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
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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: 42477 An extended recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 9/26/21 through 9/29/21 and on 11/4/21. Dells Nursing and Rehab Center, Inc. was found not in compliance with the following requirements: F550, F577, F582, F585, F600, F604, F609, F610, F637, F641, F642, F656, F658, F684, F686, F690, F725, F726, F727, F744, F758, F801, F812, F835, F837, F867, F880, F881, F882, F883, F886, and F948. NOTICE: On 11/4/21 at 11:00 a.m. an Immediate Jeopardy was identified after the Centers for Medicare and Medicaid Services (CMS) Regional Office review of the 9/27/21 Recertification Survey Form CMS-2567. The facility failed to implement CMS and CDC recommended practices to prepare for COVID-19. On 11/4/21 at 3:52 p.m. a copy of the immediate jeopardy template was emailed to the provider for review. Notice of immediate jeopardy was given verbally, via telephone to the administrator. Specifically, the provider failed to ensure: *CDC guidelines were followed for proper PPE usage to prevent the spread of COVID-19. *Unvaccinated residents who had been exposed to a staff member who had been positive with COVID-19 remained quarantined from the remaining resident population. *Staff who care for quarantined residents were wearing appropriate PPE. *One of one CNAs followed proper infection control practices after leaving one of three quarantined rooms.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Samuel Van Voorst
TITLE: Administrator
(X6) DATE: 11/12/21

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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	Continued From page 1 *Two of two observed visitors had been screened for the potential of COVID-19 illness. *Residents had been screened for signs and symptoms of COVID-19. PLAN: On 9/27/21 at 5:00 p.m. surveyors were able to verified that the Immediate Jeopardy had been removed while the survey team had been onsite. The Immediate Jeopardy was removed after the provider educated all staff, quarantined COVID-19 exposed residents, implemented infection control practices to prevent the spread of COVID-19, and screened all staff and visitors. Immediate Jeopardy was removed on 9/27/21 at 5:00 p.m. after the removal plan had been verified by the survey team. After removal of the Immediate Jeopardy, the scope/severity of this citation is level "F".	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550	F550 For the identification of multiple system failures that included lack of appropriate response to resident grievances about sharing bathrooms. Appropriate decorum of resident when transporting to bathing area. Resident 6 moved to another room that would have a more suitable bathroom situation. The administrator, governing body representative, interim DON, and/or a designee will ensure that resident rights are followed. Setting up date to review residents rights with medical director.	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 550	Continued From page 2 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Surveyor: 06365 Based on observation, interview, record review, and policy review, the provider failed to ensure: *One of one resident (32) was transported from her room to the (bathtub) room in a dignified and respectful manner. *Two of two sampled residents' (6 and 13) concerns regarding access to their shared bathrooms were addressed. Findings include: 1. Observation on 9/27/21 at 8:57 a.m. revealed: *Certified nursing assistants (CNAs) F and G	F 550	F 550 All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by 10/19/21 by Interim DON or Designee. All residents and staff have the potential to be affected if staff do not adhere to all identified areas. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by 10/19/21 by Administrator or designee. Monitoring those residents have a dignified and suitable environment 3 times weekly for 4 weeks, administrator, governing body representative, interim DON, and/or a designee making observations across all shifts to ensure staff compliance with All staff compliance in the above identified areas. 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 4 months. Monitoring results will be reported by administrator, interim DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director. Administration, governing body representation and QAPI should see resolution with an effectively implemented and sustained plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 550	Continued From page 3	F 550		

assisted resident 32 up from her bed using a stand aide lift.
*CNA F removed resident 32's brief. There was an odor of bowel at that time.
*Without wiping resident 32's bottom, CNAs F and G positioned resident 32 on a bedside toilet commode with wheels.
*CNA G pulled a white terrycloth cover-up over resident 32's head and draped it around her, but resident 32's left buttock remained exposed.
*CNA G then pulled resident 32 in the wheeled commode out of her room and down the public hallway to the bath area, while pulling the resident's wheelchair using her other hand.

Interview on 9/28/21 at 8:37 a.m. with CNA G revealed:
*She did not realize resident 32's left buttock was exposed.
*The wheeled commode was described by her as the shower chair for the facility.
*The facility practice of using the commode for transporting a resident to the bath area involved fewer steps and effort than it would be if the resident was transported in his/her wheelchair and then transferred onto the commode in the bath area.

Review of resident 32's record revealed:
*On the 8/30/21 annual minimum data set (MDS) assessment, her cognitive status was scored as severely impaired, and she is frequently incontinent of bowel.
*The bathing/showering tasks for the care plan focus of activities of daily living (ADL) self-care performance deficit, revised on 7/8/20, does not address transporting the resident to the bath area using the wheeled commode.
*The task ADL - toilet use documentation noted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 550	Continued From page 4 the resident's consistency of bowel at 8:30 a.m. on 9/27/21 was "loose/diarrhea." *None of the care conference notes documented on 7/8/20, 9/30/20, 12/23/20, 3/25/21, 6/18/21, and 9/2/21 address the method of transporting the resident to the bath area nor whether the use of the commode for transportation was consistent with the resident's prior lifestyle or personal choice. Review of facility resident rights document provided to residents revealed the right to: *Be treated with respect, dignity, and consideration. *Receive services considering a resident's "special needs, likes and dislikes." *Personal privacy with accommodations and personal care. Review of the bath aide job description revealed: *"The bathing experience for each resident will foster self respect [sic] and a feeling of worth by consistent understanding and kindness." *There was no statement regarding the facility practice of using the wheeled commode for transporting a resident to the bath area. 2. Interview of resident 6 on 9/27/21 at 10:45 a.m. while seated in his room revealed his concern about the bathroom that he shares with two other residents in a room on the opposite side of the bathroom. He said: *The "neighbors think the toilet is theirs." *One of the residents will not close the door on their side of the bathroom making it necessary for resident 6 to pull it shut before he can use the bathroom. *One of the residents will open the bathroom door while resident 6 is in there using it and "walks in	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 550	Continued From page 5 and stares at him." Observation of resident 6's bathroom during the interview confirmed his bathroom had two doors with one door the other side of the bathroom leading into a room on occupied by two other residents. Review of resident 6's record revealed the following bathroom concerns were reported by the resident: *A behavior note dated 6/8/21 documented that, at 7:30 p.m.., resident 6 went into the bathroom and "started yelling and cursing at the resident he shares the bathroom with." When [nurse's name] visited with resident 6 about his behavior, he said, "his bathroom mate never shuts the bathroom door." *A behavior note dated 9/4/21 at 10:42 p.m. documented resident 6 "went to restroom and slammed opposite door." The resident stated he will do that every time it is open. Additional review of resident 6's record revealed the following information about the resident's toileting needs: *On the 7/6/21 quarterly MDS assessment, his cognitive status was scored as intact, and he was frequently incontinent of bladder. *The task ADL - toilet use documentation between 9/5/21 and 9/29/21 showed the resident was independent with toileting 44% (35 of 79) of the time and was incontinent 49% (39 of 79) of the time. *The care plan focus of ADL self-care performance deficit, revised on 9/28/21, revealed no tasks related to toilet use except for two tasks that were removed as "resolved" on separate dates:	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 550	Continued From page 6 -The resident "requires (SPECIFY assistance) by (X) staff CNA for toileting," dated 5/29/20. -The resident is "able to toilet himself," dated 1/25/21. Review of care conference notes on 1/28/21, 4/22/21, 7/8/21, and 9/28/21 revealed no documentation to address the resident's toileting needs or concerns related to his shared bathroom. Interview on 9/28/21 at 11:10 a.m. with minimum data set (MDS) coordinator D revealed: *They discuss behaviors during the daily report. *Social services was involved. *They discuss what caused the behavior and what action was taken. *If they identify a need to change the way staff respond to a behavior, they tell the staff on duty, write a note on the electronic record dashboard, and the charge nurse adds it to their shift reports. *She will modify the care plan as needed based on the behavior reports. *She was not aware of resident 6's behaviors. Interview on 9/28/21 at 1:51 p.m. with social services/office assistant E revealed: *She was involved in discussing resident to resident incidents and behaviors through their daily stand-up report at 10 a.m. *She listed the names of residents that she knew had conflicts with a roommate or other residents. *She did not include resident 6 in the last but confirmed she was aware of resident 6's complaints of resident 14 opening the bathroom door while resident 6 is using it. *A sign was posted on the bathroom door on resident 14's side of the bathroom to remind him to knock on the door before opening it.	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 550	Continued From page 7 *She did not offer any other actions she had taken to address resident 6's complaints. Review of the MDS coordinator job description revealed essential duties included: *Continual update of the resident's care plan as orders or resident status changes. *Use nursing skills to make professional observations and assessments of residents. *Receive verbal report from charge nurse. *Check on residents with a change of condition. *Complete assessment including bowel and bladder assessment. Review of the social services designee job description revealed responsibilities included: *Understand the social and emotional needs of persons being served. *Have a strong desire to assist in coping with and solving issues in residents' everyday lives and dealing with relationships. *Assess resident needs to maintain a care plan that addresses social, emotional, and psychosocial needs. *Continually maintain contact with residents concerning all aspects of their stay. 3. Observation and interview of resident 13 on 9/26/21 at 4:35 p.m. revealed: *The resident on the other side of the shared bathroom "is in there for 2 hours sometimes." *When he cannot get in the bathroom, he goes in his incontinence brief. Review of resident 13's record revealed the following information about the resident's toileting needs: *On the 7/18/21 annual MDS assessment, his cognitive status was scored as intact, and he was	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 550	Continued From page 8 frequently incontinent of bladder. *The care plan focus for ADL self-care performance deficit, revised on 11/13/20, noted an intervention revised on 2/11/21 that the resident toileted himself independently but "occasionally he may request assistance of one." *The task ADL - toilet use documentation between 9/5/21 and 9/29/21 showed the resident was independent with toileting 44% (35 of 75) of the time and was continent 43% (34 of 79) of the time. Review of care conference notes dated 11/12/20, 2/11/21, 5/6/21, and 7/22/21 revealed no documentation to address the resident's toileting needs or concerns related to his shared bathroom. Interview on 9/28/21 at 1:51 p.m. with social services/office assistant E revealed she was not aware that resident 13 was unable to use the shared bathroom at times.	F 550		
F 577 SS=E	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of	F 577	F 577 For the identification of multiple system failures that included lack of appropriate availability of survey results and lack of contact information for reporting complaints to the department of health. The administrator, governing body representative, interim DON, and/or a designee will ensure that the residents rights are followed. Setting up date to review resident rights with medical director. Survey results were relocated to an open spot where they will not be covered and readily available. Located on wall between administrator office and MDS office. Contact information for the Department of Health is posted in the same area.	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 577	Continued From page 9 the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Surveyor: 06365 Based on observation, interview, and policy review, the facility failed to make accessible to all residents and their representatives the most recent survey results and contact information about all state agencies and advocacy groups. Findings include: 1. Interview on 9/27/21 at 11:07 a.m. with three residents (2, 19, 27) who are regular attendees of Resident Council revealed none of them knew about their right to: *Read the state survey results nor where to find them. *Contact the state to formally complain about facility care and services. Observation on 9/28/21 at 10:30 a.m. of the facility lobby and public area in the center of the facility around the nursing desk revealed: *A wire bin hanging on the wall with a blue binder in it that contained the results of the most recent survey results. *The bin was not accessible at that time due to the medication cart parked in front of it.	F 577	F 577 All staff will be informed of the new location of survey results and where number is posted for residents to contact department of health at our Inservice on 10/18/21. Maintenance Director or designee will audit availability of survey results and information posted for state agencies weekly for four weeks and monthly for 2 additional months. Monitoring results will be reported by administrator, interim DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director. Administration, governing body representation and QAPI should see resolution with an effectively implemented and sustained plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 577	Continued From page 10 *No postings were found providing contact information for reporting a complaint with the state survey agency. Interview and observation on 9/28/21 at 2:49 p.m. with activities director S confirmed: *The survey results bin and binder were behind the medication cart making them inaccessible. *A notice was posted above the bin announcing the availability of the survey results. *A posting with contact information for reporting complaints with the state was not found. Review of the facility resident rights document provided to residents revealed the right to: *See the findings of the last "inspection for the nursing facility and have them explained to you in a way you will understand." *Information from "groups representing your interests, such a [sic] resident advocate or agencies, and you may contact these agencies."	F 577		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services	F 582	F 582 For the identification of multiple system failures that included lack of appropriate contact information availability for ombudsman and state agency as well as Medicare notices given. The administrator, governing body representative, interim DON, and/or a designee created as necessary policies and procedures for the above identified areas. Setting up date to review policy with medical director.	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 582	Continued From page 11 specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Surveyor: 06365	F 582	F 582 Administrator, governing body representative, interim DON, 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. SSD or designee will audit NOMNC weekly for four weeks, then twice a month for month and monthly for an additional four months. Monitoring results will be reported by SSD or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director. Administration, governing body representation and QAPI should see resolution with an effectively implemented and sustained plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 582	Continued From page 12 Based on interview and record review, the facility failed to provide proper notices to two of three reviewed residents (36 and 94) informing them that facility charges would no longer be covered under Medicare when their skilled therapy services ended. Findings include: 1. Review of resident 36's record revealed: *He was admitted to the facility on 6/16/21. *He was started on physical therapy on 6/16/21 and occupational therapy on 6/17/21. *Occupational therapy ended 7/7/21 and physical therapy ended on 7/13/21. *A notice of Medicare non-coverage (CMS 10123) was signed by resident 36's representative on 7/13/21. *There was no notice of non-coverage for skilled nursing facility services (CMS 10055). Review of resident 94's record revealed: *He was admitted to the facility on 2/22/21. *Three therapy services - physical, occupational, and speech - started on 2/22/21. *Speech therapy services ended on 3/1/21. *Physical and occupational therapy ended on 4/9/21. *The resident was discharged from the facility on 4/24/21. *No notices of Medicare non-coverage were found in resident 94's record. Interview with social services/office assistant E on 9/29/21 at 9:14 a.m. revealed: *She did not know about providing the CMS-10055 notice when a resident remained in the facility after all therapy services had ended. *Resident 94 was discharged from the facility "before I started" as social services/office	F 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 582	Continued From page 13 assistant. *If notices were provided to resident 94's representative, she could not find them.	F 582		
F 585 SS=F	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file	F 585	F 585 For the identification of multiple system failures that included lack of appropriate response to resident grievances. The administrator, governing body representative, interim DON, and/or a designee reviewed as necessary policies and procedures for the above identified areas. Setting up date to review policy with medical director. All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by 10/19/21 by Administrator or designee. Monitoring of determined approaches to ensure effective. Implementation and ongoing sustainment include at a minimum 2 times weekly for 4 weeks, SSD, Activity Director and/or a designee making observations across all shifts to ensure staff compliance with All staff compliance in the above identified areas. 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 4 months. Monitoring results will be reported by SSD and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director.	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 585	Continued From page 14	F 585		

grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 585	Continued From page 15	F 585		

the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Surveyor: 06365
Based on observation, interview, record review, and policy review, the facility failed to follow an established grievance procedure that designated a Grievance Official, provided information on how to file a grievance, and ensured prompt resolution of grievances for three of three residents (6, 11, and 19) with grievances.
Findings include:

1. Interview on 9/27/21 at 11:07 a.m. with three residents that regularly attended the monthly resident council meeting revealed resident 19 had concerns about:
*Residents not covering their mouth when coughing and need to "stay in their room."
*Being better informed about the facility practices related to COVID, especially with children visiting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 585	Continued From page 16 *Wanting management to know "this aide should not be here because she is so not respectful, but they have so much trouble getting staff." *Saturday mail is "sometimes not passed out until later in the day." Review of the resident council minutes for April - September 2021 revealed: *None of resident 19's concerns had been previously discussed during resident council meetings. *New concerns voiced during the 4/13/21 meeting were documented the same day on a compliment/complaint form with a resolution documented on 4/16/21 and signed off as completed on 4/26/21 by business manager B. *The April concerns were noted as resolved concerns in the 5/12/21 minutes. *New concerns were noted in the 5/12/21 minutes but there was no compliment/complaint form to document the staff resolution or action taken and the administrator's response. Interview on 9/28/21 at 2:49 p.m. with activities director S revealed: *She will address the facility rules related to visiting restrictions during the next resident council meeting. *Mail delivery on Saturday has been added to the activity calendar to remind the activity assistants to pass the mail as soon as the mail carrier drops it off at the facility. Further interview and observation with activities director S on 9/29/21 at 8:40 a.m. revealed: *The compliment/complaint forms "used to be available at the nurses' desk." *Upon looking through an expandable folder at the nursing desk, she found one form in a pocket	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 585	Continued From page 17	F 585		

of the folder that was not labeled.

2. Interview on 9/27/21 at 10:45 a.m. with resident 6 revealed he had concerns about:
*Sharing the bathroom with the two residents in the room on the opposite side of the bathroom. (Refer also to F550, finding 2.)
*The clippers, pens, and clothes that have gone missing. He "reported it to the boss, but they just brush it off."
*His room is too cold at night.

