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 _____	03/01/2023

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 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/27/23 through 3/1/23. Dells Nursing and Rehab Center Inc was found not in compliance with the following requirement: F812.	F 000		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §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: A. Based on observation, interview, record review, manufacturer's instruction review for cleaning and de-liming the dishwasher and cleaning the ice machine, facility policies, and a "Semi-Annual Assignment Worksheet" review, the provider failed to maintain one of one dishwasher and one of one ice machine in a	F 812	For the identification of multiple system failures that included lack of dishwasher cleanliness, ice machine cleanliness, and unsanitary practices. All residents have the potential of being affected by unsanitary deficient practices. Administrator, Dietary Manager, Environmental Services Manager, and any others as necessary will ensure ALL facility staff responsible for the assigned tasks have received education/training with demonstrated competency and documentation by 4/20/2023. Dietary Manager and/or designee will conduct auditing and monitoring for all areas identified above, weekly for four weeks. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue for 4 months.	4/20/2023 CW 3/17/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Calyn Wenn | TITLE: Administrator | (X6) DATE: 3/17/2023

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

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F 812	Continued From page 1 clean and sanitary manner. Findings include: 1. Observation on 2/27/23 from 3:31 p.m. to 4:33 p.m. in the kitchen revealed: *The edges of the door panels of the dishwasher were encrusted with an unknown grayish-white substance. *The same unknown substance was encrusted inside the dishwasher on the: -Pipes. -Bolts and screws. -Door hook. -Drain basket. -Wash arms. -Rinse arms. -Rinse nozzles. *There was a piece of paper taped to the outside of the dishwasher which indicated: -The dishwasher was to be de-limed twice per week. -There were signatures next to the following dates: 1/27/23, 2/3/23, 2/17/23, and 2/24/23. *The inside of the ice machine was covered with an unknown black, gray, white, and orange substance that appeared to be mold and mildew. -The unknown substance was on the walls and in the ice tray. -There was moisture dripping down from the walls into the ice below. 2. Observation and interview on 2/27/23 at 4:14 p.m. with dietary assistants E and F about the ice and the ice machine revealed: *Dietary assistant F was filling mugs with water. -The water mugs were for the residents. -After he was finished with filling the mugs, he was going to deliver the water to the residents. -The mugs already had ice in them. -He confirmed he got the ice from the ice	F 812	Monitoring results will be reported by administrator, and/or designee to the QAPI committee and continues until the facility demonstrated sustained compliance then as determine by the committee and medical director.	

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F 812	Continued From page 2 machine. -That was the only ice machine in the facility. -The scoop was stored in the metal transport carts across from the ice machine. *Neither dietary assistant E nor F knew who was responsible for cleaning the ice machine. 3. Interview on 2/27/23 at 4:33 p.m. with Administrator A about the ice machine revealed: *The environmental services department oversaw cleaning and the maintenance of the ice machine. *Environmental services manager (ESM) G was not present during the survey due to illness. *Maintenance assistant H was in charge of fixing various things throughout the building, and ESM G was responsible for performing tasks on the preventative maintenance (PM) list. 4. Observation and interview on 2/28/23 at 2:54 p.m. with maintenance consultant I revealed: *He was in the kitchen cleaning the ice machine. *There were black chunks of an unknown substance falling from the walls of the ice machine as he was cleaning it. *He was called in every so often on a consultant basis to help with maintenance requests, and to train ESM G. *ESM G had started in December 2022. *Maintenance assistant H was not in charge of the PM list. *Cleaning the ice machine was on the PM list. *He did not know how often the ice machine was supposed to have been cleaned. -The online owner's manual was used as a reference on how to clean and maintain the ice machine. -He provided a printed version of the manual. *He said the state of the ice machine was unacceptable.	F 812		

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F 812	Continued From page 3 5. Interview on 2/28/23 at 3:14 p.m. with dietary manager D regarding the dishwasher and ice machine revealed: *She had implemented the de-liming checklist at the end of January 2023 because she had noticed the dishwasher was dirty. *There were several new hires within the past few months in the dietary department that could have used more training on how to clean the dishwasher. *She expected her staff to clean the dishwasher at the end of the night, and to de-lime the dishwasher twice per week. *She was unaware of the cleanliness issues identified in the ice machine. *ESM G oversaw cleaning and the maintenance of the ice machine. *While the ice machine was being cleaned, they purchased bagged ice for resident use. 6. Interview on 3/1/23 at 3:05 p.m. with administrator A regarding the dishwasher and ice machine revealed: *The maintenance department was ultimately responsible for cleaning and servicing the ice machine. *Due to staff turnover, the ice machine had not been cleaned or maintained for some time. *ESM G had just started employment in December 2022 and had not gotten to the PM list. *She had looked at the ice machine and shut it down immediately, then called maintenance consultant 1. *She was unaware of the cleanliness issues with the dishwasher. *She expected the dietary staff to clean the dishwasher daily. *Maintenance consultant I would occasionally	F 812		

