STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435037	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clarkson Health Care	1015 MT View Rd Rapid City, SD 57702

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) complaint report, record review, observation, interview, and policy review, the provider failed to monitor and implement resident-centered pressure ulcer (skin and/or underlying tissue injury due to prolonged pressure) healing and prevention interventions for one of one sampled resident (1) who was identified at risk for developing pressure ulcers and developed an unstageable (wound bed not visible due to covering, such as debris, dead tissue, scabbing, or a non-removable dressing) pressure ulcer to her coccyx (tailbone) area and required surgical debridement, and one of one sampled resident (2) who was admitted to the facility with two stage II (2; open wound or blister with partial-thickness skin loss) pressure ulcers on her left buttocks and developed two additional stage II pressure ulcers to her left buttocks. Findings include:1. Review of the 3/4/26 SD DOH anonymous complaint report revealed that resident 1 was admitted to the facility on [DATE] and did not have any skin conditions. She was walking with the assistance of two staff members and used a stand aid lift (a mechanical lift used to assist from a seated to a standing position). A pressure injury was identified on her coccyx area on 1/18/26. She developed a fever and was transferred to the emergency room on 2/11/26 for a suspected infection to that coccyx wound. Resident 1 had surgical debridement to her wound, which then required a wound vac (a portable medical device that uses suction to accelerate healing) treatment. The complaint outlined concern that the resident was not being repositioned in bed frequently enough, which led to the development of a pressure ulcer. 2. Review of resident 1's electronic medical record (EMR) revealed she was admitted to the facility on [DATE]. She had a diagnosis of cerebral infarction (a type of stroke caused by a blockage in blood vessels supplying the brain, resulting in tissue death due to the lack of oxygen) with hemiplegia (a form of paralysis causing total or partial loss of motor function on one side of the body) affecting the right side of her body. A nurse assessed her skin when resident 1 was admitted to the facility and documented in a progress note that resident 1's sacral and coccyx areas were both pink and blanchable (a red area that turns white or pale when pressed, then returns to its original color, indicating temporary constriction of blood vessels). Resident 1 had a 1/18/26 nursing note written by registered nurse (RN) E that indicted she had two non-blanchable (an area that does not turn pale or white when pressed on indicating there was blood leaking from vessels under the skin) suspected deep tissue pressure injuries (SDTI; a form of pressure injury characterized by localized damage to the underlying soft tissue while the skin is still intact) to her coccyx. The first site measured 17 centimeters (cm; length) x 25 cm (width) and the second site measured 8 cm x 7 cm. The area was dark maroon color, slightly boggy [skin tissue with a soft, spongy, or mushy texture usually indicating underlying tissue damage]. RN E initiated a repositioning schedule for resident 1 to be repositioned every 2 hours, and updated resident 1's power of attorney (POA; someone designated on a legal document to act on behalf of a resident), and physician. RN E documented both wounds as pressure ulcers. Resident 1's medication administration record (MAR) included applying a mepilex (a silicone foam dressing) to resident 1's coccyx and to change that dressing as needed ordered on 1/18/26. On 1/20/26 the mepilex order was updated to change the dressing on Tuesdays and Fridays, and to assess for signs/symptoms of infection, IE [such as]: (continued on next page)

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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F 0686 Level of Harm - Actual harm Residents Affected - Few	redness, warmth, odor, pain, and drainage, and document as needed. A physician's order to initiate repositioning every 2 hours for offloading (to lessen pressure) was added to resident 1's MAR on 1/23/26. On 1/26/26, RN F assessed resident 1's wound and noted in a skin assessment progress note that the stage cannot be confirmed because it is obscured by 100% black, dry, firmly adherent eschar [a thick, dry, leathery layer of dead, necrotic tissue that forms over severe skin wounds], measuring approximately 8 cm x 3 cm. RN F consulted with the provider's contracted wound specialist and the resident's physician, and resident 1 received a physician's order to apply medihoney (a medical-grade, sterilized honey used to treat wounds and burns) to the wound, cover it with a dry gauze dressing, and change the dressing daily. On 2/11/26 at 6:40 p.m. a nursing note indicated resident 1 had developed a fever of 100.7 degrees F (Fahrenheit). She was sent to the emergency room for that fever to determine if the cause was her coccyx wound. She was admitted to the hospital on [DATE], had surgery for debridement of her coccyx wound, and a wound vac was placed on her coccyx wound for treatment. Nursing progress notes indicate that resident 1 was discharged from the hospital and returned to the facility on 2/20/26. On 3/4/26 she received physician's orders for comfort care (a specialized medical approach focused on relieving pain, symptoms, and stress for patients with serious, terminal illness), and resident 1 passed away on 3/5/26. Her physical therapy evaluation on 1/8/26 indicated