Review of resident 6's record revealed the following concerns had been reported by the resident and documented by staff as behavior notes dated:
*9/23/20 at 10:18 a.m., resident "shouted, 'It's freezing in my room and I haven't been able to get any sleep.'" Certified nursing assistant/medication aide H told the resident she would get him a blanket and "let maintenance know that room is cold."
*5/29/21 at 7:30 p.m., resident reported a "brand new pair of shoes" were not in his room and "people keep taking thing [sic] from my room when I am not there," including pens, remotes, hard candies.
*6/8/21 at 7:30 pm., resident 6 went into the bathroom and "started yelling and cursing at the resident he shares the bathroom with." When the writer of the note visited with resident 6 about his behavior, he said, "his bathroom mate never shuts the bathroom door."
*7/22/21 at 8:12 a.m. regarding an altercation between the resident and certified nursing assistant/medication aide H over the room temperature and turning on the air conditioner. (Refer also to F600, finding 1.)
*9/4/21 at 10:42 p.m., resident 6 "went to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 585	Continued From page 18 restroom and slammed opposite door." The resident stated he will do that every time it is open. Interview on 9/28/21 at 1:51 p.m. with social services/office assistant E revealed: *She did not know the facility process for filing grievances. *"I haven't seen a grievance form." *She was not aware of resident 6's concerns about missing items. *She did not know resident 6 was "still bothered" by his room temperature. Interview on 9/29/21 at 3:46 p.m. with administrator A, business manager B, and interim director of nursing M revealed: *They were aware of resident 6's reports of missing items. *The grievance forms should be available, but they did not know where the form was. *They confirmed the compliment/complaint form used by activities director S for resident council concerns was the form they used for grievances. *They were unable to find previously completed grievance forms. *They acknowledged that grievances should be investigated with a timely response to the resident and/or representative. *Grievances related to abuse, neglect, and misappropriation (unauthorized use of a resident's property) need to be reported to the state. *All staff are mandatory reporters when a grievance involves abuse or neglect. Surveyor: 42477 3. Review of resident 11's electronic medical record (EMR) revealed:	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 585	Continued From page 19 *Her was sent through the laundry. *Social services/office assistant (SS/OA) E called resident 11's daughter notifying her phone no longer worked. *Resident 11's daughter bought resident 11 a new cell phone. Interview on 9/29/21 at 10:40 a.m. with SS/OA E regarding resident 11 and the cell phone revealed: *Laundry department unknowingly washed the resident's cell phone. *They did not have a grievance policy that they followed. *They do not offer to replace items even when the facility is at fault. Interview on 9/29/21 at 10:48 a.m. with administrator A revealed: *He had been unaware of the incident regarding resident 11's cell phone. *They would have offered to replace her cell phone if they had been aware. Review of the provider's undated grievance policy revealed: *"It is the policy of [facility name] to have accessible, responsive grievance procedure which protects residents and their families' ability to report any grievances with this facility." *Residents and representatives can "voice concerns and complaints, either orally or in writing" regarding care provided or "the behavior of other residents." *When the facility receives a grievance, they would: -Promptly investigate. -Correct any condition found to be inconsistent with their policies and procedures and the rights	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 585	Continued From page 20 and responsibilities of their residents. *"Any grievance of a resident or someone acting on behalf of a resident should be directed to our Administrator, the Director of Nursing, or appropriate department head. Details concerning time, place nature of occurrence or condition, persons involved, and other pertinent facts should be included in order to facilitate investigation and follow-up action." *Their policies and procedures for resolving complaints were "not an exclusive remedy available to their residents."	F 585		
F 600 SS=H	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: Surveyor: 06365 Based on observation, interview, record review, and policy review, the facility failed to ensure: *Three of three residents (6, 8, and 31) had been free from neglect and verbal abuse from certified nursing assistant/medication aide (CNA/MA) H.	F 600	F 600 For the identification of multiple system failures that included lack of appropriate identification of abuse, neglect, and verbal abuse. Appropriate response to resident complaints of disrespect and negligence by a staff member. Appropriate investigation, documentation, and reporting of resident incidents such as a hematoma after a fall, a burn from hot tea, instance of delay in cares and residents subjected to negligence and verbal abuse by a staff member. The administrator, governing body representative, interim DON, and/or a designee reviewed as necessary policies and procedures for the above identified areas. Setting up date to review policy with medical director. Staff in-service provided on 10/18/21 which covered Abuse, Neglect, and Mandatory reporting. ALL residents and staff have the potential to be affected if staff do not adhere to all identified areas.	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 600	Continued From page 21 *Two of two residents (3 and 41) were free from neglect related to delayed care and services. *Facility interventions related to an unexpected death of resident (95) were followed. *One of one resident (16) with a hematoma which had resulted from a fall. *One of one resident (29) was free from burns related to hot tea. Findings include: 1. Interview with resident 6 on 9/27/21 at 10:45 a.m. revealed he had concerns about his room being too cold at night and nothing had been done to fix it. (Refer also to F585, finding 2.) Review of resident 6's electronic medical record (EMR) revealed: *He had reported his concern and it had been documented as behavior notes: *On 9/23/20 at 10:18 a.m. by registered nurse Y: -CNA/MA H responded to the resident's call light. -The resident "shouted, 'It's freezing in my room and I haven't been able to get any sleep.'" -CNA/MA H told the resident she would get him a blanket and "let maintenance know that room is cold." *On 7/22/21 at 8:12 a.m. by CNA/MA H: -Went into the resident's room to get him up and dressed. -Turned on the air conditioner because "it was so hot in there." -Resident 6 "called the aid a bitch for turning his air on." -CNA/MA H told resident she "will turn it off in a [minute] that we need to finish getting ready." -The resident "stood up and swung at CNA and kept calling her a bitch." -The resident "then shoved CNA out of the way and punched her to get to the [air conditioner]."	F 600	F 600 We acknowledge what had occurred and investigated CNA/MA H. Upon completion of the investigation of alleged incidents CNA/MA H was terminated. Administrator, governing body representative, interim 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 will be included with the audits for tag F 550 ensuring they feel that they are in a safe environment. DON and/or a designee will report findings to QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director. Administration, governing body representation and QAPI should see resolution with an effectively implemented and sustained plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 600	Continued From page 22 *On 7/22/21 at 9:10 a.m. by the director of nursing (DON) X: -Resident 6 said to DON, "'This is my house. They can't do whatever they want.'" -Discussed with CNA/MA H and "reminded this is the resident's home." 2. Interview on [date and time withheld due to anonymity] with a staff member who wished to remain anonymous reported: *CNA/MA H is "mean to residents." *The staff member heard CNA/MA H tell a resident "to go in his pants" because she was not going to toilet him again. *The staff member reported the concerns to management and they replied that "she is too reliable to reprimand or let go." Interview on [date and time withheld due to anonymity] with another staff member who wished to remain anonymous reported witnessing two specific incidents: * Resident 8's call light was on. -CNA/MA H said, "I'm not going back in there; I just took her to the bathroom." -The staff member reminded her that resident 8 was just diagnosed with a urinary infection resulting in the need for more frequent and urgent toileting. -CNA/MA H was observed to walk away and not take care of resident 8. *Resident 31's wife called the staff member while the resident was in the room waiting for someone to respond to his call light. -The staff member observed that no other call lights were on at the time and "all the CNAs were at the nurses station." -CNA/MA H was heard saying, "I'll will be there when I can be there."	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 600	Continued From page 23 -As CNA/MA H walked out of the room, after taking care of resident 31, she said, "Please and thank you would be appreciated." -When resident 31's light came on again, CNA/MA H entered the room, turned off the call light, and said, "I just took care of you." -The staff member explained that the resident was having problems with loose bowel movements at the time. Surveyor 42477: Review of CNA/MA H's employee file revealed she had instances of written warnings in the past regarding residents and her behavior with them. Surveyor 06365: Interview on 9/29/21 at 3:46 p.m. with administrator A, business manager B, and interim DON M revealed: *They were not aware of the allegations related to CNA/MA H. *Administrator B said the allegations would be neglect. *All staff are mandatory reporters when a grievance involves abuse or neglect. *Grievances related to abuse and neglect need to be reported to the state. *They will investigate the allegations "right away." Surveyor 42477: Interview on [date and time withheld due to anonymity] with anonymous staff member revealed: *CNA/MA H would turn on residents' air conditioners. *Residents would complain that they were cold or want them turned off. *CNA/MA H would refuse to take care of the residents or help them unless "she was	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 600	Continued From page 24 comfortable." *This allegation coincided with CNA/MA H's documentation in finding 1. Surveyor: 26632 3. Review of resident 3's interdisciplinary progress notes revealed: *On 9/12/21 at 3:47 p.m. "Pt. [resident] insistent that staff and peers are her family member. Staff attempts to redirect pt, but continues. Pt noted to go into peers room, grab peers arms bilaterally and yell at them." *On 9/16/21 at 5:22 p.m. registered nurse (RN)/interim director of nursing (DON) M documented the following: -"Data: RN found patient [resident] on toilet. RN called CNA [certified nursing assistant] on that hallway to come to the patient's room. The patient was found sleeping against the wall still hooked up to the EZ stand. DON [director of nursing] called to patient's room. Pt's [resident] buttocks was bright red/purple. DON and RN got patient off of the toilet and into the wheelchair to go to supper. Expected time that resident was left on toilet in EZ stand was 20-25 min. [[minutes]." -"Action: Pt was taken off toilet via RN and DON. Both nurses aides were called to the room to tell their side of the situation." -"Response: DON followed up with both nurses aides." *On 9/18/21 at 7:39 a.m. "Pt is noted to approach peers and staff by the hands/arm and note [not] letting go. Staff attempts to intervene, pt becomes agitated and refused to release grip on peer. Pt states she is "healing" peer. Pt given therapeutic toy cat to hold. Pt in dining room, again grabbing at peers, hold their hands/arms and stopping them from eating. Gripping them firmly." *On 9/19/21 at 5:30 p.m. "Pt is grabbing peers	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 600	Continued From page 25	F 600		

with her hands aggressively and not letting go, stating they are her family members." "Staff physically having to remove pt hands from hurting peers." Peers are becoming agitated with pt having poor personal boundaries."
*On 9/21/21 at 7:46 a.m. "Resident seen going up to other residents and grabbing their arms, resident brought to nurses station, given a baby doll, resident doing better, will continue to monitor."
*On 9/25/21 at 6:00 p.m. "Resident was wheeling herself around dining room and near nurses station and was grabbing at other residents legs, arms."

Interview on 9/28/21 at 3:30 p.m. with interim DON M revealed:
*She had been the RN who had found resident 3 on the toilet.
*The other nurse was licensed practical nurse N, who had just started her shift.
*The two CNAs were CNA O and CNA P.
*She agreed CNAs O and P had neglected to assist resident 3 off the toilet in a timely manner.
*She had not completed any other investigation or documentation of this incident.
*She was aware of resident 3's behaviors of grabbing other residents.
-A recent reduction in her anti-psychotic medication had occurred and those behaviors started.
-There had been no incident reports to indicate who the other residents were if they had been injured physically or emotionally, family notifications, and physician notifications.