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F 812	Continued From page 4 come in to service the dishwasher, but he was not responsible for cleaning the dishwasher. 7. Review of the manufacturer's instructions for cleaning and de-liming the dishwasher revealed: *The dishwasher should have been thoroughly cleaned at the end of each working shift or at least daily. *The manufacturer's instructions on how to de-lime the dishwasher indicated to use half a gallon of de-limer, however that was scratched off and a handwritten entry "1 [cup]" was added. *It was recommended to de-lime the dishwasher on the 1st and 15th of each month. 8. Review of the provider's "Semi-Annual Assignment Worksheet" revealed: *The assignment list included: -"C. Water filter on ice machine." *The last completion date for item C was 7/12/22, which was more than six months ago at the time of the survey. 9. Review of the 7/14/22 manufacturer's instructions for cleaning the ice machine revealed: *It was recommended to replace the water filter and deep clean the ice machine every six months. *Some facilities may need three or four deep cleanings per year depending on how much it is used. *"Cleaning commercial ice equipment involves more than wiping away the dirt and grime. Ice machines also must be descaled, disinfected, and sanitized to be considered truly clean." *"Descaling is the first step of the cleaning process and involves removing mineral deposits." *"Disinfecting is the process of using chemicals to	F 812		

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F 812	Continued From page 5 kill microorganisms like bacteria, viruses, and fungi." -"During this process, any remaining algae, mold or slime should be removed." *"Sanitizing uses a lower concentration of chemicals to drop the number of bacteria to federally recognized health standards." *A bleach solution of six ounces of bleach to one gallon of water was recommended for disinfecting the equipment. *A bleach solution of two teaspoons to one gallon of bleach was recommended for sanitizing the equipment. *While deep cleaning the ice machine, it was recommended to clean all food contact surfaces, including the bin interior, water reservoir, drop zone, and evaporator. *Cleaning the ice bin was the best way to keep the ice supply safe. *The main contaminants found in ice machines included algae, mold, and slime. 9. Review of the provider's May 2016 "Ice Machine Cleaning Sanitation" policy revealed: *"1. ...Bi-annual cleaning and sanitizing cycles completed by the maintenance department." *"2. On a daily basis, dietary staff will run the scoop and scoop tray through the dishwasher or wash with soap and water." *"3. Clean the area around the ice machine as often as necessary to maintain cleanliness and efficient operation." *"4. Sponge any dust and dirt off the outside of the ice machine with mild soap and water. Wipe dry with a clean, soft cloth." 10. Review of the provider's May 2016 "Ice Machine Interior Cleaning and Sanitation" policy revealed:	F 812		

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F 812	Continued From page 6 *Under the purpose section: -"To prevent the growth of microorganisms during the storage of ice and sanitation procedures are established to minimize the risk of contamination." -"Cleaning and sanitizing procedure performed every six months for efficient operation." *Under the procedure section: -"5. Mix a solution of cleaner and warm water (1 [gallon] of water to 16 ounces cleaner)." --"Use half of the cleaner/water solution to clean all components." --"The cleaner solution will foam when it contacts lime scale and mineral deposits; once foaming stops use a soft bristle brush, sponge or cloth to carefully clean parts." --"Soak the parts for 5 minutes (15-20 minutes for heavily scaled parts)." --"Rinse all components with clean water. --The policy did not specify what type of cleaner to use. -"7. Mix a solution of sanitizer and warm water (3 [gallons] of water to 2 ounces sanitizer)." --"Use half of the sanitizer/water solution to sanitize all removed parts. Do not rinse parts after sanitizing." --The policy did not specify what type of sanitizer to use. -"8. Use remaining sanitizer/water solution to sanitize all foodzone surfaces (evaporator plastic parts and bin) of the ice machine and bin. Do not rinse the sanitized areas." B. Based on observation, interview, and policy review, the provider failed to ensure one of two kitchen staff (dietary assistant E) had practiced appropriate hand hygiene and glove use during one of one meal service observations. Findings include:	F 812		

