. *She was not sure what it meant to fit test the resident's for N-95 mask use. Interview on 3/7/23 at 11:06 a.m. with administrator A regarding infection control practices for COVID-19 positive residents revealed: *None of the residents had been fit tested for N-95 mask use. *Resident 22 was never by other residents and was allowed to come out of her room. *She had not realized that resident 1 was out of his room. Interview on 3/8/23 at 9:00 a.m. with LPN D regarding infection control practices revealed she: *Had completed the online training for the Infection Preventionist education. *Was only able to dedicate two hours per week for infection control. *Had not been receiving any current guidelines and recommendations from the Center for Disease Control (CDC) for care of residents with COVID-19. Review of provider's undated policy for COVID positive residents revealed: *Infection prevention and control considerations for residents of long-term care facilities engaging in isolation due to positive COVID-19 results. *Positive residents would have been isolated to their rooms for ten days. *Residents would have plastic placed in front of their doors. *Residents would have personal protective	F 880		

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F 880	Continued From page 17 equipment (PPE) containers placed outside of the their rooms for staff use. *Residents would have a sign on the door informing staff to wear PPE before entering the room. *Residents who were showing a dramatic decline in cognition/physical function, the interdisciplinary team would have discussed letting them come out of their rooms with a mask on at day five. -They must remain socially distant from other residents. *All close contacts would have been tested on day one, three, and five. Review of provider's January 2021 N-95 Mask policy revealed: *Infection prevention and control of N-95 mask wearing during outbreak mode. *Employees would wear an N-95 mask when they were aware of residents in the building with COVID-19. Review of provider's June 2021 COVID-19 Positive Residents-Notifying Personnel revealed: *Residents would have been notified of their positive test results. -Social services designee or designated personnel would act in informing POA/Emergency contacts of a positive resident via telephone. -Administrator, or designated personne would have reported within the requirements to National Healthcare Safety Network (NHSN) and displayed on the front door COVID was in the building. -Nurse managers would inform staff of which residents had tested positive.	F 880		

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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 3/7/23 through 3/9/23. Alcester Care and Rehab Center, Inc. was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Adminsitrator	03/26/2023

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

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/8/23. Alcester Care and Rehab Center, Inc was found not in compliance with 42 CFR 483.90 (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 K211, K321, and K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: A. Based on observation, testing, and interview, the provider failed to maintain all exit locations free of obstructions to full use. One randomly observed exit location (chapel exit) was not free of obstruction. Findings include: Observation and interview on 3/8/23 at 10:31 a.m. revealed the exit from chapel had been obstructed by a large curtain on a curtain rod. Testing of that curtain revealed it was stapled to a makeshift wall on the north end and would not	K 211	Maintenance Director or designee will address all exit locations to be free of obstructions for full use. The large curtain obstructing the chapel exit location has been removed on 03/08/2023. The Maintenance Director inquired with concrete company and obtained quote for the path of egress for the west wing exit including the cracked concrete. Inspection of concrete was conducted on 03/20/2023 and late April/early may will be estimated completion of project. This deficient practice has the potential to harm all residents if need for evacuation. Maintenance Director or designee will complete audits to ensure all paths of egress are free of obstruction monthly for three months and will report the results of the audits to the monthly QAPI committee for three months or until the QAPI committee advises to discontinue monitoring.	03/31/2023

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

Tiffany Miller

TITLE: Administrator

(X6) DATE: 03/26/2023

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K 211	Continued From page 1 slide on the rod to allow easy egress. Interview with the maintenance director at the time of the observation and testing confirmed those conditions. He stated they had installed that curtain to allow visitors to enter the building directly from the exterior for visitation during COVID-19. The deficiency had the potential to affect 100% of the smoke compartment occupants. B. Based on observation and interview, the provider failed to maintain egress paths free of hazards for one randomly observed exits (west wing exit). Findings include: 1. Observation on 3/8/23 at 11:07 a.m. revealed the path of egress for the west wing exit had cracked concrete creating abrupt level change of greater than 1/4 inch within the path of egress. LSC 7.1.6.2 Interview with the maintenance director at the time of the observation confirmed that condition. He stated he had very recently been made aware of that condition and had not yet been able to address it. The deficiency had the potential to affect 100% of the smoke compartment's occupants.	K 211		
K 321 SS=D	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.	K 321	Maintenance Director or designee will ensure the basement door, soiled utility room door, craft supply room door, and water heater/boiler room door all latch appropriately. Administrator will educate Maintenance Director and all staff on ventilation requirements on 03/17/2023 and 03/24/2023.	03/31/2023

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K 321	Continued From page 2 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) 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, testing, and interview, the provider failed to maintain separation for four randomly observed hazardous areas (New basement storage room, soiled room, craft supply room, and the water heater/boiler room) as required. Findings include: 1. Observation and testing on 3/8/23 at 10:15 a.m. revealed the door at the base of the stairs to the new basement did not close and latch into the frame under the power of its closer. That door led to a storage room over 100 square feet with combustibles stored in it creating a hazardous	K 321	Maintenance Director or designee will audit all doors that require to be latched weekly for four weeks and monthly for two months. Maintenance Director or designee will present findings from these audits at the monthly QAPI committee for review for three months or until the QAPI committee advises to discontinue monitoring.	