Surveyor: 41088
4. Observation on 9/27/21 at 10:18 a.m. of resident 41 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 600	Continued From page 26 *She had been in her room seated in her recliner. *Her eyes had been closed and appeared to be sleeping. *She was wearing a clothing protector. *There was vomit down her front chest area and on her left hand. *The call light was on the arm of the recliner next to her. *The call light had not been triggered. Interview on 9/27/21 at 10:20 a.m. with activity director (AD) S regarding resident 41 revealed: *AD S had been in the hallway near her office and next to resident 41's room and stated: -She had Alzheimer's and used a wheelchair. -She had vomited earlier and had not been feeling well. -Normally she would have been up and out of her room wandering around the facility with her wheelchair. *Refer to F690, finding 1. Observation at the following times revealed the resident in the same condition with vomit still on her: *9/27/21 at 10:43 a.m. *9/27/21 at 11:00 a.m. Observation on 9/27/21 at 11:29 a.m. of housekeeper/laundry worker Z revealed: *She had entered resident 41's room and cleaned it and exited. *Resident 41 still had vomit on her front chest area and on her hand when she left the room. Surveyor: 42477 5. Review of facility reported incident regarding resident 95 revealed he had: *Been admitted to the facility 3/9/20.	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 600	Continued From page 27 *Been admitted to the facility for rehabilitation. *The facility had identified that resident 95 had missed 10 doses of his morphine sulfate medication. *In a response to the incident the facility put the following in place: -A cheat sheet for ordering and reordering medications. -A physician will be notified any time a resident falls or early the next morning. -When a resident has a fall, they will be checked at least once per shift for 24 hours. -An audit of medication fill times will be reported to quality assurance preformance improvement (QAPI) committee for three months. -Medication error will be reported at QAPI in May 2020. -Education was provided to medication aides involved, including CNA/MA H. *Refer to F865, finding 1. Review of resident 95's EMR revealed: *He had experienced three falls during his short stay at the facility. *On 4/11/20 he had a fall with a note stating: -"At 0105 [1:05 a.m.] Resident placed his call light on, CNA answered call light, CNA summoned Nurse/writer to the room as resident appeared to be lying on the floor next to his bed with his blankets underneath him, attends 1/2 ways down & and resident was slightly incontinent. Resident's bed appeared to be in its lowest position to the floor. Nurse/Writer asked resident if he could recall what happened. Resident stated he thinks he slid out of bed, resident denies hitting his head, no visible injuries noted with no appearance of redness or bruising at this time. Resident denies hitting his head. Resident reports soreness to his left hip rating pain at 4..."	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 600	Continued From page 28 *Vital signs were checked at that time. *At 9:59 a.m. he was noted to be: -"...Resident increasingly tired and pale, complaining of chills." *The next note at 6:00 p.m. stated: -"Nurse called to resident's room. Resident is sitting in his wheelchair hunched over unresponsive to staff. Face purple. Resident was placed in bed and Nurse listened for lung sounds and heart sounds. None present. 1750[5:50 p.m.] family notified. On-Call doctor notified will be calling back." *His physician had not been notified of the fall. *His family had not been notified of the fall. *Follow-up vitals had not been completed, even when he was noted to be "pale". 6. Observation and interview on 9/27/21 at 7:47 a.m. with interim DON M and resident 16 revealed: *DON M was doing a dressing change to resident 16's head. *Resident 16 had fallen a couple of weeks ago and had a large hematoma on the back of her head. *The hematoma had split open a couple of days ago. *Resident 16 had to go to the emergency department (ED) to get stitches to close the hematoma. Review of resident 16's EMR revealed: *She had been admitted to hospice in June of 2021. *On 9/1/21: -"Head pain d/t [due to] fall/'goose egg'." *On 9/2/21: -"...Hematoma noted to left back of head..." *On 9/3/21:	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 600	Continued From page 29 -"Post fall. Resident fell 9/2. Has an abrasion to the back of the head..." *On 9/8/21: -"...Bruising noted on neck and head from previous fall.." *On 9/8/21 the minimum data set (MDS) nurse and charge nurse evaluated resident from the fall she had on 9/1/21. *That documentation stated: -"MDS nurse and charge nurse evaluated resident at this time post fall, resident continues to present with large hematoma on the left back of scull [sp] with bruising going from the back of her neck down to the left front shoulder, resident also has a bruise on her left buttock and a bruise on her right buttock..." *It was not until 9/8/21 of documentation that the family had been notified. *On 9/9/21 there had been documentation that the Physician had been updated. *On 9/25/21 she was transferred to the ED because resident 16 was noted to have bloody Kleenex in her hands. The nurse's observations stated: -"...upon observation of the back of resident's left side of head; noticed that the skin to her hematoma was not intact and was an opened area measuring 2.5 inches by 2.2 inches. Resident had a fall on 9/8 that left behind this hematoma..." *There had been inconsistancies on the date in which the fall occurred. *There had been no investigation of this fall. *There had been no report submitted to the South Dakota Department of Health regarding this fall. 7. Review of resident 29's EMR revealed: *She had received burns on her inner thighs in June of 2021.	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 600	Continued From page 30 *On 6/8/21: -"Resident grabbed another residents Hot Tea from the table and spilt it [spilled] between her legs, back of left leg is red, no blistering noted at this time, lotion applied. Nursing will continue to monitor." *On 6/10/21: -Follow up to her burn. She had three blisters, one intact and two had opened. *On 6/12/21: -Documentation of a large intact blister. *On 6/13/21: -The area was reddened/ pink, with no intact blisters. *There had been no documentation that the Physician had been notified or her family.	F 600		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 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.	F 604	F604 For the identification of multiple system failures that included lack of appropriate assessment and documentation as well as staff education about resident utilizing a safety harness. The administrator, governing body representative, interim DON, and/or a designee will review, revise, create as necessary policies and procedures for the above identified areas. Setting up date to review policy with medical director. All facility staff re-educated and shown where binder for correct use of harness is for resident 29. Harness will be evaluated for need quarterly and as needed.	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 604	Continued From page 31 §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (29) wearing a upper extremity harness had been assessed for the use as a restrictive or enabler including: *Ensured staff had been educated on how to properly put resident 29's harness on. *Ensured staff placed the harness on resident 29 or documented her refusals. Findings include: 1. Observation and interview on 9/26/21 at 1:30 p.m. with resident 29 revealed she: *Was wearing a harness, the upper and lower strap were both high on her breastbone. *Stated the harness helped her when staff put it on correctly. *Stated when it is not on correctly, she has fallen or is slumped over in her chair. *Asked this surveyor to get a staff member to help fix the harness, as she was significantly slumped over in her chair. *Surveyor asked certified nursing assistant (CNA) Q to help resident 29.	F 604	F 604 Administrator, governing body representative, interim 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. CNA and/or a designee will conduct auditing and monitoring for all areas identified above. Monitoring of determined approaches to ensure effective implementation and ongoing sustainment include at a minimum 2 times weekly for 4 weeks, 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 4 months. Monitoring results will be reported by administrator, interim DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 604	Continued From page 32 Interview on 9/29/21 at 1:45 p.m. with certified nursing assistant (CNA) Q revealed she: *Stated she had not received any education on the harness. *Had not been sure how to put on the harness correctly. 2. Observation on 9/27/21 at 11:26 a.m. of resident 29 revealed she: *Was in the TV area of the dining room. *Was slumped over in her chair. *Did not have a harness on. Review of resident 29's electronic medical record (EMR) revealed: Her diagnoses included: -Parkinson's disease. -Weakness. *The harness had been recommended by therapy in May of 2021. *Therapy included instructions and pictures to ensure resident 29 wore the harness correctly. *She had multiple falls. Review of resident 29's falls records revealed: *She had falls documented on the following dates: -6/8/21. -6/10/21. -6/29/21. -7/5/21. -8/31/21. *She had not been wearing her harness during any of those falls. *Her physician had responded to the 8/31/21 fall and stated: -"...remind her not to be leaning forward without her harness on."	F 604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 604	Continued From page 33 Review of resident 29's harness instructions revealed: *"...Do not have straps above breasts..." *"...Please not that all straps are positioned at correct length and should not need to be adjusted. Also note that if back strap is clipped above WC [wheelchair] back brackets, chest strap will raise to [too] high on chest and become incorrectly positioned." Review of resident 29's assessments revealed she had not been assessed by nursing for the harness. Review of resident 29's minimum data set (MDS) assessments revealed: *Her 6/1/21 and 8/20/21 quarterly MDS assessments stated: -For the use of a trunk restraint, it had been marked "not used." Interview on 9/28/21 at 3:45 p.m. with administrator A, business office manager B, and interim director of nursing (DON) M revealed: *Staff had been told that they were to ask resident 29 if she wanted to wear her harness. *If resident 29 refused to wear her harness then they would document that in her chart. *They agreed that a harness needed to be evaluated to see if it was a restraint and marked on the MDS. *They agreed documentation had not shown that resident 29 had been refusing to wear her harness. Review of the provider's undated Restraints Assessment policy revealed: *"Prior to a restraint being applied, a physician restraint assessment will be performed."	F 604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 604	Continued From page 34 *The data collected, and analysis will consist of: -Medical diagnosis report. -Physical assessment. -Cognitive status. -Elimination pattern. -Decision-making skills. -Behavior patterns. *There would be documentation of alternatives to restraints. *There would be a review of falls. *Care plan would be updated. *The restraint would be reviewed quarterly.	F 604		
F 609 SS=H	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609	F 609 For the identification of multiple system failures that included lack of appropriate investigation, documentation, and reporting of resident incidents such as a hematoma after a fall, a burn from hot tea, instance of delay in cares and residents subjected to negligence and verbal abuse by a staff member. The administrator, governing body representative, interim DON, and/or a 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 10/19/21 by Interim DON or designee. ALL residents and staff have the potential to be affected if staff do not adhere to all identified areas.	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 609	Continued From page 35 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Surveyor: 06365 Based on observation, interview, record review, and policy review, the facility failed to report incidents of alleged abuse and neglect to the state for: *Three of three residents (6, 8, and 31) related to neglect and verbal abuse from certified nursing assistant/medication aide (CNA/MA) H. *One of one resident (3) related to neglect from delayed care and services. *One of one resident (16) who had a hematoma that had resulted from a fall. *One of one resident (29) with burns from hot tea. Findings include: 1. Interview with resident 6 on 9/27/21 at 10:45 a.m. and review of resident 6's record revealed: *CNA/MA H had disregarded his ongoing concern regarding the temperature of his room. (Refer also to F600, finding 1.) *On 7/22/21 at 8:12 a.m. by CNA/MA H when she turned on and kept his air conditioner on while she got him ready for the day despite his verbal and physical objections. *On 7/22/21 at 9:10 a.m. by director of nursing (DON) X when she spoke with resident 6 and counseled CNA/MA H about respecting resident 6's personal space as his home. 2. Interviews with two separate staff members who wished to remain anonymous on 9/28/21 at 10:15 a.m. and 3:07 p.m. respectively reported	F 609	F 609 Administrator, governing body representative, interim 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. Administrator, governing body representative, interim 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 of determined approaches to ensure effective implementation and ongoing sustainment include at a 2 times weekly for 4 weeks, administrator, governing body representative, interim DON, and/or a designee making observations across all shifts to ensure staff compliance with all staff compliance in the above identified areas. Monthly monitoring will continue at a minimum for 4 months. Monitoring results will be reported by administrator, interim DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 609	Continued From page 36 witnessing alleged verbal abuse and neglect by CNA/MA H towards one unnamed resident, resident 8, and resident 31. (Refer also to F600, finding 2). Interview on 9/29/21 at 3:46 p.m. with administrator A, business manager B, and interim director of nursing M revealed: *They were not aware of the allegations related to CNA/MA H despite the documented progress note for resident 6 and the anonymous staff member who reported witnessing alleged verbal abuse by CNA/MA H. *All staff are mandatory reporters when a grievance involves abuse or neglect. *Grievances related to abuse and neglect need to be reported to the state. *They had not reported these allegations to the state. Surveyor: 26632 3. Review of resident 3's interdisciplinary progress notes revealed: *On 9/12/21 at 3:47 p.m. "Pt. [resident] insistent that staff and peers are her family member. Staff attempts to redirect pt, but continues. Pt noted to go into peers room, grab peers arms bilaterally and yell at them." *On 9/16/21 at 5:22 p.m. registered nurse (RN)/interim DON M documented the following: -"Data: RN found patient [resident] on toilet. RN called CNA on that hallway to come to the patient's room. The patient was found sleeping against the wall still hooked up to the EZ stand. DON [director of nursing] called to patient's room. Pt's [resident] buttocks was bright red/purple. DON and RN got patient off of the toilet and into the wheelchair to go to supper. Expected time that resident was left on toilet in EZ stand was 20-25 min. [[minutes]]."	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 609	Continued From page 37 -"Action: Pt was taken off toilet via RN and DON. Both nurses aides were called to the room to tell their side of the situation." -"Response: DON followed up with both nurses aides." *On 9/18/21 at 7:39 a.m. "Pt is noted to approach peers and staff by the hands/arm and note [not] letting go. Staff attempts to intervene, pt becomes agitated and refused to release grip on peer. Pt states she is "healing" peer. Pt given therapeutic toy cat to hold. Pt in dining room, again grabbing at peers, hold their hands/arms and stopping them from eating. Gripping them firmly." *On 9/19/21 at 5:30 p.m. "Pt is grabbing peers with her hands aggressively and not letting go, stating they are her family members." "Staff physically having to remove pt hands from hurting peers." Peers are becoming agitated with pt having poor personal boundaries." *On 9/21/21 at 7:46 a.m. "Resident seen going up to other residents and grabbing their arms, resident brought to nurses station, given a baby doll, resident doing better, will continue to monitor." *On 9/25/21 at 6:00 p.m. "Resident was wheeling herself around dining room and near nurses station and was grabbing at other residents legs, arms." Interview on 9/28/21 at 3:30 p.m. with interim DON M revealed: *She had been the RN who had found resident 3 on the toilet. *The other nurse was licensed practical nurse (LPN) N, who had just started her shift. *The two CNAs were CNA O and CNA P. *She agreed CNAs O and P had neglected to assist resident 3 off of the toilet in a timely manner.	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 609	Continued From page 38 *She had not completed any other investigation or documentation of this incident. *She was aware of resident 3's behaviors of grabbing other residents. -A recent reduction in her anti-psychotic medication had occurred and those behaviors started. -There had been no incident reports to indicate who the other residents were, if they had been injured physically or emotionally, family notifications, and physician notifications. Surveyor: 42477 4. Interview on 9/28/21 at 3:45 p.m. with administrator A, business manager B and interim director of nursing (DON) M revealed: *They agreed the incidents involving residents 16 and 29 should have been reported. (Refer to F600, findings 6 and 7.) *They had not realized that their facility had not submitted any incident reports to the South Dakota Department of Health during a six month time period.	F 609		
F 610 SS=H	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 610	F 610 For the identification of multiple system failures that included lack of appropriate identification of abuse, neglect, and verbal abuse. Appropriate investigation, documentation, and reporting of resident incidents such as instance of delay in cares and residents subjected to negligence and verbal abuse by a staff member. The administrator, governing body representative, interim DON, and/or a designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas.	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 610	Continued From page 39 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Surveyor: 06365 Based on observation, interview, record review, and policy review, the facility failed to investigate incidents of alleged abuse and neglect for: *Three of three residents (6, 8, and 31) related to neglect and verbal abuse from certified nursing assistant/medication aide (CNA/MA) H. *One of one resident (3) related to neglect from delayed care and services. *One of one resident (95) who had a fall and passed away unexpectedly. *One of one resident (16) who had a hematoma that had resulted from a fall. *One of one resident (29) with burns from hot tea. Findings include: 1. Interview with resident 6 on 9/27/21 at 10:45 a.m. and review of resident 6's electronic medical record (EMR) revealed: *CNA/MA H had disregarded his ongoing concern regarding the temperature of his room. (Refer to F600, finding 1.) *On 7/22/21 at 8:12 a.m. by CNA/MA H when she turned on and kept his air conditioner on while she got him ready for the day despite his verbal and physical objections. *On 7/22/21 at 9:10 a.m. by director of nursing (DON) X when she spoke with resident 6 and counseled CNA/MA H about respecting resident 6's personal space as his home. 2. Interviews with two separate staff members	F 610	F 610 Administrator, governing body representative, interim 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 of determined approaches to ensure effective implementation and ongoing sustainment include at a minimum 2 times weekly for 4 weeks, administrator and/or a designee making observation. 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 4 months. Monitoring results will be reported by administrator, interim DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 610	Continued From page 40 who wished to remain anonymous on 9/28/21 at 10:15 a.m. and 3:07 p.m. respectively reported witnessing alleged verbal abuse and neglect by CNA/MA H towards one unnamed resident, resident 8, and resident 31. (Refer also to F600, finding 2). Interview on 9/29/21 at 3:46 p.m. with administrator A, business manager B, and interim director of nursing M revealed: *They were not aware of the allegations related to CNA/MA H despite the documented progress note for resident 6 and the anonymous staff member who reported witnessing alleged verbal abuse by CNA/MA H. *Grievances related to abuse and neglect need to be reported to the state. *They did not investigate these allegations but will investigate them "right away." Surveyor: 26632 3. Review of resident 3's interdisciplinary progress notes revealed: *On 9/12/21 at 3:47 p.m. "Pt. [resident] insistent that staff and peers are her family member. Staff attempts to redirect pt, but continues. Pt noted to go into peers room, grab peers arms bilaterally and yell at them." *On 9/16/21 at 5:22 p.m. registered nurse (RN)/interim DON M documented the following: -"Data: RN found patient [resident] on toilet. RN called CNA [certified nursing assistant] on that hallway to come to the patient's room. The patient was found sleeping against the wall still hooked up to the EZ stand. DON [director of nursing] called to patient's room. Pt's [resident] buttocks was bright red/purple. DON and RN got patient off of the toilet and into the wheelchair to go to supper. Expected time that resident was left on	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 610	Continued From page 41 toilet in EZ stand was 20-25 min. [[minutes]." -"Action: Pt was taken off toilet via RN and DON. Both nurses aides were called to the room to tell their side of the situation." -"Response: DON followed up with both nurses aides." *On 9/18/21 at 7:39 a.m. "Pt is noted to approach peers and staff by the hands/arm and note [not] letting go. Staff attempts to intervene, pt becomes agitated and refused to release grip on peer. Pt states she is "healing" peer. Pt given therapeutic toy cat to hold. Pt in dining room, again grabbing at peers, hold their hands/arms and stopping them from eating. Gripping them firmly. *On 9/19/21 at 5:30 p.m. "Pt is grabbing peers with her hands aggressively and not letting go, stating they are her family members." "Staff physically having to remove pt hands from hurting peers." Peers are becoming agitated with pt having poor personal boundaries." *On 9/21/21 at 7:46 a.m. "Resident seen going up to other residents and grabbing their arms, resident brought to nurses station, given a baby doll, resident doing better, will continue to monitor." *On 9/25/21 at 6:00 p.m. "Resident was wheeling herself around dining room and near nurses station and was grabbing at other residents legs, arms." Interview on 9/28/21 at 3:30 p.m. with interim DON M revealed: *She had been the RN who had found resident 3 on the toilet. *The other nurse was licensed practical nurse N, who had just started her shift. *The two CNAs were CNA O and CNA P. *She agreed CNAs O and P had neglected to assist resident 3 off of the toilet in a timely	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 610	Continued From page 42 manner. *She had not completed any other investigation or documentation of this incident. *She was aware of resident 3's behaviors of grabbing other residents. -A recent reduction in her anti-psychotic medication had occurred and those behaviors started. -There had been no incident reports to indicate who the other residents were and if they had been injured physically or emotionally, family notifications, and physician notifications. Surveyor: 42477 4. Interview on 9/28/21 at 3:45 p.m. with administrator A, business manager B and interim DON M revealed: *They agreed the incidents involving residents 95, 16, and 29 needed to be investigated and should have been investigated. (Refer to F600, findings 5, 6, and 7.) *They had been unable to provide surveyors with documentation related to the investigations.	F 610		
F 637 SS=E	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the	F 637	F637 For the identification of multiple system failures that included lack of appropriate assessment and change in conditions filed. Appropriate assessment, diagnosis, and documentation for continued need for a urinary catheter. Residents 4, 16, 24, and 41 reviewed to see if updated MDS still need to be done. MDS initiated if needed. All other residents assessed to determine if significant change present.	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 637	Continued From page 43 care plan, or both.) This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on interview, record review, policy review, and resident assessment instrument manual review, the provider failed to ensure a significant change of condition Minimum Data Set (MDS) assessment had been completed for: *Two of two sampled residents (16 and 41) when they had been admitted to receive hospice services. *Two of two sampled residents (4 and 24) who had a significant change in their activities of daily living abilities (ADL). Findings include: 1. Review of resident 24's 8/9/21 quarterly MDS assessment revealed she had a decline in the following ADLs: *Bed mobility, transfers, locomotion, dressing, toilet use and personal hygiene. -She required extensive assistance of one staff person for those ADLs. *She was no longer walking. *Her 5/14/21 annual MDS assessment revealed she had required supervision of one staff or set-up assistance only with the above ADLs. Interview on 9/28/21 at 2:00 p.m. with the MDS coordinator D revealed she *Had just started working at this facility two weeks prior. *Agreed resident 24 should have had a significant change of condition completed instead of a quarterly assessment on 8/9/21. Surveyor: 41088 2. Review of resident 4's electronic medical	F 637	F 637 The administrator, governing body representative, interim DON, and/or a designee created as necessary policies and procedures for the above identified areas. Setting up date with medical director to review. All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by 10/19/21 by administrator or designee. Administrator, governing body representative, interim 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 MDS coordinator and/or a designee will conduct auditing and monitoring for all areas identified above. Monitoring of determined approaches to ensure effective implementation and ongoing sustainment include at 2 times weekly for 4 weeks, MDS coordinator and/or a designee making observations across all shifts to ensure staff compliance with all staff compliance in the above identified areas. 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 4 months. Monitoring results will be reported by MDS coordinator and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 637	Continued From page 44 record (EMR) revealed he: *Was a resident of the facility for over two years. *Had a fall on 6/17/21 that resulted in a broken left tibia. *Was hospitalized and had surgery to repair his left leg. *Returned to the facility on 6/25/21. Review of resident 4's MDS assessments revealed: *His 6/7/21 MDS quarterly assessment which revealed he had: -Walked independently in his room with a walker after staff set him up and when he ambulated around the facility. -Was independent with toilet use. -No limitations in his upper and lower extremities. *His 6/28/21 MDS admission assessment revealed he had: *Not been able to bear weight. *Not been able to walk in his room and used a wheelchair to move around the facility. *Extensive physical assistance from two or more staff to use the toilet. *Limitations in both of his lower extremities. *An indwelling catheter. No significant change of condition assessment had been completed for him after he returned to the nursing home from the hospital. *He had a decline that had impacted two or more areas of his health status. 3. Review of resident 41's EMR revealed she had: *A diagnosis of Alzheimer's. *Had been placed on hospice care on 3/19/21.	F 637		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 637	Continued From page 45 Review of resident 41's 3/25/21 quarterly MDS assessment revealed: -She had been placed on hospice care. No significant change of condition assessment had been completed for her after she had been placed on hospice. Surveyor: 42477 4. Review of resident 16's EMR revealed: *She had been admitted to hospice services in June 2021. . *She did not have a significant change MDS completed after being admitted to hospice.	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Surveyor: 41088 Based on observation, interview, and policy review, the facility failed to ensure minimum data set (MDS) assessments for three of 15 sampled residents (4, 29, and 41) had been completed accurately and reflected the current status of the residents. Findings include: 1. Review of resident 4's electronic medical record (EMR) revealed: *He currently had 3 pressure ulcers on his left foot. -One pressure ulcer was on his heel and had been identified on 7/1/21. -The other two pressure ulcers were located on his upper and lower lateral foot and had been	F 641	F 641 For the identification of multiple system failures that included lack of Appropriate assessment, planning, and implementation of care for prevention of pressure ulcers. The administrator, governing body representative, interim DON, and/or a designee reviewed as necessary policies and procedures for the above identified areas. Setting up date with medical director to review. All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by 10/19/21 by DON or designee. Administrator, governing body representative, interim 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	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 641	Continued From page 46 identified on 8/13/21. Review of resident 4's 9/21/21 quarterly MDS assessment revealed it had not reflected any skin integrity issues or identified the pressure ulcers he had. 2. Review of resident 41's EMR revealed she had: *Been placed on hospice services on 3/19/21. *Currently been on hospice care. Review of her 9/9/21 MDS quarterly assessment revealed there had been no indication that she continued to have hospice care. Surveyor: 42477 Review of resident 29's EMR revealed: *She had been using a harness for posture since May 2021. *She had quarterly MDS assessments on: -6/1/21. -8/20/21. *Neither assessment mentioned that she used a harness.	F 641	F 641 Monitoring of determined approaches to ensure effective implementation and ongoing sustainment include at a minimum 2 times weekly for 4 weeks, RN and/or a designee making observations across all shifts to ensure staff compliance with all staff compliance in the above identified areas. 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 4 months. Monitoring results will be reported by DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director.	
F 642 SS=D	Coordination/Certification of Assessment CFR(s): 483.20(h)-(j) §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.	F 642	F 642 For the identification of multiple system failures that included lack of appropriate ARD timelines for MDS assessments, signed and coordinated by an RN. No longer have an LPN serving in the MDS role. Have full time RN serving as MDS Coordinator.	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 642	Continued From page 47 §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1)Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on interview, record review, and job description review, the provider failed to ensure a registered nurse signed the Minimum Data Set (MDS) assessment verifying it as complete for eight out of forty-three current residents (11, 12, 13, 14, 17, 19, 20, and 24). Findings include: 1. Review of MDS assessments completed for residents 11, 12, 13, 14, 17, 19, 20, and 24's submitted revealed licensed practical nurse (LPN) AA. Those assessments included the following: *Resident 11's 4/22/21 quarterly MDS assessment. *Resident 12's 4/30/21 quarterly MDS assessment. *Resident 13's 4/30/21 quarterly MDS assessment. *Resident 14's 4/30/21 annual MDS assessment.	F 642	F 642 Administrator, governing body representative, interim 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 to ensure MDS signed off by an RN 1 time weekly for 4 weeks, MDS coordinator and/or a designee making observations across all shifts to ensure staff compliance with all staff compliance in the above identified areas. 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 4 months. Monitoring results will be reported by MDS coordinator, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 642	Continued From page 48 *Resident 17's 5/7/21 quarterly MDS assessment. *Resident 19's 5/7/21 annual MDS assessment. *Resident 20's 5/7/21 quarterly MDS assessment. *Resident 24's 5/14/21 annual MDS assessment. Interview on 4/29/21 at 10:30 a.m. with MDS coordinator D revealed: *She had started as the MDS coordinator approximately two weeks prior. *The previous MDS coordinator was LPN AA. *LPN AA had told her she had signed the MDS assessments as having been complete. -That LPN AA stated to her she had not been sure if a registered nurse (RN) had to sign them or not. *She agreed only an RN was qualified to sign the MDS assessment. Review of the provider's undated MDS Coordinator job description revealed the position required an RN license.	F 642		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656	F 656 For the identification of multiple system failures that included lack of Appropriate care plan implementation. The administrator, governing body representative, interim DON, and/or a designee reviewed necessary policies and procedures for the above identified areas. Setting up a date with medical director to review. Administrator, governing body representative, interim 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	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 656	Continued From page 49 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Surveyor: 06365 Based on observation, interview, and record review, the facility failed to care plan recommended interventions for staff to provide effective treatment and services to address one of one resident's (6) behaviors related to dementia and traumatic brain injury (TBI). Findings include: 1. Review of the admission record for resident 6 revealed:	F 656	F 656 DON, and/or a designee will conduct auditing and monitoring for all areas identified above. Monitoring of determined approaches to ensure effective implementation and ongoing sustainment include at a minimum 2 times weekly for 4 weeks, DON, and/or a designee making observations across all shifts to ensure staff compliance with all staff compliance in the above identified areas. 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 4 months. Monitoring results will be reported by DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 656	Continued From page 50 *He was admitted to the facility on 5/20/20. *His diagnoses included: -Non-Alzheimer's type of dementia (Lewy Body). -History of traumatic brain injury (TBI). Interview of resident 6 on 9/27/21 at 10:45 a.m. and review of resident 6's record revealed he had multiple concerns about: -His bathroom sharing neighbors. (Refer to F550, finding 2.) -Stolen items and "the boss" not doing anything about it. (Refer to F585, finding 2.) -His room being too cold with an ensuing altercation between the resident and staff. (Refer F600, finding 1.) Observation of resident 6's bathroom during the interview confirmed his bathroom had two doors with one door the other side of the bathroom leading into a room on occupied by two other residents. Review of behavior progress notes in resident 6's record between his date of admission of 5/20/20 to the last one dated 9/4/21 confirmed the concerns he reported above in addition to other incidents of impaired social interactions and aggressive reactions to situations. (Refer F744, finding 1.) Review of the most recent progress notes dated 5/25/21, 6/15/21, and 7/13/21 from [psychological service provider name], revealed recommendations for facility staff to: *Focus on the resident's "ability to control his temper ...reminding him to ask for assistance from staff ...reminding him that others could be hurt when he has reactions and altercations." *Provide "supportive therapy with reassurance	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 656	Continued From page 51	F 656		

and reframing used to reduce suspiciousness."
*Reframe the resident's "thinking to focus on positive aspects of care. The resident "did identify some meaningful activities and brightened in response to one-to-one support."

