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
	435079	A. BUILDING _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED LIVING COMMUNITY	405 FIRST AVE BROOKINGS, SD 57006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 41895 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 3/15/22 through 3/17/22. United Living Community was found not in compliance with the following requirements: F658 and F880.	F 000		
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: Surveyor: 41895 Based on interview, record review, and policy review, the provider failed to ensure for one of one sampled resident (49) professional standards of practice were followed for insulin administration and response to a low blood sugar. 1. Review of resident 49's March 2022 medication administration record revealed: *She had a blood sugar of 56 on 3/1/22 at 8:00 p.m. *There had been no documentation Glucagon or Glucose gel had been administered for the low blood sugar. *Her bedtime Lantus insulin had not been administered on 3/1/22, 3/3/22, or 3/15/22. -The reason documented for the Lantus not being administered stated "Other/See Progress Notes." Review of resident 49's progress notes revealed:	F 658	F658 Corrective Action: 1. For the identification of lack of: *Ensure professional standards of practice were followed for insulin administration and response to a low blood sugar. The administrator, DON, and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas. All facility staff who provide or are responsible for the above cares and services will be educated/ re-educated by 4/1/22 by the DON or Staff Education Nurse/Infection Preventionist. Identification of Others: 2. ALL diabetic residents have the potential to be affected by lack of:*Ensure professional standards of practice were followed for insulin administration and response to a low blood sugar. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by 4/1/22 by the DON or Staff Education Nurse/Infection Preventionist.	4/1/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kaleb C. Hight
TITLE: Administrator
(X6) DATE: 4/1/2022

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

APR 01 2022
SD DOH-OLC

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F 658	Continued From page 1 *On 3/1/2022 at 10:16 p.m. "Resident was cold and clammy to the touch. BS [blood sugar] is 56. Held Lantus and gave resident ice cream and a peanut butter and jelly sandwich. Resident remained alert." *On 3/2/2022 at 12:02 a.m. "Rechecked blood sugar: 186" *There was no documentation of physician or family notification of the low blood sugar. *There had been no documentation on 3/3/22 or 3/15/22 as to why the Lantus was not administered. Review of physician's 3/3/22 progress note revealed resident 49's Lantus had been decreased to 18 Units twice a day due to her having some low blood sugars. Interview on 3/16/22 at 3:08 p.m. with director of nursing (DON) A regarding resident 49 revealed: *There had not been specific parameters for when to notify the physician of resident 49's blood sugars. *The nurse should have called E-Care when a resident had a low blood sugar. Interview on 3/16/22 at 3:27 p.m. with registered nurse B regarding blood sugars and insulin orders revealed: *Usually the doctor would specify certain parameters for blood sugars. *She would have called the doctor before holding the Lantus. *She would have given the glucose gel and rechecked her blood sugar in about 30 minutes or called E-Care for orders. Continued interview on 3/16/22 at 3:47 p.m. with DON A regarding resident 49 revealed:	F 658	System Changes: 3. Root cause analysis conducted answered the 5 Whys: Root Cause discussions revealed several possible root causes of failure to adhere to professional standards concerning glucose control: Lack of documentation of nurse actions taken to reverse low blood sugars didn't allow for proof of compliance to procedures or professional standards of care. The procedure for Glucose Control lacked the inclusion of food as an appropriate intervention when a resident is able to do so safely. Administrator, DON, medical director, and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency and documentation. Monitoring: 4. Administrator, DON, and/or designee will conduct auditing and monitoring 2 to 3 times weekly over all shifts to ensure identified and assigned tasks are being done as educated and trained. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. * Staff compliance in the above identified area. * Any other areas identified through the Root Cause Analysis. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by administrator, DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	

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F 658	Continued From page 2 *Nurses would have needed an order to hold the Lantus. *The nurse should have called E-Care and received orders from a physician. *She did agree the provider's policy was not followed for management of hypoglycemia. Review of the provider's November 2020 Management of Hypoglycemia policy revealed for a blood sugar less than 70 the nurse should have: *Given oral glucose. *Notified the doctor immediately. *Stayed with the resident. *Rechecked the blood sugar in fifteen minutes.	F 658		
F 880 SS=D	Infection Prevention & Control 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	F 880	Directed Plan of Correction United Living Community F880 Corrective Action: 1. For the identification of lack of: *Appropriate hand hygiene and glove uses during dressing change, medication administration, and procedural processes related to dressing change and oximetry check. The administrator, DON, and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas. All facility staff who provide or are responsible for the above cares and services will be educated/ re-educated by 4/1/22 by the DON or Staff Education Nurse/Infection Preventionist.	4/1/2022

