STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435029	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avera Rosebud Country Care Center	126 S Logan Ave Gregory, SD 57533

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure the resident's medication self-administration assessment was completed and a physician's order was obtained for one of one sampled resident (21) who was not assessed to determine her ability to safely self-administer her medications or had a physician's order to self-administer those medications.Findings include:1. Observation and interview on 5/19/26 at 1:32 p.m. in resident 21's room revealed she had a nebulizer machine (a device that converts liquid medication into an inhalable mist) on top of her nightstand. She stated she received three nebulizer treatments per day.2. Observation on 5/20/26 at 2:40 p.m. in resident 21's room revealed that she was sitting in her recliner holding the nebulizer mouthpiece in her mouth, and the nebulizer machine was running. No staff members were in her room or the hallway to monitor her nebulizer medication administration.3. Interview on 5/20/26 at 2:47 p.m. with registered nurse (RN) C regarding resident 21's self-administration of her nebulizer treatment revealed RN C stated, She's okay to give it to herself.4. Review of resident 21's electronic medical record (EMR) revealed she was admitted to the facility on [DATE]. Her diagnoses included shortness of breath, wheezing, and obstructive sleep apnea. Her 3/9/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. She had a 2/24/26 physician order for Ventolin (a fast-acting bronchodilator used to relax airway muscles) 2.5 milligrams to be administered via nebulizer at 7:00 a.m., 2:00 p.m., and 7:00 p.m.There was no medication self-administration assessment completed to determine whether she could safely self-administer her medications. There was no physician order that indicated resident 21 was able to self-administer the nebulizer medication.A copy of resident 21's medication self-administration assessment was requested, but none was provided during the survey.5. Interview on 5/21/26 at 11:20 a.m. with director of patient care services (DPCS) B revealed she expected a medication self-administration assessment and a physician order for resident 21 to be documented in the EMR. She expected the nursing staff to follow the provider's medication self-administration policy, and acknowledged that the policy was not followed.6. Review of the provider's October 2023 Medication Policy revealed that Nursing personnel will administer medications until the nurse completes the Self Administration intervention in the work list AND a provider order is obtained. Self-administration of medications or storage of medications will be allowed if the resident is physically and/or cognitively able to do so. The physician must write an order for each medication to be self-administered or stored bedside: right resident, right medication, right amount, right time, and right route.

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the provider failed to ensure that a current copy of the advance directive (a document that expresses a person's health care wishes if they become unable to speak for themselves) was included in the medical record for one of one sampled resident (14) after being admitted to the facility.Findings include:1. Review of resident 14's electronic medical record (EMR) revealed that he was admitted to the facility on [DATE]. There was no documentation indicating that any advance directive paperwork expressing his wishes regarding his code status (specifies the type of emergent treatment a person wishes to receive if their heart or breathing would stop) was completed upon admission. A copy of his living will was scanned into the EMR, but it did not address his resuscitation status. The banner area where the resident's code status was typically displayed read Resuscitation status not ordered. There was no physician order addressing his code status. 2. Interview on 5/20/26 at 2:47 p.m. with registered nurse (RN) C revealed that she identified a resident's code status by referring to a paper sheet posted at the nurses' station that listed the residents' code status. There were also color-coded stickers on the residents' paper charts, which indicated their code status, and that information was available in the residents' EMR. 3. Interview on 5/20/26 at 2:58 p.m. with certified nursing assistant (CNA) G revealed that she located a resident's code status by referring to a paper sheet posted at the nurses' station, and that the residents' code status was also listed in the CNA care plan (personalized plan that addresses a resident's care needs, goals, and interventions) book. 4. Review of the paper sheet posted at the nurses' station revealed that resident 14's code status was documented as do not resuscitate/do not intubate (DNR/DNI) (no life-sustaining measures if one's heart or breathing stops). 5. Review of resident 14's paper chart revealed there was a red sticker on the outside which indicated DNR/DNI. Inside his chart, there was a form titled Patient Evacuation Form, To go with patient, which included a box labeled Other Information or Directives. In that box Code Status Full Code was written. 6. Interview on 5/21/26 at 11:20 a.m. with DPCS B revealed that resident 14 was a full code because his medical power of attorney (POA, someone designated on a legal document to act on behalf of a resident) did not decide what they wanted the resident's code status to be. She acknowledged that his living will did not address his resuscitation status and that there was no physician order specifying his code status. She expected there to be a code status order for all the residents. She acknowledged that the paper sheet posted at the nurses' station and the form in resident 14's paper chart contained conflicting information, and that the discrepancy would be confusing for the staff if resident 14 needed life-saving measures. 