Review of the current care plan for resident 6 on 9/29/21 at 1:06 p.m. revealed it did not include any of the [psychological service provider name] recommendations:
*Impaired thought processes related to dementia and TBI was:
-Initiated [started] on 6/1/20 but resolved [removed] on 9/10/21.
-All tasks were also resolved on 9/10/21.
*Potential to become disruptive related to dementia was initiated on 9/29/21. Tasks also initiated on 9/29/21 included:
-Administer medications as ordered.
-Educate caregivers on successful coping and interaction strategies.
-Anticipate and meet residents' needs.
*Potential activities of daily living (ADL) self-care deficit related to weakness was:
-Initiated on 5/20/20 and revised on 9/28/21.
-All tasks related to ADLs such as dressing, toileting, and personal hygiene were resolved on 9/10/21.

Interview on 9/28/21 at 11:10 a.m. with the minimum data set (MDS) coordinator D revealed They will modify the care plan based on the reports from [psychological service provider name].

Interview on 9/28/21 at 1:51 p.m. with social services/office assistant (SS/OA) E revealed:
*She was not aware of all resident 6's behaviors as documented in the progress notes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 656	Continued From page 52 *The [psychological service provider name] had visited since July 2021, but SS/OA E had not scanned the August and September reports into the electronic record yet.	F 656		
F 658 SS=F	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: 26632 Based on interview, record review, and policy review, the provider failed to ensure professional standards had been followed for documentation of assessments including: *Screening of all forty-three current residents for COVID-19 signs and/or symptoms. *Appropriate care and treatment for one of one sampled resident (25) with a new supra-pubic (S/P) urinary catheter. *One of one sampled resident (16) who had oxygen had not had her oxygen tubing changed. Findings include: 1. Interview on 9/27/21 at 9:49 a.m. with administrator A and business manager B revealed: *They had not been aware they should still be monitoring residents for signs and symptoms of COVID-19. *They had not put unvaccinated residents who had been exposed to positive staff certified nursing assistant/certified medication assistant H in quarantine.	F 658	F 658 For the identification of multiple system failures that included lack of Appropriate professional standards followed with care of surgical wounds and ongoing assessment needs during COVID-19 pandemic. Appropriate assessment, diagnosis, and documentation for continued need for a urinary catheter. Doctor contacted and agreed to the continuation of catheter for resident 25. Residents surgical wounds assessed. The administrator, governing body representative, interim DON, and/or a designee reviewed and created as necessary policies and procedures for the above identified areas. Setting up date to review with medical director. All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by 10/22/21 by administrator or designee. Have ensured that there are ongoing assessments for residents during the COVID 19 pandemic. Administrator, governing body representative, interim 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.	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 658	Continued From page 53 Review of the provider's undated COVID-19 Prevention and Control Guidance policy revealed: *"To ensure the health and safety of [facility name]'s residents and staff by enforcing the standards required to help each resident maintain their highest level of well-being due to the virus that causes coronavirus disease (COVID-19)." 2. Review of resident 25's medical record revealed: *He had a S/P urinary catheter surgically inserted on 8/12/21. *An 8/12/21 at 5:03 p.m. nurses progress note "Data: Resident returns to facility via WC [wheelchair] transit, blood tinged urine in foley tubing present, resident goes straight to supper at this time, returns with no new orders, does have SP cath care instructions. Resident denies pain at this time." *The next nurses progress note regarding his new S/P catheter was on 8/19/21 at 10:46 a.m. This was a skin/wound note. "Resident skin assessed during shower, BLE [bilateral lower extremity] edema present, SP cath site looks good, no s/s [signs or symptoms] of infection, res [resident] denies pain, no other issues noted at this time." *There had been no assessments of his S/P catheter site when he returned and not until seven days after it had been surgically inserted. Interview on 9/28/21 at 3:30 p.m. with interim director of nursing M agreed resident 25's new surgical site for his S/P catheter should have been assessed at least daily. Interview on 9/27/21 at 10:00 a.m. with administrator A revealed they did not have any	F 658	F 658 Monitoring of wounds, covid 19 assessments, and need for catheters a minimum 2 times weekly for 4 weeks, DON, and/or a designee making observations across all shifts to ensure staff compliance with all staff compliance in the above identified areas. 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 4 months. DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 658	Continued From page 54 specific professional standards that were followed. They did not have any professional nursing manuals they would have referred to. Surveyor: 42477 3. Observation on 9/26/21 at 10:20 a.m. of resident 16 revealed: *She had been sitting in her recliner. *She was wearing an oxygen cannula that had been connected to an oxygen concentrator. *The date on the tubing stated 9/12/21. Interview on 9/26/21 at 10:37 a.m. with certified nursing assistant (CNA) Q revealed staff were supposed to change oxygen tubing weekly.	F 658		
F 684 SS=H	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Surveyor: 41088 Surveyor: 42477 Surveyor: 26632 Based on observation, interview, record review, and policy review, the provider failed to ensure residents received treatment and care in accordance with professional standards of	F 684	F 684 Please refer to plan of correction for tags F600, F609, F610, F686, F690, F726, F727 and F886.	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 684	Continued From page 55 practice. Findings include: 1. Observations, interviews, record reviews, and policy reviews revealed a failure to ensure residents received care to obtain their highest practicable wellbeing. *Routine COVID-19 testing for residents and staff. Refer to F886. *COVID-19 testing of all residents who had contact with a staff member who had tested positive. Refer to F886. *Ensure staff had competencies and training to provide the care that residents needed. Refer to F726. *Ensure the facility had registered nurse coverage to oversee the care of residents. Refer to F727. *Ensure investigations and reports had been completed of residents who had experienced falls or accidents. Refer to F600, F609, and F610. *Ensure all allegations of abuse and/or neglect have been investigated. Refer to F600. *Ensure a comprehensive skin program had been developed for the prevention of pressure ulcers. Refer to F686. *Ensure the bowel management program was followed for residents. Refer to F690, findings 2, 3, 4, 5, and 6. *One of one resident (4) who had an in-dwelling foley catheter had been reassessed for its continued use. Refer to F690 finding 1.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 686	F686 For the identification of multiple system failures that included lack of Appropriate assessment, planning, and implementation of care for prevention of pressure ulcers.	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 686	Continued From page 56 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Surveyor: 41088 Surveyor: 42477 Surveyor: 26632 Based on observation, interview, record review, and policy review, for two of two residents (3 and 4) with facility-acquired pressure ulcers the provider failed to: *Develop a comprehensive preventative skin program. *Identify and document pressure ulcer stage and size. *Update the care plan to include interventions. Findings include: Surveyor: 41088 1. Interview and observation on 9/26/21 at 11:21 a.m. with resident 4 revealed he: *Was seated in a wheelchair in his room. *Had a gauze dressing on his left foot. *Was not wearing boot protectors. *Stated he had "blisters" on his left foot. *Had the sores since a fall in June when he broke his left leg. Surveyor: 42477	F 686	F 686 The administrator, governing body representative, interim DON, and/or a designee reviewed as necessary policies and procedures for the above identified areas. Setting up date to review with medical director. ALL residents and staff have the potential to be affected if staff do not adhere to all identified areas. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by 10/19/21 by administrator. Administrator, governing body representative, interim DON, 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. DON, and/or a designee will conduct auditing and monitoring for all areas identified above. Monitoring pressure ulcers 2 times weekly for 4 weeks, DON, and/or a designee making observations across all shifts to ensure staff compliance with all staff compliance in the above identified areas. 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 4 months. Monitoring results will be reported by DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 686	Continued From page 57 Observation and interview on 9/27/21 at 10:57 a.m. with interim DON M while completing a dressing change for resident 4 revealed: *There were two open wounds on the left lateral side of his foot. *There had been a pressure ulcer wound on his left backside of his heel. -The wound was in the spot where his heel made contact when the recliner. *Surveyor asked what stage the interim DON would stage the wounds at. *She stated the two on his left lateral side were both stage four wounds. *The pressure on his heel would be a stage III pressure ulcer. Surveyor: 41088 Observation and interview on 9/27/21 at 11:36 a.m. with resident 4 revealed he: *Had not been wearing his boot protectors. *Had been seated in his recliner. *Was not sure where his boot protectors were. *Thought the staff had forgotten to put them back on him after he had his dressing change and physical therapy. *Knew he was to always wear the protectors. Observation on 9/28/21 at 10:45 a.m. of resident 4 revealed: *He was in his room seated in his recliner with his feet elevated and without boot protectors. Review of resident 4's electronic medical record (EMR) revealed: *A diagnosis of chronic venous insufficiency, peripheral. *He had a brief interview for mental status (BIMS) score of 15 which indicated he was cognitively intact. *He fell and broke his left tibia on 6/17/21, was	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 686	Continued From page 58 hospitalized, and had surgery to repair it and returned to the facility on 6/25/21. Review of resident 4's 6/25/21 re-admission assessments revealed: *A re-admission skin observation tool had identified an open left heel blister 3.5 centimeters (cm) x 3 cm. *A nursing admission screening history revealed a left heel blister with no measurements completed. -Those assessments had been completed by two different staff. Review of resident 4's Braden Scale assessments for predicting pressure sore risk revealed: *His 3/15/21 quarterly assessment: he had a score of 21 that indicated he was at no risk for pressure ulcers. *His 6/9/21 quarterly assessment: he had a score of 20 that indicated he was at no risk for pressure ulcers. *His 6/25/21 re-admission assessment and 9/21/21 quarterly assessment: he had a score of 17 that indicated he was at risk for pressure ulcers. -The score changed due to his being chairfast, having extremely limited mobility and a potential problem with friction and shearing. Further review of resident 4's EMR revealed: *A 7/2/21 fax that stated: -"Open blister to back of left heel, superficial. May we have the following order: Left heel cleanse and apply Opti foam daily and prn [as needed]." *A 7/29/21 physician order for boot protectors to be always worn on both feet.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 686	Continued From page 59 Review of resident 4's weekly wound assessments revealed: *There had been three wound assessments completed on each of the following days, one for each pressure ulcer. *On 7/29/21: -A stage two heel ulcer measured 35 millimeters (mms) x 24 mms with a depth of 1 mm. -A stage two upper lateral pressure ulcer measured 18 mms x 17 mms with a depth of 5 mms. -A stage two lower lateral pressure ulcer measured 10 mms x 10 mms with a depth of 2 mms. -Special preventative measures/equipment: alternating air mattress, a pressure relief cushion in chair, Prevalon boots to both feet. -No inflammation was noted. *On 8/12/21: -A stage two heel ulcer measured 20 mms x 28 mms with a depth of 3 mms. -A stage two upper lateral pressure ulcer measured 15 mms x 20 mms with a depth of 1 mm. -A stage two lower lateral pressure ulcer measured 20 mms x 25 mms with a depth of 3 mms. -Special preventative measures/equipment: Intermittent pressure exchange air mattress, Prevalon boots, heel cradle. -No inflammation was noted. *On 8/24/21: -A stage two heel ulcer measured 20 mms x 25 mms with a depth of 3 mms. -A stage two upper lateral pressure ulcer measured 20 mms by 25 mms with a depth of 3 mms. -A stage two lower lateral pressure ulcer measured 20 mms x 14 mms with a depth of 3	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 686	Continued From page 60 mms. -Special preventative measures/equipment: No changes from the previous assessment. -No inflammation or symptoms of infection were noted. *After the initial wound on his heel had been discovered, the initial wound assessment was not completed for another 27 days. -This was after wound care had identified the two additional sores on his left lateral foot. Review of resident 4's September 2021 treatment administration record (TAR) revealed: *Missing documentation on 9/9/21 of Endoform and Mepilex placement one time a day every other day for left heel wound. *Missing documentation on 9/9/21 and 9/15/21 for triad paste, gauze and kerlix daily for left later foot ulcers. Review of resident 4's revised 9/23/21 care plan revealed: *His care plan had not been revised to include: -The two additional lateral pressure ulcers he had developed. -His boot protectors were to be worn at all times. -Any changes with his wounds. *His care plan stated: -Wounds were to be documented weekly which were to include: -Measurement of each area. -Breakdown's width. -Length. -Depth. -Type of tissue and exudate. -Any other notable changes or observations. *They had missed a total of 10 weeks of wound assessments.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 686	Continued From page 61 Interview on 9/28/21 at 2:30 p.m. with interim DON M revealed: *She was familiar with resident 4. *Wound assessments were to be completed weekly for his pressure ulcers. *He had been going to the wound clinic weekly for the care of his pressure ulcers. *He was to wear boot protectors at all times. *She had not been aware he was observed not wearing them. *Confirmed there had been no further wound assessments completed since 8/24/21. *She would expect them to be done and for physician orders to be followed and documented on the TAR. Surveyor: 26632 2. Review of resident 3's medical record revealed: *On 6/4/21 documentation on the provider's skin observation tool revealed "Resident skin clear and intact, no skin issues noted at this time." *A 7/1/21 at 9:10 a.m. skin/wound note "Resident in bath today and skin assessment completed. Right outer ankle has stage 2 pressure wound. Cleansed and dressed with mepilex. Nursing order for Prevalon boots at HS {hour of sleep]." *A 7/1/21 facsimile to resident 3's physician. "Today I noted a stage 2 pressure ulcer to [resident] R [right] outer ankle lateral malleolus. OK for dressings daily & PRN [as needed] til [until] healed? Prevalon padded booties on @ HS [hour of sleep] for padding & protection bilat. [bilateral]?" *A 7/2/21 at 12:19 p.m. skin/wound note "Dressing change to PU [pressure ulcer] of the R outer ankle; redness-scant drainage on the old dressing. Area cleansed and new optifoam applied."	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 686	Continued From page 62 *A 7/8/21 at 2:19 p.m. skin/wound note "Skin assessed during bath, no new skin issues noted at this time, dressing change to R out ankle." *A 7/15/21 at 1:45 p.m. skin/wound note "Skin assessed during shower, R ankle continues to be dressed per TAR [treatment administration record] for protection, see TAR [treatment administration record], tops of toes continue to be red, res [resident] has not complaints at this time, no other new skin issues noted at this time." *A 7/19/21 facsimile to resident 3's physician. "[Resident] R [right] lateral ankle wound is resolved. May we discontinue dressing change?" *A 7/29/21 at 1:54 p.m. skin/wound note "Skin assessed during residents shower. Resident has healed are to right ankle, area is pink, boney prominence, but no concerns at that time. No new skin issues." *An 8/5/21 at 10:20 a.m. skin/wound note "Skin assessed during shower, resident continues to have reddened R outer ankle, not new skin issues noted at this time." *An 8/12/21 at 10:19 a.m. skin/wound note "Resident skin assessed during shower. R outer ankle continues to be reddened on the bony prominence, denies pain, resident does wear prevalon boots at HS, will continue to monitor." *A 9/2/21 at 6:29 p.m. skin/wound note "Skin is clean/dry/intact with no new open areas or bruising noted." *A 9/9/21 at 8:54 a.m. skin/wound note "Mepilex intact to right ankle. No new skin issues notes [[noted]." *A 9/11/21 at 3:14 p.m. health status note included: "Pt. [resident] refused to let RN [registered nurse] change dressing to R outer ankle." "Pt did allow dsg [dressing] to be changed later in the afternoon." *A 9/16/21 at 1:29 p.m. skin/wound note included	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 686	Continued From page 63 no new skin issues noted. *There had been no measurements when the pressure ulcer had been discovered and subsequently. *The dietician had not been made aware of the pressure ulcer. She had listed resident 3's skin as being intact on her 7/1/21 and 9/20/21 nutrition progress note. Review of resident 3's TARs revealed: *July 2021: -Daily and prn dressing change to lateral right ankle for stage two pressure ulcer. This treatment was started on 7/1/21 and was discontinued on 7/19/21. -Prevalon boots on at HS both feet for stage two pressure ulcer right ankle. This was started on 7/1/21. *August 2021: --Prevalon boots on at HS both feet for stage two pressure ulcer right ankle. *September 2021: -Apply corn cushion to outer right ankle for protection. This was started on 9/1/21 and discontinued on 9/8/21. -Apply Mepilex to right outer ankle every 3 days for protection. This was started on 9/9/21. Review of resident 3's revised 1/18/21 care plan revealed: *Focus: "[Resident] has a potential for impaired skin integrity r/t [related to] Impaired Mobility, Impaired Cognition, Incontinence." *Goal: "[Resident] will have intact skin through review date." *Interventions included: -"[Resident] has a pressure redistributing mattress on her bed." -"[Resident] has a pressure relief cushion in her	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 686	Continued From page 64 chair." -"Monitor/document/report PRN any changes in skin status." -"Weekly skin inspection by licensed staff. Daily sin inspections with cares." *The care plan was reviewed for any changes or cancelled items. *Resident 3's stage two pressure ulcer to her right outer ankle had not been included. *Her use of the Prevalon boots on at HS had not been included. Interview on 9/28/21 at 3:30 p.m. with the interim director of nursing (DON) M revealed she: *Had not reviewed any of the residents skin documentation to ensure all preventative, ongoing wound assessments, care plan updates, and documentation had been completed. Review of the provider's undated Wound Care policy revealed: *Guidelines for the care of wounds to promote healing. *How to perform a wound care dressing change. *Documentation including: -The type of wound care performed. -Any change in the resident's condition. -All assessment data obtained when inspecting the wound. Wound bed color, size, and drainage. *The provider did not have any preventative skin policy.	F 686		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to	F 690	F 690 For the identification of multiple system failures that included lack of Appropriate assessment and monitoring to ensure regular bowel movements.	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 690	Continued From page 65 maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Surveyor: 41088 Based on interview, record review, and policy review, the facility failed to ensure: *One of one resident (4) who had an in-dwelling Foley catheter had been reassessed for its continued use. *A bowel management program was followed for	F 690	F 690 The administrator, governing body representative, interim DON, and/or a designee reviewed as necessary policies and procedures for the above identified areas. Setting up a date with medical director to review. Put into place that nights will print off BM list and days will follow up with necessary interventions based on length of time without a BM. ALL residents and staff have the potential to be affected if staff do not adhere to all identified areas. Administrator, governing body representative, interim 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 bowels and intervention will happen 2 times weekly for 4 weeks, administrator, governing body representative, interim DON, and/or a designee making observations across all shifts to ensure staff compliance with all staff compliance in the above identified areas. 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 4 months. Monitoring results will be reported by administrator, interim DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 690	Continued From page 66 6 of 15 sampled residents (4, 11, 16, 29, 38, and 41) who had gone three or more days without having a bowel movement (BM). Findings include: 1. Observation and interview on 9/26/21 at 11:21 a.m. with resident 4 revealed he: *Had a Foley catheter in place. *Was hospitalized in June 2021 to repair his broken left leg and a foley catheter was placed at that time. *Had not had a catheter before he had been in the hospital for surgery. *Could not remember a time that he had problems with his bladder. *Thought the catheter was "handy" and convenient for him and staff because he had not needed to call staff for help. Review of resident 4's electronic medical record (EMR) revealed: *His brief interview for mental status (BIMS) score of 15 which indicated he was cognitively intact. *Diagnosis of disorder of prostate, unspecified. Review of discharge orders from the hospital revealed: *"Foley d/cd [discontinued] on 7/1/21 around 0600 [6:00 a.m.] at the hospital. Please have nursing home straight cath [catheter] if patient unable to void after 4 hours of being admitted back to the facility, and if unable to void 4 hours after straight cath please place foley for overnight." -Nurses note on 7/1/21 at 5:16 p.m. stated: "Resident has urinal placed and trying to void on his own. Will give him ample time to void but if he is unable we will place a catheter for the night." -Nurses note on 7/1/21 at 5:41 p.m. stated:	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 690	Continued From page 67	F 690		