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F 880	Continued From page 3 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, 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	F 880	Identification of Others: 2. ALL residents and staff have the potential to be affected by lack of: *Appropriate hand hygiene and glove use during dressing change, medication administration, and procedural processes related to dressing change and oximetry check. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by 4/1/22 by the DON or Staff Education Nurse/Infection Preventionist. System Changes: 3. Root cause analysis conducted answered the 5 Whys: Root Cause discussions revealed several possible root causes of failure to adhere to hand hygiene: Increased anxiety of newer nurse due to first time monitored by surveyor, sanitizer supply not immediately within treatment field, and nurse focused on results and not process. Administrator, DON, medical director, and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency and documentation. The Administrator, DON & Staff Education Nurse/Infection Preventionist contacted the South Dakota Quality Improvement Organization (QIN) on 3/25/22 and included discussions on ways to offer infection control reminders to staff through additional education, resources to review prior to treatments, audits and utilizing secret shopper auditors. Additional auditing for the purpose of familiarizing staff with being monitored will help nurses to be more comfortable when being audited by a surveyor and minimize "momentary" stress mistakes.	

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F 880	Continued From page 4 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: Surveyor: 41895 Based on observation, interview, and policy review, the provider failed to ensure infection prevention and control practices were maintained for: *Hand hygiene by one of one licensed practical nurse (LPN) (C) when conducting a dressing change and checking oxygen saturation for resident 13. *Cleaning of re-usable medical equipment by one of one LPN (C) for resident 13. Findings include: 1. Observation on 3/15/22 at 10:55 a.m. of LPN C performing a dressing change and checking an oxygen saturation for resident 13 revealed she: *Removed a dressing from resident 13's abdominal wound. *Changed her gloves but did not perform hand hygiene. *Cleansed the abdominal wound. *Changed her gloves but did not perform hand hygiene. *Applied a new dressing to the abdominal wound. *Used resident 13's scissors to cut the tape used to hold the dressing in place five times. *Did not clean the scissors prior to use. *Removed her gloves, and without performing hand hygiene she gave the resident his inhaler. *Removed an oximeter from her pants pocket, checked resident 13's oxygen level, and then put it back into her pocket.	F 880	Monitoring: 4. Administrator, DON, and/or designee will conduct auditing and monitoring 2 to 3 times weekly over all shifts to ensure identified and assigned tasks are being done as educated and trained. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. *Staff compliance in the above identified area. *Any other areas identified through the Root Cause Analysis. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by administrator, DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	

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F 880	Continued From page 5 -Had not cleaned the oximeter before or after she used it. *Walked out of the room and obtained medications from the medication cart. *Returned to the room and without performing hand hygiene she administered the oral medications, then put a glove on her right hand, and applied a medicated gel to resident 13's back. *Removed her glove and performed hand hygiene. Interview directly after the above observation with LPN C revealed she: *Should have performed hand hygiene with each glove change and when entering and exiting a resident's room. *Should not have used the residents scissors without cleaning them first. *Had not thought about her pants pocket not being clean. *Should have cleaned the oximeter before and after use. *Should not store the oximeter in her pocket. Interview on 3/16/22 at 4:48 p.m. with director of nursing (DON) A revealed she: *Had reviewed hand hygiene with staff that morning. *Expected staff to perform hand hygiene when hands were soiled, before patient contact, before and after a procedure, and when entering and exiting a resident's room. *Had expected staff to disinfect the re-usable medical equipment after they used it. *Agreed staff should not carry the oximeter in their pockets. Review of the provider's 1/25/21 Hand Hygiene	F 880		

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F 880	Continued From page 6 policy revealed hands should have been washed: *"Before and after glove use." *"Before and after providing care to each resident." Review of the provider's 6/26/19 Wound Dressing/Change Policy revealed: Hand hygiene should have been completed after removal of old dressing, after cleansing the wound, and after completion of the dressing change. Review of the provider's October 2018 Cleaning and Disinfection of Resident-Care Items and Equipment policy revealed: "d. Reusable items are cleaned and disinfected or sterilized between residents..."	F 880		

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E 000	Initial Comments Surveyor: 41895 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 3/15/22 through 3/17/22. United Living Community was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kaleb C. Hight
TITLE: Administrator
(X6) DATE: 03/31/2022

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

APR 01 2022
SD DOH-OLC

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	435079	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/16/2022

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K 000	INITIAL COMMENTS Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/16/22. United Living Community 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 K293 and K361 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation and interview, the provider failed to maintain required illumination for 3 randomly observed exit signs (dietary corridor, employee entryway, and basement corridor). Findings include: 1. Observation on 3/16/2022 at 11:19 a.m. revealed the internally illuminated exit sign from	K 293	K 293 Exit Signage Corrective Action: 1. For the identification of lack of: *Maintaining required illumination for 3 randomly observed exit signs (dietary corridor, employee entryway, and basement corridor). The administrator in consultation with the Environmental Services Director will review, revise, create as necessary policies and procedures for the above identified areas. 1. Dietary Corridor - New exit sign was installed on 3/25/22 and is functioning properly. 2. Employee Entrance - New exit sign was installed on 3/25/22 and is functioning properly. 3. Basement Corridor - Bulb was replaced on 3/15/22 and is functioning properly. Identification of Others: 2. ALL exit signage was reviewed at time of survey on 3/15/22 by surveyor and Environmental Services Director. No other signs were identified as deficient. An additional review by a maintenance technician took place on 3/15/22 and no other exit signage was deficient.	4/1/2022