7. Review of the provider's August 2024 Advance Directive Policy revealed When an advance directive is received, it will be incorporated into the patient's plan of care. Caregivers need to know the status of each patient's advance directive to communicate and advocate for the patient's wishes and rights concerning life-prolonging health care decisions. At the time of admission, all patients, age [AGE] or older. will be assessed regarding advance directives as set forth in this policy. During the admission assessment, admitting personnel will ask patients whether they have an advanced directive. The patient's response is to be documented on the assessment form.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interview, the provider failed to ensure the Notice of Medicare Non-Coverage (NOMNC) was provided for two of two sampled residents (19 and 21) who's Medicare-covered services were ending, still had remaining Medicare benefit days, and remained in the facility.Findings included:1.Review of resident 19's Center for Medicare and Medicaid Services (CMS) Skilled Nursing Facility (SNF) Beneficiary Notification Review form provided by social worker designee (SWD) J revealed that resident 19's Medicare Part A Skilled Services Episode start date was 10/28/25. Resident 19's last covered day of Part A was 12/31/25. He was not given the NOMNC (notice that informs residents that their Medicare-covered services are ending on a specific date and explains their right to request an appeal)and he remained in the facility. 2. Review of resident 21's CMS SNF Beneficiary Notification Review form provided by SWD J revealed that resident 21's Medicare Part A Skilled Services Episode start day was 12/9/25. Resident 20's last covered day of Part A was 1/15/26. She was not given the NOMNC and she remained in the facility. 3. Interview on 5/20/26 at 11:06 a.m. with SWD J regarding Medicare non-coverage notices revealed he was unaware that resident 19 and 21 should have been provided a NOMNC form. SWD J was hired on 9/11/23. 4. Interview on 5/20/26 at 3:40 pm. with social worker consultant (SWC) K revealed that she met with SWD J quarterly to review resident items. SWC K's focus was on resident discharge planning when residents would leave the facility. She did not discuss with SWD J when to provide the NOMNC forms to the residents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure infection control practices were followed for the cleaning of nebulizers (a device that converts liquid medication into an inhalable mist) for two of two sampled residents (8 and 21). 1. Observation and interview on 5/19/26 at 1:32 p.m. of resident 21 in her room revealed there was a nebulizer machine on top of her nightstand that had the tubing and mouthpiece connected to it, and the medication reservoir (the clear container that holds the liquid medication) appeared wet. The mouthpiece was lying directly on the nightstand, uncovered. She stated she received three nebulizer treatments a day and that the staff sometimes disconnected her nebulizer to clean it. When the staff came to administer her treatment, they usually took the medication reservoir to the bathroom and rinsed it out before giving her the treatment. 2. Review of resident 21's electronic medical record (EMR) revealed she was admitted to the facility on [DATE]. Her diagnoses included shortness of breath, wheezing, and obstructive sleep apnea. Her 3/9/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. She had a 2/24/26 physician order for Ventolin (a fast-acting bronchodilator used to relax airway muscles) 2.5 milligrams to be administered via nebulizer at 7:00 a.m., 2:00 p.m., and 7:00 p.m. 3. Interview on 5/20/26 at 2:47 p.m. with registered nurse (RN) C revealed that her nebulizer cleaning process was to disassemble the resident's nebulizer after each treatment, clean the components, and leave them to dry on a barrier. She confirmed that the mouthpiece and medication reservoir should be cleaned and left to dry after each nebulizer treatment. 4. Observation and interview on 5/19/26 at 1:49 p.m. with resident 8 in his room revealed was a nebulizer machine with an attached mouthpiece lying on his bedside table. The medication reservoir appeared to have multiple small wet spots on the inside of the reservoir. Resident 8 stated he received two nebulizer treatments a day. The staff would clean the nebulizer components but he was unsure how often they cleaned it during the day. 5. Review of resident 8's EMR revealed he admitted to the facility on [DATE]. His 8/12/25 BIMS assessment score was 9, which indicated his cognition was moderately impaired. His diagnosis included chronic obstructive pulmonary disease (COPD). He had a 8/14/25 physicians order, arformoterol neb [nebulizer] [Brovana] 15 mcg [microgram]. There was no documentation that the staff had cleaned his nebulizer after each treatment. 6. Observation on 5/20/26 at 10:35 a.m. in resident 8's room revealed that the nebulizer with the attached mouthpiece was lying on resident 8's bedside table. The medication reservoir had appeared to have multiple small wet spots and a mist film on the inside portion of the reservoir. 7. Interview on 5/20/26 with RN C in resident 8's room regarding the cleaning of the nebulizer components revealed that she had forgotten to come back to resident 8's room and clean the nebulizer components after his treatment that morning. After each use the mouthpiece, extender and the medication reservoir should be cleaned. The nebulizers components should be cleaned with soap and water once a day. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. Interview on 5/20/26 with director-patient care services (DPCS) B regarding cleaning of resident 8's nebulizer components revealed she expected the staff to follow the provider's policy and to wash the nebulizer components after each treatment. After the last nebulizer treatment of the day the nebulizer components should be cleaned with soap and water. 9. Review of the provider's updated May 2026 Nebulizers policy revealed: a. Nebulizers components (mask, mouthpiece, and reservoir) will be rinsed in clean running tap water. Do not let components touch the sink. Place components on a clean towel and cover with a clean paper towel after each treatment. Change towels after each treatment. Once every 24 hours wash all components with dish soap and water, rinse, and allow to air dry on and under clean paper towels.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure urinary catheter (flexible tubing inserted into the bladder to drain urine) bags were cleaned and stored in a manner to prevent contamination and potential infection to one of one sampled resident (31) whose urinary catheter bag was stored in his bathroom shower without the catheter tubing connector (that attaches to the resident's indwelling catheter) capped. Findings include:1. Observation on 5/19/26 at 1:58 p.m. in resident 31's bathroom revealed there was a toilet without a lid next to a shower stall with a half-opened plastic shower curtain. Inside the shower stall, there was a bench attached to the shower wall that had a towel with a urinary catheter bag placed on it. The shower stall had a handrail attached to the wall with another urinary catheter bag hanging on that handrail. Neither of the catheter bags were labeled with the date that they were last used, or had a cover over the catheter tubing connector. There was a plastic container with a plastic syringe in it next to the urinary catheter bag on the bench. That syringe had a date of 1/19/26 written on it. 2. Observation on 5/20/26 at 11:06 a.m. in resident 31's bathroom revealed the same two urinary catheter bags in the same position; one was on the handrail, and one was on the shower bench. 3. Review of resident 31's electronic medical record (EMR) revealed that he admitted to the facility on [DATE] and had a Brief Interview for Mental Status (BIMS) score of 15, indicating that his cognition was intact. His diagnoses included a kidney transplant (replacing a failed kidney with a healthy one), chronic kidney disease (a long-term, progressive loss of kidney function), and urinary retention (the inability to empty the bladder) requiring a urinary catheter. His care plan had a focus area of [urinary] catheter use with interventions for the staff to change that urinary catheter monthly and to clean his urinary catheter and measuring devices per facility policy. 4. Interview on 5/20/26 at 1:36 p.m. with certified nursing assistants (CNA) E and G revealed that the CNAs were expected to clean the urinary catheter bags using a syringe filled with a vinegar mixture. They were expected to change the syringes once per week and label those syringes with the date, and the resident's name and room number. After the CNAs cleaned the bags, they were expected to place a cap over the open end of the tubing and store it in a clean area. They only had to clean the urinary catheter bags after it was used by the residents. 5. Interview on 5/20/26 at 4:49 p.m. with CNA D revealed that none of the current residents with urinary catheters regularly switched between day and night urinary catheter bags. She indicated that resident 31 only switched from his regular catheter bag to a larger catheter bag when he left the facility for medical appointments. 6. Interview and policy review on 5/21/26 at 9:55 a.m. with registered nurse (RN) F revealed that she was the infection preventionist for the facility. She expected urinary catheter bags to be cleansed, drained, and for the staff to place a cap over the end of the tubing of the urinary catheter bag to keep that bag clean. She agreed that if a urinary catheter bag did not have a cap over the tubing, and the bag was hanging next to a toilet, then that bag would be considered contaminated. RN F expected the syringe that was used to clean the urinary catheter bags to be changed weekly, and acknowledged this expectation was not clearly stated in the facility's policies. She indicated that resident 31 only changed his urinary catheter bags when he left the facility for a medical appointment. 7. Interview and policy review on 5/21/26 at 11:11 a.m. with director of patient care services (DPCS) B revealed that she considered a urinary catheter bag without a tubing cap that was stored next to a resident's toilet to be contaminated. She acknowledged that the policy regarding cleaning urinary catheter equipment did not identify when the syringe used to clean the urinary catheter tubing or the urinary catheter bag should be changed to a new one, and who was expected to perform those tasks. 8. Interview and EMR review on 5/21/26 at 11:28 p.m. with support specialist H regarding resident 31 confirmed that the last time he left the facility was on 5/19/26 for an appointment with his primary care physician. 9. Review of the provider's April 2023 Care of Indwelling Urinary Catheters and Drainage Systems policy revealed that (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	if a resident switched from a overnight urinary catheter bag to a urinary catheter leg bag during the day, the staff were expected to ensure both of the urinary catheter bags were cleansed once every 24 hours. After cleansing the bag, the staff were to hang the bag to dry and do not allow the outlet valve to touch anything including your hands as it could become infected.