"Resident did not void in urinal. #16 Fr [French] caudet with 15cc [cubic centimeter] balloon placed without difficulty. Draining amber urine, clear. Instructed staff to aide resident with drinking fluids and reposition every 2 hours. Charge nurse updated."
- Fax sent on 7/2/21 at 12:06 p.m. to on-call PCP [primary care physician]: Updated on resident's change in condition including- decreased oxygen saturations, lethargy, blood-tinged urine.
-Nurses note on 7/7/21 at 8:04 a.m. stated: "Resident seen on [physician name] rounds this morning. Medication changes ordered. D/c [discontinued] Inhalers and initiated neb [nebulizer] tx [treatment]. Resident's pain medication management changed. See orders on chart..."
--No mention of assessment of foley catheter.
-Nurses note on 7/20/21 stated: received signed lab results from pcp [primary care physician] [physican name]. states "his labs all look stable. we can continue his current medications and change this BMP [basic metabolic panel] standing order to every 3 months"

Interview on 9/28/21 at 10:14 a.m. with licensed practical nurse (LPN) I revealed:
*She was familiar with resident 4.
*Resident 4 had returned from the hospital with the catheter.
*She stated he had been non-weight bearing and thought that was the reason the catheter had continued to be in place.
*He had a diagnosis of a prostate disorder.
*She had not known him to have any problems with infections or bladder issues.

Interview on 9/29/21 at 10:59 a.m. with interim director of nursing (DON) M revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 690	Continued From page 68 *She was unaware of the reason for continued use of the foley catheter for resident 4. *Had been unable to find a diagnosis for the catheter other than prostate disorder, unspecified. *She agreed that he should have been reassessed for the need of the catheters continued use. No documentation had been provided to show the resident had been reassessed for the need to have a catheter in place. 2. Review of resident 41's electronic medical record (EMR) revealed: *Her diagnosis of Alzheimer's disease. *Her brief interview for mental status (BIMS) score of 2 which indicated severe cognitive impairment. *She was on hospice. *She had not been feeling well and had vomited several times. Review of resident 41's bowel record revealed: *She had gone three days without a BM from 9/26/21 through 9/28/21. *Her last BM on 9/25/21 had been described as constipated. Review of resident 41's nursing progress notes from 9/26/21 through 9/29/21 revealed there was no documentation regarding her constipation or lack of BM or that any intervention had been taken. Review of resident 41's medication administration record (MAR)for September 2021 revealed: *A 9/23/21 physician order for Milk of Magnesia (MOM) 30 milliliter (ml) every 24 hours as needed if no BM [bowel movement] by day three.	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 690	Continued From page 69 *A 9/28/21 physician order for Bisacodyl 10 milligrams (mg). Insert one rectally every 24 hours as needed for constipation. -There had been no documentation either medication had been administered to the resident for the above-named dates before the survey exit on 9/29/21. Interview on 9/28/21 at 11:33 a.m. with LPN I revealed: *She had arrived for her shift at 6:00 a.m. *The resident had not been feeling well since 9/27/21. *The overnight staff had informed her that she had vomited throughout the night. *The vomit appeared to be bile last night but this morning it had been dark, foul-smelling and they thought it had been stool. *The resident had vomited earlier today, had been assessed, and taken to the emergency room. *The emergency room had been in contact with the facility and planned to send the resident back. *She had not been informed of the results of the emergency room visit. Interview on 9/28/21 at 11:44 a.m. with interim DON M revealed: *The overnight nurse had reported she had continued to vomit bile throughout the night. *The bathing aid had gone in to get her ready for her bath and discovered the resident had vomited and alerted the nurse. *She assessed the resident and checked for bowel sounds which were hypoactive. *She had a tender area when she palpated her abdomen. *The vomit was dark, smelled foul, and she thought it was stool.	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 690	Continued From page 70 *She was taken to the emergency room. *She was unsure of the last time resident 4 had a BM. *Since she had taken over DON duties, she had noticed problems with gaps in the resident bowel records. *She confirmed the documentation had not been consistent. *She would expect staff to follow physician orders and bowel management protocols. 3. Review of resident 38's bowel record revealed: *He had gone without a BM for six days from 9/18/21 through 9/23/21. Review of resident 38's September 2021 MAR revealed he had: *An 8/30/21 physician order for a 10 mg suppository to be inserted rectally every 24 hours as need for constipation. *An 8/30 physician order for MOM 30 ml by mouth every 24 hours as needed for constipation. -There had been no documentation either medication had been administered to the resident. Refer to F600 finding 4. Surveyor: 42477 4. Review of resident 11's EMR revealed: *On 9/17/21 she had a note which stated: -"No BM since 9/10." *She was given as needed (PRN) MOM for constipation on 9/16/21 and 9/17/21. *This was after there had been no BM's charted for six days. *She had a BM documented on 9/23/21 and not again until 9/30/21.	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 690	Continued From page 71 -She had not been given any PRN MOM during this period. 5. Review of resident 29's EMR revealed: *In thirteen days, she had one BM. *On 9/29/21 she had documentation of no bowel movement in 5 days. *She had been given one dose of PRN constipation medication on 9/29/21. *That had been the only PRN Constipation medication that she had received. 6. Review of resident 16's EMR revealed she had: *Three days without a bm in September of 2021. *An order for PRN MOM for constipation. *Not been given any MOM in the month of September 2021. Interview on 9/29/21 at 10:10 a.m. with DON M revealed: *She had recently been aware that constipation issues were not being communicated. *She had recently started printing off a clinical alert report for constipation. *If residents had not had a BM in three days, they were given MOM. *If residents had not had a BM in four days, they were given a suppository. *There had been four residents on the report for 9/29/21. *Surveyor asked why resident 11 was not listed on the report. *DON M was not sure why resident 11 had not been listed in the report. Interview on 9/29/21 at 10:40 a.m. with LPN I revealed: *Residents are not being toileted as often as they	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 690	Continued From page 72 should be due to a lack of staffing. *Nurses are not being told when residents have not had a BM. *Night shift is supposed to relay any constipation issues to the next shift. *This had often not been done. Interview on 9/29/21 at 10:48 a.m. with administrator A revealed: *He had no expectations as to how often someone should be toileted. *He had not been aware of the constipation issues for residents. *His expectation was for nurse to be following their standing orders and notifying the physician. Review of the provider's 2/9/21 standing orders revealed: *For Constipation: -MOM 30 cubic centimeter (cc) everyday PRN. -A 10 milligram (mg) suppository PRN.	F 690		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services	F 725	F 725 For the identification of multiple system failures that included lack of appropriate staffing that includes – quantity necessary to provide for all resident needs; RN coverage for at a minimum of 8 hours in a 24-hour period; full-time DON to ensure sufficient and competently trained staff, ensure all aspects of care including medications are monitored, those with dementia are cared for as needed, and supervision for those staff augmenting dining assistance. Have increased starting pay for CNAs. Have increased referral bonuses for both CNAs and nurses. Have been trying to get additional contracted staff to help fill in gaps.	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 725	Continued From page 73 by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Surveyor: 41088 Surveyor: 42477 Based on observation, interview, record review, policy review, and facility assessment review, the provider failed to ensure sufficient nursing staff were available to provide nursing services to meet residents' needs safely and in a manner that promoted each resident's rights and physical, mental, and psychosocial well-being, Findings include: 1. Observation and findings throughout the duration of the survey revealed there had been residents with falls with major injuries, accidents, facility acquired pressure ulcers. Refer to F600 all findings. F609 all findings, F610 all findings, and F684 all findings. Surveyor 41088: 2. Interview on 9/29/21 9:46 a.m. with certified nursing aide (CNA) T revealed she had: *Worked in the facility for 35 or 38 years. *Worked the whole facility and filled in for bathing.	F 725	F 725 Full time administrator and DON have been hired. Monitoring Rn coverage 1 time weekly for 4 weeks, MDS coordinator, and/or a designee making observations across all shifts to ensure staff compliance with all staff compliance in the above identified areas. 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 4 months. Monitoring results will be reported by MDS coordinator and/or a designee to the QAPI committee and continued until the facility demonstrates sustained	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 725	Continued From page 74 *Stated it depended on the bath days because it could be challenging to get everything done with residents needing baths. *Filled in when people called in. *Been difficult to get things finished. *Stated normally there are three CNAs scheduled on the floor and one in bathing. *Stated one restorative staff helps on the floor. *Believed the high school students on the weekend *Stated leadership does not listen or follow up with getting more help. Surveyors had requested call light logs. Administrator A stated they did not have call light logs. Surveyors asked to review any call light audits. They were unable to provide any call light audits. If in the room, do not see that a call light has been depressed. The red light is the bathroom call light. Yellow is in the resident room. There is no audible alarm that goes off and does not know which light has gone off unless saw it firsthand. The light is the only notification. There was no audible alarm to alert staff that a call light had been triggered. 2. Interview on 9/29/21 10:02 a.m. with CNA F revealed: *They have not had enough staff coverage. *She had worked in the facility for 43 years. *In all her years of working here, this had been the most challenging year with staffing. *Call lights are not audible, so they must look for the lights. *Call lights do not get answered as they should. *Weekends are tough.	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 725	Continued From page 75	F 725		

3. Interview 9/29/21 10:59 a.m. with interim director of nursing (DON) M:
*She had been hired for crisis and to help out with staffing issues.
*Her position had since grown into more.
*It had never been specified that she would work full-time.
*Her first day was 9/13/21.
*She had not known administrator A wanted her to serve in the DON role.
*That had not been discussed and evolved after she arrived.

Surveyor 42477:
4. Interview on 9/27/21 at 9:49 a.m. with administrator A and business manager B revealed they had:
*Been aware that they have been having staffing issues.
*Posted open shifts and do their best to cover them.
*Been using contract and temporary agency staff.
*Been using a certified nursing aide/certified medication aide H to help them do the schedule.
*Been aware that staffing had been an issue on the weekends.
*Not applied for a staffing waiver.

Interview on 9/28/21 at 11:44 a.m. with interim DON M revealed she:
*Tried to be in the facility during the week.
*Is available by phone twenty-four hours, seven days per week.
*Is currently working as a full-time DON for another company .
*Had been hired to fill in the staffing gaps, not as a full-time DON.

Interview on [date and time withheld due to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 725	Continued From page 76 anonymity] with anonymous staff member revealed: *They did not have enough staff to care for the residents. *Residents had not been getting toileted as they should be. *Part of the issues of lack of care is laziness but the other part is because of staffing. *They have also had more falls. Review of the provider's 2021 facility assessment revealed: *The assessment had been completed for a daily census of 42 residents. *The staffing plan was: -One full-time DON. -One full-time minimum data set (MDS) coordinator. -One licensed practical nurse or registered nurse as a charge nurse for each shift. -Four to five direct care licensed staff on days. -Three to four staff on evenings. -Two on nights. *Also, the administrator, DON, social worker, and activities director all had CNA licenses. Review of the provider's September 2021 schedule revealed: *One evening shift they did not have a medication aide show and they had no nurse after 6:30 p.m. to 10:00 p.m. *They did not have an RN 8 hours a day, seven days per week. Refer to F 727, all findings.	F 725		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with	F 726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 726	Continued From page 77 the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 41088 Based on interview, and facility assessment review, the provider failed to ensure nursing staff had completed annual competency evaluations. Findings include: 1. Surveyors had asked for documentation that confirmed all nursing staff had completed annual competencies.	F 726	F 726 For the identification of multiple system failures that included lack of appropriate staffing that includes – quantity necessary to provide for all resident needs; RN coverage for at a minimum of 8 hours in a 24-hour period; full-time DON to ensure sufficient and competently trained staff, ensure all aspects of care including medications are monitored, those with dementia are cared for as needed, and supervision for those staff augmenting dining assistance. Have started to get all licensed staff up to date on competencies and will complete yearly competencies on all licensed staff. DON, and/or a designee will conduct auditing and monitoring for completed staff competencies 1 time weekly for 4 weeks. 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 4 months. Monitoring results will be reported by DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 726	Continued From page 78 *Documentation was requested on 9/29/21 at 11:30 a.m. from business manager B. *No documentation had been provided prior to survey exit. Interview on 9/29/21 at 11:10 a.m. with administrator A revealed he: *Was aware annual competencies were to be completed. *Was unable to find any supporting documentation. Review of the provider facility assessment revealed: *"All RN [registered nurse], LPN [licensed practical nurse], TMA [trained medication assistant], CNA [certified nursing assistant] staff are required to complete new-hire orientation. Staff with no experience with long-term care will have longer orientation periods. Licensed staff will have at least three days of shadowing a well-trained staff member before entering a probationary period for new-hires. Ongoing training/education opportunities are completed initially upon hire and annually. Competency testing is done on an annual basis. Staff from all other departments completes an initial training upon hire and annually. Staff is assigned to a team leader to train and assist them with resident ADLs process of nursing care, (admission, discharge, transfer) charting/documentation, observations and reporting."	F 726		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility	F 727		11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 727	Continued From page 79 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: Surveyor: 42477 Based on record review and interview, the provider failed to ensure a registered nurse (RN) had been scheduled for eight hours for one of four weekends in September 2021. Findings include: 1. Interview on 9/27/21 at 9:49 a.m. with administrator A, business manager B, and interim director of nursing (DON) M revealed they had not been aware there were days where they did not have registered nurse coverage or a registered nurse in the building. Refer to F725, all findings. Review of the provider's staffing schedule for September 2020 revealed they did not have RN coverage the weekend of September 26, 2021. Interview on 9/28/21 at 11:44 a.m. with interim DON M revealed she: *Tried to be in the facility during the week. *Is available by phone twenty-four hours, seven days per week. *Is currently working as a full-time DON for a contract agency.	F 727	F 727 For the identification of multiple system failures that included lack of appropriate staffing that includes – quantity necessary to provide for all resident needs; RN coverage for at a minimum of 8 hours in a 24-hour period; full-time DON to ensure sufficient and competently trained staff. Applied for staffing waiver. The administrator, governing body representative, interim DON, and/or a designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas. MDs coordinator will audit for RN coverage to ensure that have at least RN coverage for M-F Weekly for 4 weeks and twice a month for one month, and monthly for 4 additional months. Monitoring results will be reported by administrator, interim DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 727	Continued From page 80 *Had been hired to fill in the staffing gaps, not as a full time DON. Interview on 9/29/21 at 10:48 a.m. with administrator A revealed: *It had been his expectation that there was RN coverage eight hours per day, seven days a week. *He had not been aware there had been times where there had been no RN in the building.	F 727		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Surveyor: 06365 Based on observation, interview, and record review, the facility failed to ensure staff provided effective treatment and services to address one of one resident's (6) behaviors related to dementia and traumatic brain injury (TBI). Findings include: 1. Review of the admission record for resident 6 revealed he was admitted on 5/20/20 with diagnoses of a non-Alzheimer's type of dementia (Lewy Body) and a history of traumatic brain injury (TBI). Interview of resident 6 on 9/27/21 at 10:45 a.m. revealed he had concerns about: *The "neighbors think the toilet is theirs." *One of the residents will not close the door on	F 744	F 744 For the identification of multiple system failures that included lack of appropriate care plan implementation. staff were provided education in written form f or them to read about the differences involving Lewy body dementia vs other types of dementia by MDS coordinator or designee. Will have more in depth dementia training at 11/19 Inservice. Resident 6 care plan updated, and interventions added. ALL residents and staff have the potential to be affected if staff do not adhere to all identified areas. The administrator, governing body representative, interim DON, and/or a designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas. DON or designee will follow up with new admissions to ensure staff are educated on proper interventions for their type of Dementia.	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 744	Continued From page 81 their side of the bathroom making it necessary for resident 6 to pull it shut before he can use the bathroom. *One of the residents will open the bathroom door while resident 6 is in there using it and "walks in and stares at him." *The clippers, pens, and clothes that have gone missing. He "reported it to the boss, but they just brush it off." *His room is too cold at night. (Refer to F550, finding 2 and F585, finding 2.) Observation of resident 6's bathroom during the interview confirmed his bathroom had two doors with one door the other side of the bathroom leading into a room on occupied by two other residents. Review of documented behavior notes in resident 6's record revealed multiple examples of impaired social interactions and aggressive reactions to situations on: *6/2/20 at 11:55 p.m., the resident claimed his light had been on "since 10:00" when it had been on for "approximately" 20 minutes according to the nurse who wrote the note. The resident said he would talk to "administration in the morning to 'find out what's going on here.'" *6/3/20 at 9:35 p.m., the resident said he "just tapped" his roommate because he was "coming on his side of the house." The nurse wrote she found the roommate on the floor when she entered the resident's room. *9/23/20 at 10:18 a.m., the resident "shouted, 'It's freezing in my room and I haven't been able to get any sleep.'" Certified nursing assistant/medication aide (CNA/MA) H responded she would get him a blanket and "let maintenance know that room is cold." *9/26/20 at 12:30 p.m., the resident yelled the	F 744	F 744 DON or designee will audit dementia training/ interventions in place 1 time per week for four weeks, twice a month for 1 additional month and monthly for an additional 4 months. DON or designee will report findings at QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 744	Continued From page 82	F 744		