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

Kaleb C. Hight | Administrator | 4/1/2022

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APR 01 2022
SD HOH OLC

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K 293	Continued From page 1 the dietary corridor to the employee entryway was not lit. Further observation of that exit sign revealed it only had one of two bulbs installed and that bulb was not functioning. Interview with the maintenance supervisor at the time of those observations confirmed those conditions. 2. Observation on 3/16/2022 at 11:35 a.m. revealed the internally illuminated exit sign at the south end of the employee entrance only had one of two fluorescent lamps installed and functioning for the fixture. Exit signs are required to have multiple elements such that the failure of any single element does not leave the unit unlit. Interview with the maintenance supervisor at the time of the observations confirmed that condition. 3. Observation on 3/16/2022 at 1:17 p.m. revealed the internally illuminated exit sign at the north end of the main basement corridor was not lit. Interview with the maintenance supervisor at the time of the observations confirmed those conditions. The deficiencies affected two locations required to be provided with a marked and identifiable path of egress. Ref. NFPA 101 Sec. 7.10.5.2.1 and 7.8.1.4	K 293	System Changes: 3. Root cause analysis conducted answered the 5 Whys: Root Cause discussions revealed possible root cause of failure to exit signage maintenance: Previously employed maintenance technician signed off on monthly review of exit signs but failed to maintain fixtures. Administrator, Environmental Services Director and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/ training with demonstrated competency and documentation. Monitoring: 4. Administrator or Environmental Services Director will conduct auditing and monitoring 2 times monthly over all shifts to ensure identified and assigned tasks are being done as educated and trained. After 1 month of monitoring demonstrating expectations are being met, monitoring may reduce to once monthly for one month. Monitoring results will be reported by administrator or Environmental Services Director to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	
K 361 SS=D	Corridors - Areas Open to Corridor CFR(s): NFPA 101 Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1.	K 361	K 361 Corridors - Areas Open to Corridor Corrective Action: 1. For the identification of lack of: *Maintaining required corridor separation from areas not protected by an approved electrically supervised automatic smoke detection system (fire alarm) in the Activities room.	4/1/2022

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K 361	Continued From page 2 18.3.6.1, 19.3.6.1 This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation and interview, the provider failed to maintain a corridor separation from areas not protected by an approved electrically supervised automatic smoke detection system (fire alarm) in one randomly observed area (Activities room). Findings include: 1.) Observation and interview on 3/16/22 at 11:26 a.m. revealed the activities room had two swinging doors that opened into the corridor system. Those doors did not automatically latch into the door fame when the fire alarm was activated and therefore left that area open to the corridor. That area did not have a smoke detector connected to the buildings fire alarm system as required for areas open to the corridor. Interview with the maintenance supervisor at that same time confirmed those findings. The deficiency could affect 100% of the smoke compartment occupants. Ref: LSC 19.3.6.1(1)(c), NFPA 72 chapter 17.	K 361	The administrator in consultation with the Environmental Services Director will review, revise, create as necessary policies and procedures for the above identified areas. 1. Automatic door closures were reinstalled on the Activities room on 4/1/22 to ensure a smoke barrier exists at all times. 2. Installation of smoke detectors in the Activities room began on 4/1/22 and is expected to be completed on 4/8/22. Identification of Others: 2. No other Areas Open to Corridors with inadequate smoke/fire detection were identified as deficient. System Changes: 3. Root cause analysis conducted answered the 5 Whys: Root Cause discussions revealed possible root cause of failure to maintain smoke detection in area open to a corridor: Environmental Services Director was given direction from LS surveyor during previous inspections for approval to remove the door closures due to perceived adequate smoke detection in the Activities room,which one half of the room contained smoke detectors. Monitoring: 4. Administrator or Environmental Services Director will conduct auditing and monitoring 2 times monthly over all shifts to ensure identified and assigned tasks are being done as educated and trained. After 1 month of monitoring demonstrating expectations are being met or upon installation of automatic smoke detectors, monitoring will be reduced to monthly or monitored real-time by external vendor. Monitoring results will be reported by administrator or Environmental Services Director to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	

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
	10601	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED LIVING COMMUNITY	405 1ST AVE BROOKINGS, SD 57006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement Surveyor: 27198 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/15/22 through 3/17/22. United Living Community was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 41895 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 3/15/22 through 3/17/22. United Living Community was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kaleb C. Hight

TITLE: Administrator

(X6) DATE: 03/31/2022

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