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K 321	Continued From page 3 area. Hazardous area doors are required to be fire rated and must latch into their frames to maintain their labeled fire rating. Interview with the maintenance director at that same time confirmed those findings. The deficiency affected one of numerous requirements for hazardous storage rooms and had the potential to affect 100% of the occupants of the smoke compartment. 2. Observation and testing on 3/8/23 at 10:47 a.m. revealed the soiled utility room in the west resident wing did not close and latch into the frame under the power of its closer. Soiled utility rooms and other hazardous area doors are required to be fire rated and must latch into their frames to maintain their labeled fire rating. Interview with the maintenance director at that same time confirmed those findings. The deficiency affected one of numerous requirements for hazardous storage rooms and had the potential to affect 100% of the occupants of the smoke compartment. 3. Observation and testing on 3/8/23 at 11:12 a.m. revealed the craft supply room in the basement was over 100 square feet and had large amounts of combustibles stored in it. The door was equipped with a closer but was held open by a brass pipe nipple wedged into the top of the door frame. Supply rooms over 100 square feet and other hazardous area doors are required to be fire rated and must latch into their frames to maintain their labeled fire rating. Interview with the maintenance director at that same time confirmed those findings.	K 321		

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K 321	Continued From page 4 The deficiency affected one of numerous requirements for hazardous storage rooms and had the potential to affect 100% of the occupants of the smoke compartment. 4. Observation and testing on 3/8/23 at 11:29 a.m. revealed the door to the water heater/boiler room in the basement did not close and latch into the door frame under the power of its closer. Water heater/boiler rooms and other hazardous area doors are required to be fire rated and must latch into their frames to maintain their labeled fire rating. Interview with the maintenance director at that same time confirmed those findings. The deficiency affected one of numerous requirements for hazardous storage rooms and had the potential to affect 100% of the occupants of the smoke compartment.	K 321		
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete	K 918	Maintenance Director or designee contracted outside company on 03/10/2023 and findings were to adjust carburetor. Generator started multiple times in 10 seconds or less. This deficient practice has the potential to harm all residents if need for emergency electricity. Administrator will educate Maintenance Director on the generator on 03/17/2023 and to notify Administrator if generator does not start in 10 seconds. Maintenance Director or designee will complete audits to ensure generator is running properly monthly for three months and will report the results of the audits to the monthly QAPI committee for three months or until the QAPI committee advises to discontinue monitoring.	03/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435062	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/08/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALCESTER CARE AND REHAB CENTER, INC	**101 CHURCH STREET** **ALCESTER, SD 57001**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 5 simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on testing, observation, and interview the provider failed to furnish a generator or alternate power source capable of suppling service within 10 seconds. Findings include: 1. Testing and observation on 3/8/23 at 10:28 a.m. revealed the generator would turn over for fifteen seconds before it started continuous operation. Generators or other alternate power sources are required to supply service within 10 seconds. Interview with the maintenance director at that same time confirmed that finding. He stated he was aware of that issue, and he had noticed the generator had recently started taking longer to start. That deficiency had the potential to affect 100	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435062	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/08/2023**

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K 918	Continued From page 6 percent of the building occupants. Reference: 6.4.4, 6.5.4 6.6.4 (NFPA 99) NFPA 100, NFPA 111, 700.10 (NFPA 70)	K 918		

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
	10591	A. BUILDING: _____ B. WING _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALCESTER CARE AND REHAB CENTER, INC	101 CHURCH ST ALCESTER, SD 57001

(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 3/7/23 through 3/9/23. Alcester Care and Rehab Center, Inc was found not in compliance with the following requirement: S157.	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 two randomly observed rooms (tub room and soiled holding room). Findings include: 1. Observation on 3/8/23 at 10:43 a.m. revealed the exhaust ventilation for the tub room was not functioning. Testing of the grille with tissue paper at the time of the observation confirmed that finding. Interview with the maintenance director at that same time confirmed that finding. He revealed he was unaware as to why the exhaust ventilation was not working at that location. He added the rooftop exhaust fan that served that room, and he thought the rooftop exhaust fan's drive belt might have slipped off recently. That room was required to have exhaust ventilation directed to the exterior of the building.	S 157	Maintenance personnel or designee will fix ventilation for the tub room and soiled holding room once Johnsen Heating and Cooling is able to come out and indicates they are safe to go on roof. Maintenance director or designee will audit all ventilation systems using the tissue test to ensure they are operating correctly weekly for four weeks and monthly for two months. Maintenance director or designee will present findings from these audits at the monthly QAPI committee for review for three months or until the QAPI committee advises to discontinue monitoring.	03/31/2023

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

TITLE: Administrator

(X6) DATE: 03/26/2023

STATE FORM 6899 WIIO11 If continuation sheet 1 of 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10591	A. BUILDING: _____ B. WING _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALCESTER CARE AND REHAB CENTER, INC	101 CHURCH ST ALCESTER, SD 57001

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S 157	Continued From page 1 2. Observation on 3/8/23 at 11:01 a.m. revealed the exhaust ventilation for the soiled holding room in the laundry was not functioning. Testing of the grille with tissue paper at the time of the observation confirmed that finding. Interview with the maintenance director at that same time confirmed that finding. He revealed he was unaware as to why the exhaust ventilation was not working at that location. He added the rooftop exhaust fan that served that room, and he thought the rooftop exhaust fan's drive belt might have also slipped off recently. He further added the exhaust fan for that location served most of the east wing. That room was required to have exhaust ventilation directed to the exterior of the building.	S 157		