neighbor's television was too loud and he proceeded to close that resident's door to the room.
*1/13/21 at 2:25 p.m., the resident yelled at a female resident as he passed her in the hallway because she "comes into his room and takes his socks."
*1/13/21 at 2:35 p.m., 3/16/21 at 11:19 a.m., and 5/22/21 at 3:09 p.m., the resident hallucinated about children making noise and keeping his from sleeping.
*5/24/21 at 6:15 p.m., the resident yelled at another resident who "was not going as fast as resident wanted." Resident 6 yelled profanity at the other resident and "grabbed other resident's walker and started shaking it."
*5/29/21 at 7:30 p.m., resident reported a "brand new pair of shoes" were missing and "people keep taking thing [sic] from my room when I'm not there."
*6/8/21 at 1:30 a.m., resident claimed he did not get medication to help him sleep.
*6/8/21 at 7:30 pm., resident "started yelling and cursing at the resident he shares the bathroom with." He said, "his bathroom mate never shuts the bathroom door."
*7/22/21 at 8:12 a.m., resident reacted verbally and physically towards CNA/MA H who turned on and kept on the air conditioner while she assisted him dress for the day. (Refer to F600, finding 1.)
*8/13/21 at 10:09 a.m., resident kicked another resident's wheelchair and "told him to get out of his way."
*8/28/21 at 9:41 p.m., resident was sexually suggestive to a certified nursing assistant.
*8/31/21 at 1:29 p.m., resident yelled and grabbed at the "bath aide."
*9/4/21 at 10:42 p.m., resident "went to restroom and slammed opposite door," yelled profanity and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 744	Continued From page 83 said, "I will slam it every time." Review of physician progress notes and rounds notes dated 8/4/21 revealed: *An assessment of Lewy Body dementia without behavioral disturbance. *The resident reported to the physician that he is concerned about people stealing from him and/or coming into his room. *Orders related to the treatment of his dementia diagnosis included: -Tylenol 650 mg at "midnight per written resident request," started on 6/29/20. -The [psychological service provider name] to provide psychological services as of 1/15/21. -Seroquel 25 MG at bedtime, an antipsychotic medication started on 2/3/21. -Donepezil HCl 10 mg once a day, a drug to improve mental function started on 4/4/21. -Melatonin 3 Mg at bedtime for sleep, started on 6/1/21. -Trazodone HGI 100 mg at bedtime, an antidepressant started on 6/9/21. Review of the [psychological service provider name] initial assessment, completed on 1/19/21, included: *Referral was for treatment of resident's hallucinations, delusions, agitation, irritability, verbal aggression, confusion, and memory loss. *Psychological consultation was recommended to assist staff in developing and implementing behavior plans to reduce patient's affective and/or cognitive symptoms. *Provide individual therapy to reduce patient's affective and/or cognitive symptoms. *A treatment frequency of four times a month for four months.	F 744		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 744	Continued From page 84 Review of the [psychological service provider name] progress notes on the most recent dates revealed on: *5/25/21: -Intervention with "emphasis on boundaries and appropriate interactions with others due to suspiciousness, paranoia, and a recent altercation with a peer." -Resident 6 reported to the writer that "others do things to him on purpose ...others speak to him and threaten him," but that was previously "determined to be false" by staff. -Recommendations "focused on the patient's ability to control his temper ...reminding him to ask for assistance from staff ...reminding him that others could be hurt when he has reactions and altercations." *6/15/21: -Intervention of "supportive therapy with reassurance and reframing used to reduce suspiciousness." -Resident 6 was "somewhat anxious and expressed the belief that his remote was stolen," and he "was difficult to remain engaged in session due to his suspiciousness." *7/13/21: -Intervention "focused on reframing, validation, and positive aspects of the care setting in order to improve mood and outlook." -Resident 6 expressed "a sense of loneliness due to missing family and aspects of his independence." -Recommendation to "reframe his thinking to focus on positive aspects of care. The resident "did identify some meaningful activities and brightened in response to one-to-one support." A pharmacist note dated 8/23/21 to the physician regarding a recommended dose reduction of	F 744		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 744	Continued From page 85 Seroquel revealed the physician responded that a reduction in Seroquel would "worsen delusions and hallucinations." Interview on 9/28/21 at 11:10 a.m. with the minimum data set (MDS) coordinator D revealed: *Behaviors that have occurred are discussed during the daily report. *Social services was involved in that report. *They discuss the cause of the behavior and the staff's response to it. *If there needs to be a different approach, they tell the staff on duty, write a note on the electronic record dashboard, and the charge nurse adds the approach to shift reports. *They will modify the care plan based on the reports from the [psychological service provider name]. Interview on 9/28/21 at 1:51 p.m. with social services/office assistant (SS/OA) E revealed: *Behavior management is discussed during the daily stand-up. *She was not aware of all of resident 6's behaviors as documented in the progress notes. *The [psychological service provider name] had visited since July 2021, but SS/OA E had not scanned the August and September reports into the electronic record yet. *She was not aware of any education provided to staff regarding Lewy Body dementia. Review of the most recent minimum data set (MDS) assessment dated 7/6/21 for resident 6 revealed: *His cognitive patterns were intact. *No mood or behavior symptoms were reported during the 7-14 days before the assessment date of 7/6/21.	F 744		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 744	Continued From page 86 *He needed the weight-bearing support of one person for dressing, toileting, and personal hygiene. Review of the care plan for resident 6 on 9/29/21 at 1:06 p.m. revealed the following: *Impaired thought processes related to dementia and TBI was: -Initiated [started] on 6/1/20 but resolved [removed] on 9/10/21. -All tasks were also resolved on 9/10/21. *Potential to become disruptive related to dementia was initiated on 9/29/21. Tasks also initiated on 9/29/21 included: -Administer medications as ordered. -Educate caregivers on successful coping and interaction strategies. -Anticipate and meet residents' needs. -None of the [psychological service provider name] therapy recommendations were included in the care plan. (Refer to F656, finding 1.) *Potential activities of daily living (ADL) self-care deficit related to weakness was: -Initiated on 5/20/20 and revised on 9/28/21. -All tasks related to ADLs such as dressing, toileting, and personal hygiene were resolved on 9/10/21. During the interview on 9/29/21 at 2:45 p.m. with administrator A, interim director of nursing K, and business manager B: *A modified care plan for resident 6 was provided by email attachment from administrator A. *No changes had been made to the above focuses and tasks.	F 744		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 758	Continued From page 87 §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their	F 758	F 758 For the identification of multiple system failures that included lack of appropriate staffing that includes ensuring all aspects of care including medications are monitored. The administrator, governing body representative, interim DON, and/or a designee in consultation with the medical director created as necessary policies and procedures for the above identified areas. Setting up date with medical direct for review. All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by 10/19/21 by DON. MDS coordinator and/or a designee will conduct auditing and monitoring for PRN anti- psychotic medications. Monitoring of determined approaches to ensure effective implementation and ongoing sustainment include at a minimum 3-5 times weekly for 4 weeks, administrator, governing body representative, interim DON, and/or a designee making observations across all shifts to ensure staff compliance with all staff compliance in the above identified areas. 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 4 months. Monitoring results will be reported by administrator, interim DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 758	Continued From page 88 rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review and interview, the provider failed to ensure a physician included in the order a duration of time for an as needed (prn) psychotropic medication for one of one sampled residents (3) who received a prn psychotropic medication. Findings include: 1. Review of resident 3's medical record revealed: *A 9/20/21 physician's order for haloperidol lactate (Haldol Injection) 5 milligram (mg) per 1 milliliter (5mg/ml) vial. Give 5 mg now. *A request on 9/22/21 to the physician stated: - "Requesting order Haldol IM [intramuscularly] for increased [arrow up] behaviors." -"Requesting prn Haldol until therapeutic level of Seroquel is reached." -"If can't do Haldol can we get it in pill form." -The physician wrote "ok" by each request and signed it at 11:15 a.m. Review of resident 3's September 2021 medication administration record revealed medications that included: *Haldol 5mg/ml IM one time only for anxiety and agitation. It had been administered on 9/21/21. The order date was 9/20/21. *Haldol 5mg/ml IM every 24 hours prn for	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 758	Continued From page 89 agitation. I had been administered on 9/23/21. There was no stop order date. Interview on 9/28/21 at 3:30 p.m. with interim director of nursing M confirmed the above physician's orders. She was not aware a prn anti-psychotic medication could only be ordered for 14 days before the physician had to assess the resident. She stated no policy on the stop dates for anti-psychotic medications was found.	F 758		
F 801 SS=D	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the	F 801	F 801 For the identification of multiple system failures that included lack of Appropriate dietary supervision. DM has been enrolled in a Certified food management course. Administrator will audit progress 1 time per week for 4 weeks and Monthly for 2 additional months.	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 801	Continued From page 90 supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for	F 801		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 801	Continued From page 91 food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Surveyor: 41088 Based on interview and job description review, the provider failed to employ a full-time qualified registered dietician (RD) while the dietary manager (DM) did not meet the requirements to serve as a certified dietary manager. Findings include: 1. Interview on 9/27/21 at 8:27 a.m. with dietary manager C revealed she: *Had recently started her employment on 9/20/21. *Had not completed training to be a certified dietary manager but planned to do so. *Stated the RD was only part-time, came once a week, but had been available by phone for any questions or concerns. *Had been hired by the facility, who had been aware she had not completed training to be a certified dietary manager. Review of the provider's 8/6/13 dietary manager job description revealed: *"Assures that the dietary department is in compliance with all state, federal and local regulations."	F 801		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812	F 812 For the identification of multiple system failures that included lack of appropriate food storage and labeling.	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 812	Continued From page 92 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Surveyor: 41088 Based on observation and interview, the provider failed to: *Ensure the kitchen had stored, labeled, and monitored food processes for the facility residents per professional standards for foods located in the kitchen freezers. *Ensure one of one floor fan is maintained in a clean and sanitary condition. Findings include: 1. Observation and interview on 9/26/21 at 10:32 a.m. during the initial kitchen tour with cook R revealed: *She had worked for the facility for 30 years. *The upcoming meals were being prepared by the dietary staff. *The walk-in and reach-in freezers had several items that had not included expiration dates or when they had been placed in the freezer.	F 812	F 812 The DM and/or a designee will created as necessary policies and procedures for the above identified areas. Setting up date with medical director to review. All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by 11/5/21 by Dietary Manager. Administrator, governing body representative, interim 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. Dietary Manger and/or a designee will conduct auditing and monitoring for all areas identified above. 1 time weekly for 4 weeks. 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 4 months. Monitoring results will be reported by administrator, interim DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 812	Continued From page 93 *When asked why there were so many undated items in the freezers, she stated that is just what they had always done. *She stated the foods were rotated by first in, first out. *She knew which foods to use first when making meal preparations. *She was one of the four hired cooks. *She agreed that if the foods were not labeled it could be confusing. Observation on 9/26/21 at 10:37 a.m. revealed: *A small fan on the floor beside the stand mixer blowing air into the dish room. *The fan had a thick, dark, fuzzy layer of dust and debris attached to it. *The dish room had a section for storage of clean dishes used for meal service for the residents. -The fan had been blowing on the clean dishes. Observation and interview on 9/27/21 at 8:27 a.m. with dietary manager C revealed: *Observation of same frozen food items as above not being marked and labeled. *The facility got some vegetables in bulk and the dietary staff would place the product into smaller plastic zip-lock bags for convenience and easier storage. *She confirmed those items should be labeled and dated when stored. *Agreed if a fan is used in the kitchen it should be clean and maintained in a sanitary manner.	F 812		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and	F 835	F 835 Administration will be directly involved in resolving all identified deficiencies.	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 835	Continued From page 94 efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on observation, interview, record review, policy review, and job description review, the provider failed to ensure the facility was operated and administered in a manner that ensured the safety and overall well-being of all forty-three residents in the facility. Findings include: 1. Observations, interviews, record reviews, and policy reviews from 9/26/21 at 10:00 a.m. through 9/29/21 at 3:00 p.m., revealed administrator A had not ensured the safe management and overall well-being of all the residents who lived in the facility. Interview on 9/26/21 at 10:16 a.m. with licensed practical nurse (LPN) V revealed: *She had been working as charge nurse. *She was not sure who the administrator was or who was in charge of the facility. Entrance conference on 9/26/21 at 12:15 p.m. with administrator A revealed he had: *Been acting as the administrator over this facility and another facility. *Been waiting for someone to bring him a key to the administrator office, as he did not have a key. Review of the provider's 8/5/12 Administrator job description revealed the administrator: *"Reports to the Governing Board/Management." *"Administers, directs and coordinates all activities of the care center to carry out its objectives as to the care of the individuals who	F 835	F 835 Administration will be a part of the process for reviewing, revising, and creating policies. Will review all audits completed weekly for four weeks and monthly for five additional months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 835	Continued From page 95 need nursing care. Carries out programs within policies and general directives from the governing board/management. Promotes public relations within the community. Coordinates activities of the medical staff. Recommends and develops policies and procedures for aspects of the care center according to state and federal regulations. Performs related administrative and supervisory duties to ensure efficient operations of the care center." *"Coordinates and integrates the total overall program of the facility." *"Interprets and transmits policies of the governing board/management to the medical staff and personnel of the facility to assure compliance with policies and that residents are meeting their highest level of professional care needed." *"Develops and monitors all departments within the facility to meet the standards put forth by the governing board, management, and state and federal regulations." Review of the provider's 1/15/14 Director of Nursing (DON) job description revealed the DON: *"Reported to the administrator." *Would direct the licensed and non-licensed staff who provided health care and nursing services to the residents in the facility. *Primary responsibility was to ensure the provision of quality nursing care on a twenty-four hour basis. *Was to plan, organize, and direct the activities of the nursing department to ensure the delivery of quality nursing care with the goal of facilitating the highest level of functioning and independence for each resident. *Monitored the job performance of the nursing staff by use of performance evaluations. *Monitored the staffing levels of various nursing	F 835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 835	Continued From page 96 sections, and as necessary, directed staff rotations and rescheduled personnel to meet increased or decreased nursing service demands. *Continuously monitored quality measures, federal, and state regulations and revised departmental procedures. *Reviewed grievances and responsible for overseeing and implementation of the infection control program. *Participates in committees for quality review for falls, skin, pharmaceutical, and restraints. *Responds to incident reports. *Oversees the ongoing quality improvement activities and any survey plans of correction.	F 835		
F 837 SS=F	Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Surveyor: 42477	F 837	F 837 Governing Body will be directly involved in resolving all identified deficiencies. Governing Body will be a part of the process for reviewing, revising, and creating policies. Will review all audits completed weekly for four weeks and monthly for five additional months.	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 837	Continued From page 97 Based on observations, interviews, record reviews, job description reviews, and policy reviews, the governing body failed to ensure the facility was operated in a manner that ensured the safe management and overall well-being for all forty-three residents in the facility. Findings include: 1. During the survey, from 9/26/21 at 10:00 a.m. through 9/29/21 at 3:00 p.m., the provider had not been operated in a manner to ensure the residents had received quality care. Administrator A had not been assisted with his duties to ensure he was able to effectively provide guidance to staff to be able to provide quality care. Refer to F550, F577, F582, F585, F600, F604, F609, F610, F637, F641, F642, F656, F658, F684, F686, F689, F690, F725, F726, F727, F744, F758, F812, F835, F867, F880, F881, F882, F883, F886, and F948.	F 837		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on interview, record review, job description review, and policy review, the provider failed to identify concerns with grievances and to implement an effective performance improvement plan (PIP) and quality assurance program. Refer	F 867	F 867 Will implement PIPs into the QAPI process. Will ensure that antibiotic stewardship is included in the QAPI process. Will Audit to ensure above resolutions are put into place monthly for 6 months	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 867	Continued From page 98 to 585 all findings, Findings include: 1. Interview on 9/28/21 at 3:45 p.m. with administrator A, business office manager B, and interim director of nursing M revealed: *Quality assurance performance improvement (QAPI) program was meeting on a regular basis. *There had been no PIP's in place for the past six months. *Antibiotic stewardship had not been a part of QAPI. *QAPI had not identified any areas of improvement for the facility. *Surveyors requested audits brought to QAPI regarding the facility identified incident for resident 95. -They had no record of those audits or the results from those audits.	F 867		