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F 812	Continued From page 7 1. Observation on 3/1/23 from 11:48 a.m. to 12:05 p.m. during lunch service with dietary assistant E and dietary prep cook (DPC) J revealed: *DPC J was getting the meal trays ready, while dietary assistant E was serving the meal. *The lunch menu included barbecued pulled pork on a bun, California vegetable blend, a hashbrown triangle, and a brownie. *Without performing hand hygiene, dietary assistant E put on a pair of clean single-use gloves. *She picked up a plate with her left gloved hand. *With her right gloved hand, she: -Picked up the bottom half of a bun and then placed it on the plate. -Touched a scoop to place the pork on the bun. -Picked up the top half of the bun then placed it on top of the pork. -Touched a scoop to serve the vegetables on the plate. -Touched a spatula to serve the hashbrown triangle on the plate. *She then placed the plate on a resident's meal tray. *With those same gloved hands, she grabbed two cloth hot pads and then took the pan of hashbrowns back to the oven area. -She grabbed a thermometer to measure the temperature of the hashbrowns. -She brought the pan of hashbrowns back to the serving line. *Without changing her gloves or performing hand hygiene, she continued to prepare plates of food by grabbing the plate with her left gloved hand and touching the buns with her potentially soiled right gloved hand. *Without changing her gloves or performing hand hygiene during the meal service, she also	F 812		

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F 812	Continued From page 8 touched potentially contaminated cupboard door handles, a tub of butter and a knife that had been sitting on the counter. *She continued to touch the buns with her potentially soiled gloved hands. -The buns were served to residents. Interview at that time with dietary aide E about her use of the same gloves throughout lunch service revealed: *She indicated she had been spoken to about her inappropriate glove use in the past. *She said, "I just can't get used to it," about using utensils instead of her gloved hands when serving ready-to-eat foods. 2. Interview on 3/1/23 at 12:06 p.m. with dietary manager D regarding the above lunch service observations revealed: *She was not surprised that dietary assistant E was using the same gloves throughout lunch service. *She had spoken to dietary assistant E in the past about her glove use during resident meal services. *Dietary manager D was new in her position and sometimes had a difficult time coaching the dietary employees who had been employed for many years. 3. Interview on 3/1/23 at 3:05 p.m. with administrator A regarding the above lunch service observations revealed: *She was aware that dietary assistant E tended to use the same gloves throughout the resident meal service. *She and dietary manager D had previously tried to address the issue with dietary assistant E but were unsuccessful.	F 812		

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F 812	Continued From page 9 -Dietary assistant E would comply with the appropraite glove use during the resident meal services for a day or two, and then go back to her old way. *Her expectation would have been for dietary employees to use utensils when serving ready-to-eat foods such as buns. Review of the provider's undated "Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices" policy revealed: *Policy Statement: "Food Services employees shall follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness." *Under the policy interpretation and implementation section: -"6. Employees must wash their hands:" --"4. Before coming in contact with any food services." --"6. After handling soiled equipment or utensils." --"7. During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks." --"8. After engaging in other activities that contaminate the hands." -"9. Food service employees will be trained in the proper use of utensils such as tongs, gloves, deli paper and spatulas as tools to prevent foodborne illness." -"10. Gloves are considered single-use items and must be discarded after completing the task for which they are used. The use of disposable gloves does not substitute for proper handwashing."	F 812		

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 2/27/23 through 3/1/23. Dells Nursing and Rehab Center inc was found in compliance.	E 000		

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

Carlyn Wenn | Administrator | 3/17/2023

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	435129	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	02/28/2023

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 2/28/23. 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 3/1/23. 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 K271, K343, and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
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: Based on observation and document review, the	K 241		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Calyn Weni
TITLE: Administrator
(X6) DATE: 3/17/2023

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K 241	Continued From page 1 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 2/28/23 at 10:10 a.m. revealed the basement had only one conforming exit 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 the condition 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 271 SS=D	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to provide a clear egress discharge path to the public way. One of seven exit discharge paths (basement level) was not cleared of snow. Findings include:	K 271	Exit discharge path cleared of snow. Maintenance director re-educated on clearing snow from all seven exit discharge paths. Maintenance director or designee will audit snow has been cleared from all seven discharge paths weekly for 4 weeks and monthly for 2 months. Maintenance director or designee will present finding from these audits at the monthly QAPI committee for review until the QAPI committee advises to discontinue monitoring.	4/20/2023 CW 3/17/23