resident 1 was able to transfer with the assistance of two staff members and a stand aid lift. The occupational therapy notes from 1/8/26 indicated that resident 1 required a mechanical lift sling for completion of all ADLs [activities of daily living] for positioning. Donned [put on] sling to promote posture and positioning. Occupational notes indicated that she required verbal cues for repositioning. Her 2/11/26 physical therapy note indicated that she used a stand aid lift well and was able to stand for longer periods when the physical therapist supported her right upper extremity. Her right arm and right leg remained flaccid and physical therapy had to assist with passive range of motion (moving a joint through its range without muscle contraction from the resident) exercises for that arm and leg. Resident 1's 1/5/26 baseline care plan (a personalized plan that addresses a resident's care needs, goals, and interventions) included a problem area, I have potential for pressure ulcers related to immobility, incontinence [involuntary urine or bowel leakage], dx [diagnosis] of CVA [cerebral infarction] with hemiparesis/hemiplegia affecting the right side. The interventions listed for this problem area included please complete a Braden assessment on me per facility protocol, please monitor my skin daily during cares and bathing, and report any changes to my nurse, and I have a pressure reducing device, pressure redistributing mattress, and [a] wheelchair cushion. Resident 1's care plan remained the same from her admission to the facility on 1/5/26, to 1/18/26 when the coccyx wound was first identified, to 2/11/26 when the resident was admitted to the hospital and required surgical debridement of her coccyx wound. Resident 1 had a 1/6/26 Braden score (a tool used to assess the risk of developing pressure ulcers) of 14, which indicated that she had a moderate risk of developing pressure ulcers. She had a 1/7/26 physician's order to complete her Braden assessment every week for the first four weeks at the facility. Her second Braden assessment score on 1/13/26 was 15, her third Braden assessment score on 1/20/26 was 16, and her fourth Braden assessment score on 1/27/26 was 15. These scores indicated that resident 1 continued to have a moderate risk of developing pressure ulcers during her first four weeks at the facility. Resident 1's 2/20/26 hospital discharge summary indicated that she was admitted on [DATE] for evaluation of fever and concern for sepsis (a life-threatening emergency in response to an infection) in the setting of a worsening sacral wound. The physician summarized that in the emergency room, resident 1 has laboratory results that revealed evidence of systemic inflammation. A magnetic resonance imaging (MRI; a non-invasice medical imaging technique that created a detailed image of soft tissues, organs, and bones) was performed on 2/12/26 and the results did reveal surrounding cellulitis [a bacterial infection causing red, hot, swollen, and painful skin] and mild reactive edema [excessive fluid buildup caused by an underlying condition] in the coccyx. Surgical services were consulted and she had (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	debridement (the medical removal of dead, damaged, or infected tissue from a wound to promote healing and prevent infection) of her wound on 2/14/26. On She had a bone biopsy (a surgical procedure that removes a small sample of bone tissue to diagnose disease) performed during her surgery that showed multiple bacteria, including Pseudomonas, E. Coli, and Enterococcus. 3. Review of resident 2's EMR revealed that she was admitted to the facility on [DATE]. Her 3/25/26 nursing admission note written by RN G indicated that resident 2 had two stage II pressure ulcers to her left buttock, one measuring 0.5 cm x 0.5 cm and the other measured 3 cm x 5 cm. A 3/28/26 nursing progress note written by RN H indicated that resident 2 had two new open wounds to the left buttock. One was to the outer left buttock and one to the upper left buttock. They both measured 1 cm x 0.5 cm and were labeled as pressure injuries. Resident 2's 3/24/26 care plan indicated that she had a problem area I have potential for pressure ulcers related to immobility, incontinence, and diagnosis of neuropathy (nerve damage often causing numbness, tingling, muscle weakness, and pain typically in the hands and feet). The interventions listed for this problem area included please complete a Braden assessment on me per facility protocol, please monitor my skin daily during cares and bathing, and report any changes to my nurse, and I have a pressure reducing device, pressure redistributing mattress, and [a] wheelchair cushion. She had a problem area on her care plan that listed out her current skin conditions, including pressure injury to right buttocks - stage III (3; open wound with full-thickness skin loss) and pressure injury to left buttock - stage III The approaches for this intervention included please turn and reposition me as appropriate, please assess and document on the condition of my ulcer per facility protocol, and please treat my ulcer per facility protocol. Further review of resident 2's EMR showed no further documented wound measurements or characteristics (measurements, color, drainage, odor,) after the 3/28/26 documentation. 4. Interview on 4/14/26 at 4:10 p.m. with LPN I revealed that the residents received a bath two times a week. The bath aide was responsible for monitoring the resident's skin and would notify a nurse of a skin concern that the bath aide might have seen. LPN I stated that if a resident was admitted to the facility and had a pressure injury, then that resident would be provided with a pressure redistributing mattress. She was not sure who updated the care plan or ordered the specialty mattress. 