F 880 SS=L	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,	F 880	F 880 Time cannot be turned back to a time prior to the identification of lack of appropriate response to COVID-19 that includes screening, testing of staff and residents. Appropriate use of personal protective equipment (PPE). Appropriate hand hygiene and glove use as well as procedural technique with dressing change and providing personal cares. Appropriate cleaning and maintenance of multi-resident used equipment such as mechanical lifts. Appropriate use and contact time for cleaning solutions.	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 99 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, 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.	F 880	F 880 The administrator, governing body representative, and DON and whomever else identified will designate an infection control nurse and will reviewed as necessary policies and procedures about: Appropriate response to COVID- 19 that includes screening, Testing of staff and residents. Appropriate use of PPE. Appropriate hand hygiene and glove use as well aS procedural technique with dressing change and providing personal cares. Appropriate cleaning and maintenance of multi-resident used equipment such as mechanical lifts. Appropriate use and contact time for cleaning solutions. Staff provided with education in written form for the m to read about proper PPE and Donning and Doffing. All staff who provide above services will be educated/re-educated by 10/22/21 by DON or Designee. ALL residents and staff have the potential to be affected if staff do not adhere to all identified areas. Administrator, DON, infection control nurse, 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. Administrator contacted the South Dakota Quality Improvement Organization (QIN) on 10/22/21 and touched base on full survey and set up another date to continue the conversation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 100 §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: Surveyor: 42477 Based on observation, interview, record review, and policy review, the provider failed to ensure appropriate infection control precautions had been followed with: *Certified nursing assistants (CNA)s F, G, O, U and W had not performed hand hygiene after care of residents. *Two of two observed dressing changes by interim director of nursing (DON) M. *COVID-19 precautions were not taken with residents exposed to someone who had tested positive for COVID-19. *Lifts had not been disinfected in between residents (4 and 8). *CNA T had not followed appropriate putting on and removal of personal protective equipment (PPE) when for caring for a resident who was presumed positive with COVID-19. *Two of two observed visitors had not been screened for COVID-19. *No screening residents for COVID-19 signs and/or symptoms. *Environmental Services staff Z while cleaning resident 41's room. Findings include: These failures have a potential to expose all residents, staff, and visiting essential personnel to	F 880	F 880 MDS coordinator or designee will audit hand hygiene 3 times per week for 4 weeks, 2 times per month for 1 month and monthly for 4 additional months. Designated CNA or designee will audit lift cleaning 2 times per week for 4 weeks, 2 times per month for 1 month and monthly for 4 additional months. MDS coordinator or designee will audit covid testing 2 times per week for 4 weeks, 2 times per month for 1 month and monthly for 4 additional months Monitoring results will be reported by MDS coordinator and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 101 COVID-19, a viral infection that could lead to serious harm or death. NOTICE: On 11/4/21 at 11:00 a.m. an Immediate Jeopardy was identified after the Centers for Medicare and Medicaid Services (CMS) Regional Office review of the 9/27/21 Recertification Survey Form CMS-2567. The facility failed to implement CMS and CDC recommended practices to prepare for COVID-19. On 11/4/21 at 3:52 p.m. a copy of the immediate jeopardy template was emailed to the provider for review. Notice of immediate jeopardy was given verbally, via telephone to the administrator. Specifically, the provider failed to ensure: *CDC guidelines were followed for proper PPE usage to prevent the spread of COVID-19. *Unvaccinated residents who had been exposed to a staff member who had been positive with COVID-19 remained quarantined from the remaining resident population. *Staff who care for quarantined residents were wearing appropriate PPE. *One of one CNAs followed proper infection control practices after leaving one of three quarantined rooms. *Two of two observed visitors had been screened for the potential of COVID-19 illness. *Residents had been screened for signs and symptoms of COVID-19. PLAN: On 9/27/21 at 5:00 p.m. surveyors were able to verified that the Immediate Jeopardy had been removed while the survey team had been onsite. The Immediate Jeopardy was removed after the provider educated all staff, quarantined COVID-19 exposed residents, implemented	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 102 infection control practices to prevent the spread of COVID-19, and screened all staff and visitors. Immediate Jeopardy was removed on 9/27/21 at 5:00 p.m. after the removal plan had been verified by the survey team. After removal of the Immediate Jeopardy, the scope/severity of this citation is level "F". 1. Observation on 9/26/21 at 10:35 a.m. with CNA O revealed she: *Was grabbing a bag of trash out of a resident 16's room. *Tied the bag with bare hands and took the trash down the hall to the soiled utility room. *Had not performed hand hygiene after doing this. *Then went back in resident 16's room to make her bed. Observation on 9/26/21 at 10:52 a.m. of the facility's front entrance revealed: *Two visitors walked into the facility, through the front door. *No one had asked them if they had screened themselves. *No one had inquired about their COVID-19 status/exposure. Observation on 9/26/21 at 11:35 a.m. with CNA Q revealed She had: *Been taking a bag of trash to the soiled utility room. *Not sanitized her hands and went into resident 30's room. *Grabbed resident 30's trash and dropped it off in the soiled utility room. *Not sanitized her hands and went into resident 22 and 28's room.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 103 *Grabbed resident 22 and 28's trash and brought it to the soiled utility room. *Not sanitized her hands when leaving. 2. Observation and interview on 9/27/21 at 7:47 a.m. with interim DON M revealed she: *Went into resident 16's room and put her clean gloves on top of the resident's dresser. *Put on gloves to check resident 16's wound. *Removed the gloves, did not sanitize hands. *Went back into the hallway to get an alcohol pad. *Came back in the room and put on a new pair of gloves. -That pair of gloves had also been laying on the resident's dresser with her personal belongings. Interview on 9/27/21 at 9:49 a.m. with administrator A and business manager B revealed: *Had not been aware they needed to test all unvaccinated staff per their county level positivity rate. Refer to F886. *Employees are self-screening themselves. *Employees walk through the building to screen themselves at the nurses' station. *They were unable to say who monitored those screening forms. *They did not have a list of employees that had been fit-tested. *Interim DON M was fit-testing staff. *They had not been aware they should still be monitoring residents for signs and symptoms of COVID-19. *They had not put unvaccinated residents who had been exposed to positive staff CNA/MA H in quarantine. *They had not implemented any precautions for isolation.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 104 Observation and interview on 9/27/21 at 10:57 a.m. with interim DON M revealed she: *Was going to change resident 4's dressing. *Laid her clean gloves on the resident's blanket. *Sanitized her hands and put the gloves that had been on the blanket. *Had braced herself with one gloved hand on the floor. *With that same glove that was on the floor she assessed the resident's foot wounds. *With the same soiled gloves, she touched the wound with she had reached into resident 4's treatment box to grab supplies. *While wearing soiled gloves she applied ointment by using her finger to obtain and apply the ointment. Observation and interview on 9/27/21 at 11:31 a.m. with environmental services staff Z revealed she: *Had walked into resident 41's room. *Stated resident 41 had been sick and not feeling well. -Resident 41 had vomit on down her clothing protector, and piled on her left hand. *Started cleaning resident 41's room. *Sprayed the doorknobs with a cleaner. *Had no idea of a contact time for the cleaner. *Then swept the room and mopped the room. *Had not cleaned any bedside tables, remotes, or rails in the resident's room. *Stated she usually does not clean those items because they have residents' things on them. Observation on 9/27/21 at 11:37 a.m. of CNA T revealed she brought a lift out of resident 8's room and did not disinfect it.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 105 Observation and interview on 9/28/21 at 8:44 a.m. with CNA T revealed she: *Been coming out of a COVID-19 quarantine room. *Was not wearing a face shield. *Was not wearing an N95 mask. *Had not changed her surgical mask upon leaving the quarantine room. *Did not believe she needed to wear an N95 mask or a face shield since the resident was "just on precautions." *Surveyor informed her that the resident was on quarantine because they could be positive with COVID-19. Surveyor: 41088 3. Observation on 9/28/21 at 8:38 a.m. with CNAs G and W assisting resident 4 revealed: *Resident 4 had been sitting in his wheelchair in his room and requested assistance to use the restroom. *CNA G washed her hands and put on gloves. *CNA W brought the mechanical stand aid into the room and closed the door then put on gloves without performing hand hygiene. *CNA G moved the wheelchair foot pedals to the side, placed resident 4's feet on the floor and then removed the foot pedals and placed them to the side. *CNA W rolled the mechanical stand aid into position next to the toilet. *CNA G attempted to move him to the restroom but the oxygen tubing was not long enough to reach. *Using the same gloved hands, she removed the nasal cannula from his nose, attached the tubing to the oxygen tank on the back of his wheelchair, rearranged the resident, turned the oxygen on and then placed the nasal cannula back into his	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 106 nostrils. *CNA G rolled him into the restroom into position by the stand aid, placed the back brace around him and attached the straps. *CNA W removed the nasal cannula to untangle it, then put it back into his nostrils. *CNA W placed the leg strap around the resident's legs, raised the resident into position and lowered him onto the toilet after removing his adult brief. *Both CNAs removed their gloves. *CNA G left the room. *When finished assisting the resident, the mechanical stand aid had been parked in the hallway by CNA W and had not been sanitized. Interview on 9/28/21 at 8:47 p.m. with CNA W revealed: *She had been a CNA for 7 years. *She recognized they had missed opportunities for hand hygiene and glove changes while assisting resident 4. *She agreed the lift should have been sanitized after being used. Review of the undated electric lift cleaning policy revealed: *"Purpose: To provide clean equipment for resident care. To prevent growth of bacteria. *At the end of each shift each item used will be cleansed with the Vindicator solution. *Equipment will be cleansed ant [at] the time of soil age [soilage]." Surveyor: 06365 4. Observation on 9/27/21 at 8:57 a.m. of CNA F assist CNA G to get resident 32 up from bed revealed CNA F failed to follow proper procedures for hand hygiene and glove use.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 107 *She did not wash or sanitize her hands before putting on the gloves. *CNA F was on the left side and in front of resident 32 as she and CNA G positioned the resident in the stand aid sling and stood her up from the edge of the bed. *Once resident 32 was standing, CNA F removed the resident's brief and placed it into the trash can. There was an odor of bowel at that time. *Without wiping resident 32's bottom, CNAs F and G positioned resident 32 on a bedside toilet commode with wheels. *While wearing the same gloves she used to remove resident 32's brief, CNA F proceeded to strip the linens off resident 32's bed, placing them in the linen cart, and picking up the pillows and blankets to the head end of the mattress. *CNA F pushed the linen cart into the hallway, removed her gloves, placed them into a cart, then sanitized her hands. Interview with CNA F on 9/28/21 at 8:41 a.m. revealed she was taught to "wear gloves whenever we are handling residents," and to sanitize hands before and after. Surveyor 42477: Review of the provider's undated COVID-19 Prevention and Control Guidance policy revealed: *"The Infection Control Preventionist will track how many and which residents were isolated and/or quarantined." *"A list of which residents are isolated and/or quarantined will be posted each day on the [electronic charting software] dashboard so that staff are aware." Review of the provider's undated Hand Washing policy revealed:	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 108 *The purpose of hand washing was to: -"Medical asepsis [the absence of viruses, bacteria, and other organisms] to control infection." -"To reduce transmission of organisms from resident to resident." -"To reduce transmission of organisms from nursing staff to resident." -"To reduce transmission of organisms from resident to nursing staff." Review of the provider's undated Hoyer Lifts, PALS, Electric Lift Cleaning policy revealed: *Hoyer lifts, PALS, and Electric lifts were to be cleaned: -"At the end of each shift each item used will be cleansed with [cleaner's name] solution." -"Equipment will be cleansed ant [at] the time of soil age." Review of the provider's Infection Control and Prevention Policy revealed: *Staff were to use standard and transmission-based precautions to keep the residents safe as well as themselves from infection. *Standard precautions included: -Hand washing. -Use of PPE. *Transmission-based precautions included: -Droplet. -Airborne. -Contact. *"...If eye protection is indicated, wear goggles or a face shield during ALL contact with the individual, not just when splashes or sprays are anticipated, as well standard precaution."	F 880		
F 881 SS=D	Antibiotic Stewardship Program	F 881		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 881	Continued From page 109 CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on interview and record review, the provider failed to have an ongoing Antibiotic Stewardship program. This failure placed all residents at risk for potential adverse outcomes, associated with the inappropriate and/or unnecessary use of antibiotics. Findings included: 1. Surveyors requested any documentation related to antibiotic stewardship throughout the survey. *Antibiotic stewardship information had been requested from administrator A on the following dates and times: -9/26/21 at 12:15 p.m. -9/27/21 at 9:50 a.m. -9/29/21 at 9:30 a.m. *The facility had been unable to show any antibiotic stewardship information or their involvement with the quality assurance performance improvement (QAPI) program. Refer to F867. Review of the provider's undated Infection Control and Prevention policy revealed: *Leadership would be responsible for:	F 881	F 881 Time cannot be turned back to a time prior to the identification of lack of Appropriate use and monitoring of antibiotics through antibiotic stewardship. Administrator contacted the South Dakota Quality Improvement Organization (QIN) on 10/22/21 and have set up another date to go over implementing anti biotic stewardship program. Monitoring of determined approaches to ensure effective infection control and prevention include at a minimum 1 times weekly for 4 week. 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, interim DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director.	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 881	Continued From page 110 *"C. Antibiotic Stewardship." *"a. The facility will work to optimize the treatment of infections while reducing adverse events associated with antibiotic use." *"b.The Infection Preventionist will be accountable for overseeing the Antibiotic Stewardship program at [facility name]." *"d. Antibiotic use will be tracked and reported monthly at QAPI." *The information tracked would consist of the number of: -Residents prescribed antibiotics. -Infections and types of infections. -Lab proof of infections. -Residents with antibiotic-resistant organisms.	F 881		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment	F 882	F 882 Time cannot be turned back to a time prior to the identification of lack of an appropriate infection control preventionist. MDS appointed as the infection control preventionist.	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 882	Continued From page 111 and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on observation and interview, the provider failed to designate an infection preventionist to oversee the facility's infection control and prevention program. Findings include: 1. Interview on 9/26/21 at 12:15 p.m. with administrator A revealed: *The director of nursing (DON) for the facility left two weeks ago. *The previous DON had been in charge of infection prevention for the facility. *He had not designated anyone to be in the infection preventionist for the facility. *Refer to F880, F881, and F886.	F 882		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been	F 883	F 883 Time cannot be turned back to a time prior to the identification of lack of appropriate documentation of receipt of or declination of pneumonia vaccination. The administrator, governing body representative, and DON in consultation with the medical director and whomever else identified will designate an infection control nurse and will reviewed as necessary policies and procedures about appropriate documentation of receipt of or declination of pneumonia vaccination.	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 883	Continued From page 112 immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive	F 883	F 883 Administrator, DON, infection control nurse, and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency. MDS coordinator will audit Pneumococcal immunizations weekly for 4 weeks and monthly for 2 additional months. MDS coordinator and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 883	Continued From page 113 the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review, interview, and policy review, and Centers for Disease Control and Prevention (CDC) recommendations, the provider failed to ensure three of five randomly sampled residents (3, 23, and 30) had documented pneumonia vaccination administration or refusal in their care records. Findings include: 1. Review of resident 3's medical record revealed: *She had been admitted on 10/27/20. *Only a pneumococcal conjugate vaccine (PCV13) had been documented from history. *There was no record or refusal documentation of the pneumococcal polysaccharide vaccine (PPSV23). 2. Review of resident 23's medical record revealed: *He had been admitted on 3/4/21. *There was no record or documentation of refusal for the PCV13 and PPSV23 vaccinations. 3. Review of resident 30's medical record revealed: *She had been admitted on 8/25/21. *Only a pneumococcal conjugate vaccine (PCV13) had been documented from history. *There was no record or refusal documentation of the pneumococcal polysaccharide vaccine (PPSV23). Interview on 9/29/21 at 11:00 a.m. with Minimum Data Set coordinator D confirmed the above	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 883	Continued From page 114 findings. She was aware of the requirement for the pneumococcal vaccinations to have been offered, given, or documentation of refusal. Request for the provider's pneumococcal vaccine policy was made on 9/29/21 at 1:00 p.m. The only immunization policy that was received was for the influenza vaccine. Per the CDC recommendations, "CDC recommends routine administration of pneumococcal polysaccharide vaccine (PPSV23) for all adults 65 years or older. In addition, CDC recommends PCV13 based on shared clinical decision-making for adults 65 years or older who do not have an immunocompromising condition, cerebrospinal fluid leak, or cochlear implant and have never received a dose of PCV13. Clinicians should consider discussing PCV13 vaccination with these patients to decide if vaccination might be appropriate."	F 883		
F 886 SS=L	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in	F 886	F 886 Time cannot be turned back to a time prior to the identification of lack of Appropriate response to COVID-19 that includes screening, testing of staff and residents. The administrator, governing body representative, and interim DON in consultation with the medical director and whomever else identified will designate an infection control nurse and will review, revise, create as necessary policies and procedures about appropriate response to COVID-19 that includes screening, Testing of staff and residents. All staff who provide above services will be educated/re-educated by 10/22/21 by administrator.	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 886	Continued From page 115 this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.	F 886	F 886 ALL residents and staff have the potential to be affected if staff do not adhere to all identified areas. Policy education/re-education about roles and responsibilities for the above identified assigned tasks will be provided by 10/22/21 by MDS Coordinator. Administrator, DON, infection control nurse, 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. Monitoring of determined approaches to ensure effective infection control and prevention include at a minimum 2 times weekly for 4 weeks, administrator, governing body representative, interim DON, and/or a designee making observations across all shifts to ensure staff compliance with necessary infection control and prevention plan that includes compliance in the above identified areas. 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 completed by MDS coordinator and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 886	Continued From page 116 §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on observation, interview, record review, and reference source review, the provider failed to follow outbreak and county level testing procedures for staff and residents in their building. Findings include: These failures have a potential to expose all residents, staff, and visiting essential personnel to COVID-19, a viral infection that could lead to serious harm or death. NOTICE: On 11/4/21 at 11:00 a.m. an Immediate Jeopardy was identified after the Centers for Medicare and Medicaid Services (CMS) Regional Office review of the 9/27/21 Recertification Survey Form CMS-2567. The facility failed to implement CMS and CDC recommended practices to prepare for COVID-19. On 11/4/21 at 3:52 p.m. a copy of the immediate jeopardy template was emailed to the provider for review. Notice of immediate jeopardy was given verbally, via telephone to the administrator. Specifically, the provider failed to ensure: *Unvaccinated staff had been tested for COVID-19 according to the provider's county level positivity rate. *Perform outbreak testing when a staff member had tested positive for COVID-19.	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 886	Continued From page 117	F 886		