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 _____	02/28/2023

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

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K 271	Continued From page 2 1. Observation on 2/28/23 at 10:10 a.m. revealed the basement discharge for the boiler and laundry area from the ship's ladder was not cleared of snow to the public way. Measuring revealed approximately four feet of snow at the discharge from the ship's ladder. Interview with the administrator at the time of the observation confirmed that condition. She noted the drift should have been cleared, as well as a path to the public way. The deficiency had the potential to affect 100% of the smoke compartment occupants.	K 271		
K 343 SS=E	Fire Alarm System - Notification CFR(s): NFPA 101 Fire Alarm - Notification 2012 EXISTING Positive alarm sequence in accordance with 9.6.3.4 are permitted in buildings protected throughout by a sprinkler system. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. 19.3.4.3, 19.3.4.3.1, 19.3.4.3.2, 9.6.4, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain notification from the fire alarm system as required and had not put a fire watch in place. Findings include: 1. Observation on 2/28/23 at 10:30 a.m. revealed	K 343	Issue has been corrected. Educated maintenance director and necessary staff of putting fire watch in place.	4/20/2023 CW 3/17/23

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K 343	Continued From page 3 the fire alarm system was alarming. The primary fire panel for the building was found alarming in the basement boiler room. The alarm panel revealed the trouble location was the activity room. The alarm panel recorded the alarm first occurred on 2/13/23 at 3:34 p.m. Interview with the administrator at the time of the observation confirmed those findings. She stated she had contacted the fire alarm company, but they had not corrected the issue. She was unaware she should have had a fire watch. The deficiency affected all occupants of the smoke compartment.	K 343		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review, the provider failed to conduct fire drills to ensure staff were familiar with the provider's fire drill procedures at least once per shift per quarter. Drill documentation did not include the location of the drill or verification of alarm transmission. Findings include:	K 712	Maintenance director has been re-educated for required number of fire drills, location documentation, and verification of alarm transmission. Administrator or designee will audit frequency per shift, location, and verification of alarm transmission monthly for 3 months. Administrator or designee will present finding from these audits at the monthly QAPI committee for review until the QAPI committee advises to discontinue monitoring.	4/20/2023 CW 3/17/23

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

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K 712	Continued From page 4 1. Document review was conducted on 2/28/23 at 1:00 p.m. Fire drill documentation for the past twelve months revealed drills were not performed in June, August, and September 2022 and in January 2023. The documentation did not include location for any drills, and did not include any verification of alarm transmission. No drills were performed during the overnight shift, and only two were performed during the first (day) shift. Interview with the administrator at the time of the observation confirmed those findings. She declined the opportunity to perform a drill since the maintenance supervisor was absent. The deficiency had the potential to affect 100% of the occupants of the building.	K 712		

South Dakota Department of Health

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/27/23 through 3/1/23. Dells Nursing and Rehab Inc was found not in compliance with the following requirements: S206 and S236.	S 000		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and. (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section. Additional personnel education shall be based on	S 206	The facility will review and revise an orientation program and all ongoing education programs for all employees which cover the 11 required subjects on an annual basis. Administrator and all staff responsible for hiring will be re-educated on the initial orientation and ongoing annual program. Administrator or designee will provide education to employees K, L, N, and O to ensure completion of the required annual training of the 11 subjects by 4/20/2023. All other employees will be re-educated for proper completion of the annual training of the 11 subjects. Administrator or designee will audit employee files to ensure the required training occurs for all staff weekly for 4 weeks and monthly for 2 months. Administrator or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	4/20/2023 CW 3/17/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Calyn Wenn — TITLE: Administrator — (X6) DATE: 3/17/2023

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S 206	Continued From page 1 facility identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel record review, interview, and policy review, the provider failed to ensure: *Two of five employees reviewed (dietary aide K and housekeeper L) had received orientation training for nine of the ten mandated topics relevant to their job (fire prevention and response, emergency procedures and preparedness, infection prevention and control, accident prevention and safety procedures, resident rights, confidentiality of resident information, incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms, care of residents with unique needs, and dining assistance and nutrition/hydration risks for residents). *One of five employees reviewed (certified nursing assistant N) had received orientation training for ten of the eleven mandated topics relevant to direct care staff (fire prevention and response, emergency procedures and preparedness, infection prevention and control, accident prevention and safety procedures, proper restraint use, resident rights, confidentiality of resident information, incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms, care of residents with unique needs, and dining assistance and nutrition/hydration risks for residents). *One of five employees reviewed (certified nursing assistant O) had received orientation training on abuse, neglect, misappropriation of resident property and funds, and mistreatment. Findings include: 1. Review of dietary aide K and housekeeper L's	S 206		