5. Interview on 4/15/26 at 7:52 a.m. with certified nurse aide (CNA) C and CNA D revealed that the CNAs were responsible for repositioning the residents on the hallways that the CNAs were assigned to. If a resident was on a repositioning schedule, then that information would be provided to the next CNA during their change of shift report. The facility utilized a paper sheet for the CNAs to refer to that had resident information such as the residents' room number, if the resident needed their bed linen changed, a bath, when they took a nap, and special considerations regarding their care on a particular day. Those paper sheets were updated daily by the night shift staff. CNA C and D would write on their paper sheet if a resident was on a repositioning schedule, including the last time that they were repositioned. At the end of their shift, they would document a checkmark on the reposition Q2 [every two hours] task in the resident's EMRs and then the CNAs would shred that paper with resident information on it. CNA C and D stated that they were unable to document every individual time they repositioned the residents in the EMR or MAR. 6. Interview on 4/16/26 at 7:52 a.m. with director of nursing (DON) B and RN F revealed RN F was the skin nurse. The direct care staff were expected to fill out an incident report and checklist when a resident's wound was discovered. The resident's RN was expected to notify the resident's physician, document the wound in their care plan, and indicate the interventions from the physician in that residents MAR. All residents have a bath at least once per week and have their skin checked by the bath aide at that time. If there were concerns with the resident's skin, the bath aide was expected to call a nurse into the shower room so they could perform a skin assessment. There were several different bed options for the residents. The bed option that was chosen for a resident depended on the stage of the resident's pressure ulcer. The facility had beds that could accommodate up to a stage IV (4; open wound with full-thickness skin loss. Bone, tendon, or muscle may be visible) pressure ulcer. When a resident was placed on a specialty mattress, it was expected to be (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	documented in that resident's care plan. The CNA's were expected to document the two hour turns/repositioning in the resident's EMR, and the nurse was expected to document if a resident refused or was unable to be repositioned. 7. Interview on 4/16/26 at 1:33 p.m. with DON B revealed that when a resident was bathed, the bath aide was expected to notify the RN so they could assess the new skin concern. The RN would then relay this information to RN F to assess the wound, help develop a treatment plan, contact the resident's physician to receive orders to treat that wound, and update the resident's care plan. DON B acknowledged that any nurse could document a resident's wound, and it was not just the responsibility of the skin nurse. DON B expected the staff to be repositioning residents who were at risk for developing pressure ulcers. She was not aware that CNAs were only able to document one checkmark per shift on the resident's EMR to indicate the resident was repositioned. DON B acknowledged that the residents who were admitted with a risk for developing pressure ulcers had the same interventions in their care plans. DON B stated that if skin concerns were found during the resident's admission, then she expected the resident's care plans to reflect those concerns. She acknowledged that documenting a dressing change was not the same as documenting an assessment of a wound. She stated that the nurses were not expected to document a full wound assessment when they performed the dressing changes throughout the week, and that there was not a process for the completion of resident wound assessments. DON B did not know how resident 1 developed an unstageable pressure ulcer when she was able to stand and walk with the assistance of two staff members and worked with physical and occupational therapy. She would have expected resident 2's EMR to have weekly wound assessments and she would have expected the care plan to be updated if more pressure injuries were found at the facility. 8. Review of the provider's 6/17/15 Skin Care/Pressure Ulcer policy revealed that all residents were considered at risk upon admission. Some of the listed interventions in the policy for all residents included a pressure reducing mattress, a full-body skin assessment, a review by the registered dietician, incontinence products if applicable, interventions addressed on the care plan as appropriate, and interventions to be implemented based on the resident/responsible party's choice. The policy indicated that the assessment of pressure ulcers included the type of ulcer (pressure or non-pressure), the ulcer's stage, characteristics, progress toward healing and potential complications, if an infection was present, pain, dressings or treatments, and if there wass no improvement in two to three weeks, then the physician would be notified. Weekly pressure ulcer documentation should also include location, stage, size, undermining [a complication where tissue destruction occurs under the skin at the wound edges creating a pocket] /tunneling [a narrow passageway of skin destruction from the wound bed into surrounding tissue or muscle], wound bed color, drainage, peri-wound tissue (color, temp, bogginess, fluctuation) and any need for debridement or presence of odor.