PLAN:
On 9/27/21 at 5:00 p.m. surveyors were able to verified that the Immediate Jeopardy had been removed while the survey team had been onsite. The Immediate Jeopardy was removed after the provider educated all staff and tested all residents and staff in the building to identify COVID-19 infections within the building.

Immediate Jeopardy was removed on 9/27/21 at 5:00 p.m. after the removal plan had been verified by the survey team. After removal of the Immediate Jeopardy, the scope/severity of this citation is level "F".

1. Observation on 9/26/21 at 10:00 a.m. of the facility's main entrance revealed:
*Surveyors had walked through the entrance.
*An unidentified staff member was talking to a resident with a mask under her chin.
*Surveyors introduced themselves, they had not been:
-Asked any questions regarding COVID-19 status.
-Screened for the potential of having COVID-19.
-Given any instructions to prevent the spread of COVID-19.

2. Interviews, observations, record reviews, and policy reviews, throughout the survey revealed the facility was not testing all residents and staff every three to seven days since being in outbreak status starting on 9/22/21.

3. The facility had not been testing all unvaccinated staff per their county level positivity rate to detect COVID-19 in staff members.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 886	Continued From page 118 Review of the facility's COVID-19 testing documentation revealed they had: *A symptomatic staff member test positive on 9/22/21. *Not performed outbreak testing for their residents or staff. *Had not been testing unvaccinated staff per their county level positivity rate. Interview on 9/27/21 at 9:40 a.m. with administrator A and business office manager B revealed: *Business office manager B had been the previous administrator and was keeping track of COVID-19 testing. *Business office manager B not been aware they should have been: -Testing every three to seven days during outbreak status. -Testing two times per week since their county was of high transmission status. Review of the provider's undated COVID-19 Prevention and Control Guidance policy revealed: *"To ensure the health and safety of [facility name]'s residents and staff by enforcing the standards required to help each resident maintain their highest level of well-being due to the virus that causes coronavirus disease (COVID-19)." Review of Centers for Disease Control and Prevention's (CDC) Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 [COVID-19] Spread in Nursing homes <www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html> 9/10/21 guidance revealed: *Unvaccinated staff were to be tested based off county level positivity rates.	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 886	Continued From page 119 *Healthcare personal (HCP), residents and families were to be notified of an outbreak in the facility. *An outbreak consisted of: -One resident or HCP *A person should be designated as the infection control person to oversee the COVID-19 effort and management of infection control program. Review of the provider's undated Infection Control and Prevention Policy revealed: *"LTC [long-term care] facilities must test residents and staff, including volunteers and/or contracted service providers for Covid-19 based upon the following parameters." *Those parameters included: -Symptoms. -An outbreak, which was any new case in the facility. -County-level positivity testing.	F 886		
F 948 SS=D	Training for Feeding Assistants CFR(s): 483.95(h) §483.95(h) Required training of feeding assistants. A facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a State-approved training program for feeding assistants, as specified in §483.160. This REQUIREMENT is not met as evidenced by: Surveyor: 41088 Based on interview, record review, and job description review, the provider failed to ensure a registered nurse (RN) had been designated to oversee the paid feeding assistant program. Findings include:	F 948	F 948 For the identification of multiple system failures that included lack of Appropriate staffing that includes – quantity necessary to provide for all resident needs; RN coverage for at a minimum of 8 hours in a 24-hour period; full-time DON to ensure sufficient and competently trained staff, ensure all aspects of care including and supervision for those staff augmenting dining assistance. The administrator, governing body representative, interim DON, and/or a designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas.	11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 948	Continued From page 120 1. Interview on 9/29/21 at 8:09 a.m. with business manager B revealed: *They had two paid feeding assistants on staff that they referred to as dining assistants. -Cook/dining assistant K and dietary aid/dining assistant L. *They both worked full-time in the kitchen but helped feed residents on their days off. *Both had received training to be feeding assistants. -Documentation for their feeding assistance training was verified. *There had been a list of residents that needed assistance in the kitchen. *She was unaware of those residents that the feeding assistants were able to feed and those they could not. *The past director of nursing (DON) had overseen the program and they had not assigned someone when she left. *The resident feeding assistance list was to be updated by nursing staff, or the DON if something changed. *She was unaware an RN needed to oversee the feeding assistants. Interview on 9/29/21 at 8:41 a.m. with cook/dining assistant K revealed: *She had completed training to work as a feeding assistant. *She picked up shifts when she could help out and was not scheduled to work in the kitchen. *There was a resident list located above the food warmer in the kitchen for residents that needed help eating. *The list had been updated by the dietary manager with the direction of the nursing staff. *She was never told of anyone on the list that she	F 948	F 948 Administrator, governing body representative, interim 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. MDS coordinator will oversee the feeding program and update as needed list for residents that feeding assistance can and cannot feed. Monitoring results will be reported by MDs coordinator and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 948	Continued From page 121 would not be able to feed. Review of the resident feeding assistance list revealed: *Eight residents' first names. *The list had not: -Identified what the list was for or why they residents were on the list. *Explained if there were any special resident needs such as swallowing or choking concerns. *Included those residents that could not be fed by the feeding assistants. Interview on 9/29/21 at 8:50 a.m. with administrator A and business manager B revealed: *A replacement had not been designated to be in charge of the dietary feeding assistance program. *They were unaware: - An RN needed to oversee the program. -The resident assistance list should identify residents who had choking, swallowing concerns, or other special needs. -Residents with choking, swallowing concerns, or special needs should not be fed by feeding assistants. Review of the revised 4/27/18 Dining Assistant job description revealed: *Reports to: Charge Nurse, Director of Nursing, Administrator. "Works under the supervision of the charge nurse and performs duties related to resident dining experience. Handles and treats residents in a manner conductive to their safety and comfort, adheres to instructions issued by the nurse and to established routine, and performs duties in accordance with established methods and techniques and in conformance with recognized	F 948		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 948	Continued From page 122 standards."	F 948		

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
	435129	A. BUILDING _____ B. WING _____	09/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Surveyor: 40506 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 9/26/21 through 9/29/21. Dells Nursing and Rehab Center Inc was found not in compliance with the following requirement(s): E 001.	E 000		
E 001 SS=E	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and	E 001	E 001 Administrator and Interdisciplinary team will revise or create plans for Sheltering in place, sewage and waste disposal, use of volunteers, relocation of residents and a communication.	10/29/21

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

Administrator 10/25/21

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	09/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 001	Continued From page 1 local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on interview and record review, the provider failed to establish a complete emergency preparedness program that included policies, procedures, communication plan and contact information. Findings include: 1. Interview and review of the provider's emergency preparedness program documentation on 9/27/21 at 2:30 p.m. with Administrator A and maintenance manager H revealed: * They did not have a complete emergency preparedness program. * they had not: -Addressed need for provisions to shelter in place. -Addressed policies and procedures for sewage and waste disposal. -Addressed policies and procedures for sheltering in place for residents, staff, and volunteers who	E 001		

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
	435129	A. BUILDING _____ B. WING _____	09/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 001	Continued From page 2 remained in the facility -Addressed the use and role of volunteers in their policies and procedures. -Addressed plans to relocate residents if it became necessary. -Developed arrangements with other long term care facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to residents. -Developed a communication plan that had: --Included emergency officials contact information. --Included names and contact information for residents' physicians, other long term care facilities, and volunteers. *They had not been aware of all requirements for a complete emergency preparedness program and had instead relied upon a generic plan.	E 001		

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
	435129	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 000	INITIAL COMMENTS Surveyor: 40506 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 9/27/21. Dells Nursing 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 and the Fire Safety Evaluation System (FSES) dated 9/29/21. Please mark an F in the completion date column for K241 deficiencies identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K 211, K321, K345 and K 923 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: Surveyor: 40506	K 211	K 211 Ladder extended on both sides of railing to make an full exit out of basement more accessible.	10/29/21

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

TITLE: Administrator

(X6) DATE: 10/25/21

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 211	Continued From page 1 Based on observation, testing, and interview, the provider failed to provide unimpeded egress as required at one randomly observed location (partial basement second exit). Findings include: 1. Observation beginning at 2:30 p.m. on 9/27/21 revealed the ships ladder exit from the partial basement was blocked at the top by a fence. The fence was 36 inches high and had an available width at the top step of three inches. Interview at the time of the observation with the maintenance director and the administrator confirmed those conditions. They acknowledged the difficulty of climbing over the fenced ladder.	K 211		
K 241 SS=C	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation and document review, the provider failed to maintain at least two conforming exits from each floor level of the building. The basement had only one conforming exit. Findings include: 1. Observation on 9/27/21 at 12:10 p.m. revealed the basement had only one conforming exit	K 241		F

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 241	Continued From page 2 directly to the exterior of the building. The second egress routes were through hazardous areas of the boiler and laundry rooms to an area equipped with a fixed ladder. Review of previous survey data confirmed that condition had existed since the original construction. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000. This deficiency would not affect any of the residents and minimal staff within the facility.	K 241		
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) c. Repair, Maintenance, and Paint Shops	K 321	K 321 Door closures installed on room 168 and basement medical storage room. Educated associated staff on not blocking open doors.	10/25/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 321	Continued From page 3 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: Surveyor: 40506 Based on observation and interview, the provider failed to maintain three separate hazardous areas (room 168, basement medical storage room and kitchen storage room) as required. Findings include: 1. Observation on 9/27/21 at 11:05 a.m. revealed room 168, a patient room that was being used as a storage room on the west wing was over 100 square feet and had large amounts of combustibles stored in it. The door was not equipped with a closer. 2. Observation on 9/27/21 at 12:00 p.m. revealed basement medical storage room was over 100 square feet and large amounts of combustibles stored in it. The ceiling had a breech where a 12" x 8" portion had been cut away and a pipe hung below the ceiling. 3. Observation on 9/27/21 at 1:15 p.m. revealed the supply room in the kitchen on the south side of the entry was over 100 square feet and had large amounts of combustibles stored in it. The door was equipped with a closer but was blocked open with a dustpan. Interview with the maintenance director at the times of the observations confirmed those	K 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 321	Continued From page 4 findings.	K 321		
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on document review and interview, the provider failed to maintain one of one fire alarm system as required. Findings include: 1. Record review on 9/27/21 at 3:00 p.m. revealed the annual fire alarm inspection report dated 12/22/20 did not list sensitivities for the ionization-type smoke detectors. Ref: 2010 NFPA 72 Section 14.6.2.4, Figure 14.6.2.4 Section 7.12-7.14. Interview with the maintenance director at the time of the record review confirmed those findings. He stated the contractor who provided the testing only confirmed a pass or fail condition. He added the fire alarm panel was an older model not an 'intelligent' model which did not have the capability to show the sensitivities of the smoke detectors. The deficiency affected 100% of the occupants.	K 345	K 345 Contacted fire alarm vendor and the will be adding sensitivity testing to their annual inspection.	10/29/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 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 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	K 923	K 923 Installed signs for empty and full tanks. Got another oxygen containment holder and tanks that were not properly stored now have extra space from them to be stored in.	10/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 923	Continued From page 6 by: Surveyor: 40506 Based on observation and interview, the facility failed to protect medical gas storage as required. Five oxygen cylinders were not secured in any way. 1. Observation on 9/27/21 at 1:45 p.m. revealed three b-cylinders and two e-cylinders that were not stored in a rack or otherwise stabilized. The deficiency affected one of five smoke compartments.	K 923		

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
	10613	A. BUILDING: _____ B. WING _____	09/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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: 26632 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 9/26/21 through 9/29/21. Dells Nursing and Rehab Center was found not in compliance with the following requirements: S157, S290, S301, and S355.	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: Surveyor: 40506 Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation in five randomly observed rooms (two of two soiled utility rooms, two of two housekeeping closets with mop sinks, and one of one soiled laundry rooms). Findings include: 1. Observation on 9/27/21 at 10:50 a.m. revealed the exhaust ventilation for the soiled utility room and the housekeeping closet on the west wing were not functioning. Testing of the grilles with a paper towel at the time of the observation confirmed that finding. 2. Observation on 9/27/21 at 11:50 a.m. revealed the exhaust ventilation for the soiled laundry room in the basement was not functioning. Testing of the grille with a paper towel at the time of the observation confirmed that finding.	S 157	S 157 Will get ventilation working in all identified areas. Will audit weekly for 4 weeks and monthly for 2 additional months to ensure proper ventilation in required areas.	10/29/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator (X6) DATE 10/25/21

STATE FORM 6899 QQQ211 If continuation sheet 1 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10613	A. BUILDING: _____ B. WING _____	09/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 157	Continued From page 1 3. Observation on 9/27/21 at 1:50 p.m. revealed the exhaust ventilation for the soiled utility room and the housekeeping closet on the west wing were not functioning. Testing of the grilles with a paper towel at the time of the observation confirmed that finding. Interview with the maintenance director on 9/27/21 at the time of the observations confirmed the findings. He revealed he was unaware as to why the exhaust ventilation was not working at these locations.	S 157		
S 290	44:73:07:05 Food Supply The facility shall maintain an on-site supply of perishable and nonperishable foods adequate to meet the planned menus for three days. A facility shall maintain an additional supply of nonperishable foods as part of their emergency preparedness plan. Military meals ready to eat (MRE) are not a substitute for the nonperishable food supply for residents, but may be used to address other emergency food supply needs. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 41088 Based on observation and interview the provider failed to maintain a food supply sufficient to provide meals for three days and an additional supply in case of emergency. 1. Observation and interview during the kitchen tour on 9/27/21 at 8:27 a.m. with dietary manager C revealed: *She had started her position as dietary manager on 9/20/21.	S 290	S 290 Ordered and received the necessary food for the emergency on-site needs. Will audit weekly for 4 weeks and monthly for 2 additional months to ensure proper amounts of emergency food.	

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
	10613	A. BUILDING: _____ B. WING _____	09/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 290	Continued From page 2 *The food supplies that were observed during the tour had been limited. *When asked if they had enough food supply on hand to feed the residents for three days with an additional supply for an emergency, she said they did not. *She stated she was aware of the requirement but had a limited budget to follow. *She had been informed by administration that the current supply that they had was what they had always done. *No policy had been provided requiring food supply prior to survey exit. Interview on 9/28/21 at 3:50 p.m. with administrator A revealed he was unaware of the above information.	S 290		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 41088 Based on interview and record review, the provider failed to ensure nine of nine required dietary trainings (food safety, handwashing, food handling and preparation, food-borne illnesses, serving and distribution policies, leftover food handling, time and temperature controls, nutrition	S 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10613	A. BUILDING: _____ B. WING _____	09/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 301	Continued From page 3 and hydration, and sanitation) were completed by all dietary staff. Findings include: 1. Interview on 9/27/21 at 8:27 a.m. with dietary manager (DM) C revealed she: *Had been in her current position for one week. *Was unsure who had provided the dietary training for dietary staff before she had been hired. *Was unaware of when the last training had taken place. *Was aware that all dietary and food handling staff were to have training on an annual basis. On 9/27/21 at 2:36 p.m. DM C brought a paper that stated: *"Wednesday, August 18th Dining Assistance, Nutritional Risks, and Hydration Needs of Residents by [registered dietician]." *It included a list of 8 dietary employees. *There were 15 dietary employees on staff. *It had not included the year the training took place. *It had not included a description of the training content. *There were no signatures included for the staff that had attended the training. *No other documentation had been provided to confirm the required dietary training had taken place for all dietary staff. *A dietary training policy had not been provided prior to survey exit. Interview on 9/28/21 at 3:46 p.m. with administrator A confirmed he was aware the dietary staff should have had ongoing required trainings.	S 301	S 301 Training will be provided to all necessary dietary staff and on going training items will be put into place.	

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
	10613	A. BUILDING: _____ B. WING _____	09/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 355	Continued From page 4	S 355		
S 355	44:73:10:04 Provision of Social Services A facility shall provide or make arrangements to provide social services for each resident as needed. A staff social worker or social service designee shall be designated as responsible to facilitate the provision of social services. If the staff member is not a social worker, the facility shall have a written agreement with a social worker for consultation and assistance to be provided on a regularly scheduled basis but at least quarterly. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 06365 Based on interview and consultant report review, the facility failed to ensure at least quarterly consultation with a social worker for the social service designee. Findings include: 1. Employee information provided by the facility revealed social service/office assistant (SS/OA) E was hired on 6/14/21. Interview with SS/OA E on 9/28/21 at 1:51 p.m. revealed she had not yet met with the social work consultant. She reported her first meeting will be next week. Administrator A provided the previous two social work consultant reports dated 1/19/21 and 4/13/21. No report was provided for July 2021.	S 355	S 355 Licensed Social worker did consultation on 10/18/21 and will continue to provide consultations on at least the quarterly requirement.	
S 000	Compliance/Noncompliance Statement Surveyor: 26632 A licensure survey for compliance with the	S 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10613	A. BUILDING: _____ B. WING _____	09/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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	Continued From page 5 Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 9/26/21 through 9/29/21. Dells Nursing and Rehab Center was found not in compliance with the following requirement: S035.	S 000		
S 035	44:74:02:07 Approval and Reapproval of Training Programs The department must shall approve nurse aide training programs. To obtain approval, the entity providing the nurse aide training program shall submit to the department an application on a form provided by the department that contains information demonstrating compliance with requirements specified in this chapter. The department shall respond within 90 days after receipt of the application. The department may grant approval for a maximum of two years. At the end of the approval period, the entity shall apply for reapproval. As part of the reapproval process, the department shall conduct an unannounced on-site visit to determine compliance with the requirements. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 26632 Based on interview and record review, the provider failed to notify the South Dakota Board of Nursing (SD BON) of changes in the NATP (nurse aide training program) coordinator within thirty days after the change. Findings include: 1. Review of the provider's SD BON NATP approval document revealed: *The NATP had been approved until 3/31/22.	S 035	S 035 We will not update the nurse aide program and will inform state of inability to provide the program at this time.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10613	A. BUILDING: _____ B. WING _____	09/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(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 035	Continued From page 6 *The NATP coordinator had been registered nurse (RN) CC. -RN left that position on 5/21/21. *The previous DON had been designated as the NATP primary instructor. -She had taken over those duties after RN CC had left. *No change had been submitted for the change of the NATP coordinator. Phone interview on 9/28/21 at 10:00 a.m. with the NATP coordinator at the sister facility revealed she had only been doing the testing. Interview on 9/28/21 at 1:30 p.m. with business manager B confirmed the previous DON had taken over the NATP. She was not aware the SD BON should have been notified of that change.	S 035		