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S 206	Continued From page 2 employee file revealed: *Dietary aide K was hired on 6/6/22. *Housekeeper L was hired on 7/19/22. *There were no records for training on the following topics: -Fire prevention and response. -Emergency procedures and preparedness. -Infection prevention and control. -Accident prevention and safety procedures. -Resident rights. -Confidentiality of resident information. -Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms. -Care of residents with unique needs. -Dining assistance, nutrition risks, and hydration needs of residents. 2. Review of certified nursing assistant (CNA) N's employee file revealed: *She was hired on 5/31/22. *She had training about abuse, neglect, misappropriation of resident property and funds, and mistreatment; no other training topics were reflected. 3. Review of CNA O's employee file revealed she: *Was hired on 9/16/22. *Had training on all the required topics except for abuse, neglect, misappropriation of resident property and funds, and mistreatment. 4. Interview on 3/1/23 at 3:05 p.m. with administrator A about the employee files revealed: *She confirmed there were no records or documentation to show if dietary aide K, housekeeper L, CNA N, and CNA O had received the above-listed training topics. 5. Review of the provider's "New Employee	S 206		

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S 206	Continued From page 3 Checklist" revealed: *The director of nursing was responsible for providing the "In-service checklist." *The social services designee was responsible for training new employees on the "resident bill of rights." *Department-specific managers were responsible for "policies and procedures-location explained." 6. On 3/1/23, a personnel training and orientation policy was requested. The provider printed off the website page for: "Administrative Rules of South Dakota, 44:73:04:05, Personnel Training." No further policy or procedure was provided.	S 206		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a	S 236	Employees K, L, and N, medical files were reviewed and revised to reflect the correct tuberculin screening requirements. Unable to correct the noncompliance target date of 14 days of date hire. The tuberculosis policy will be reviews and revised as needed and all staff responsible for admissions will be re-education on the correct process for compliance by 4/20/2023. Business office manager or designee will audit area identified to ensure compliance for all new hires weekly for 4 weeks and monthly for two months. Business office manager or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	4/20/2023 CW 3/17/23

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S 236	Continued From page 4 previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel file review, interview, and policy review, the provider failed to ensure five of five employees reviewed (dietary aide K, housekeeper L, registered nurse M, certified nursing assistant N, and certified nursing assistant O) had received the two-step method for the Mantoux tuberculin (TB) skin test or TB screenings within 14 days of hire. Findings include: 1. Review of dietary aide K's personnel file revealed: *They were hired on 6/6/22. *There was no record of TB screening. 2. Review of housekeeper L's personnel file revealed: *They were hired on 7/19/22. *There was no record of any TB screening. 3. Review of registered nurse M's personnel file revealed: *She was hired on 5/25/22. *The two-step TB screen was completed about five months after hire. 4. Review of certified nursing assistant (CNA) N's personnel file revealed: *She was hired on 5/31/22. *There was no record of TB screening.	S 236		

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S 236	Continued From page 5 5. Review of CNA O's personnel file revealed: *She was hired on 9/16/22. *The two-step TB screen was completed about two months after hire. 6. Interview on 3/1/23 at 3:05 p.m. with administrator A about employee TB screening revealed: *She confirmed they did not have records of TB screening for dietary aide K, housekeeper L, and CNA N. *TB screening had fallen through the cracks with some of the new hires, and they were trying to update all employee TB screens. 7. Review of the provider's 7/1/21 "Employee TB testing" policy revealed: *Under the policy statement section: -"It is the policy of [facility name] that every new healthcare worker shall receive Quantiferon Gold testing to establish a baseline within 14 days of employment." -"If there are already two documented Mantoux skin tests or a negative quantiferon test completed within the 12 months prior to the date of employment, this shall be considered evidence of a completed TB test and no further testing will be initiated." *Under the procedure section: -"1. Upon hire, the human resources department will notify the Infection Control Nurse or designee that a new employee will be starting." -"2. As a secondary back-up, the Infection Control Nurse or designee will check ...each week to determine hire dates for any new employees that week." -"3. Each new hire will be given instructions to report to [company name] occupational medicine for new hire screening or to provide	S 236		

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S 236	Continued From page 6 documentation of previous negative test that is no older than 12 [months]." -"4. Human resources will notify the department supervisor for each new hire that does not get their test completed or provide documentation of a previous test in the required time frame."	S 236		