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	07/24/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Number of residents sampled:Number of residents cited:Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (30) observed self-administering a nebulizer (device that converts liquid medication into an inhaled mist) treatment in his room, was assessed for the ability to safely self-administer medications according to the provider's policy.Findings include: 1. Observation and interview on 7/23/25 at 8:52 a.m. of a medication pass with licensed practical nurse (LPN) I revealed:*LPN I assembled resident 30's medications taken by mouth, his inhaler, and nebulizer solutions from the Elm/Oak medication cart in the Oak common area.*She brought the medications and supplies to resident 30's room.*Resident 30 was administered his pills and his inhaler.*LPN I put two nebulizer solutions, ipratropium bromide (a medication used to open the airway of people with lung disease), and levalbuterol (a medication for wheezing and shortness of breath) into resident 30's nebulizer administration device, placed the mask on resident 30's face and turned on the nebulizer.*LPN I told resident 30 she would set a timer to remind her to return and take off his nebulizer mask and left the resident's room.*LPN I stated there were not any residents in the facility who self-administered medications.*She confirmed by leaving resident 30 after setting his nebulizer treatment up for administration he was self-administering the medication.*She would not be able to verify resident 30 was administered all of the medication in the nebulizer device because she had not remained in the room while he was taking the nebulizer.*She did not know if resident 30 had a completed assessment for the ability to safely self-administer his nebulizer medications. 2. Review of resident 30's electronic medical record (EMR) revealed:*His 6/5/25 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated he was cognitively intact.*He had a diagnosis of chronic obstructive pulmonary disease (a group of lung diseases that block airflow and can make it difficult to breathe).*A 7/1/25 physician's order for Ipratropium bromide 0.02% solution for inhalation [generic]; [physician's name]: Inhale 2. 5 ml [milliliters] (0.5 mg [milligrams] total) by nebulization Three Times a Day, and Levalbuterol 1.25mg / 3ml solution for nebulization [generic]; (physician's name): 3 ml (1.25 mg total) by nebulization Three Times a Day.*There was no physician's order for him to self-administer the nebulizer medications.*There was no self-administration of medications assessment completed.*Self-administration of medications was not included in resident 30's 7/23/25 care plan. 3. Interview on 7/23/25 at 3:25 p.m. with resident 30 revealed:*Nursing staff would usually set up his nebulizer medications for administration, leave his room while the nebulizer was being administered, and then return after the nebulizer was complete to clean the nebulizer mask.*He was comfortable self-administering his nebulizer medications. 4. Interview on 7/23/25 at 3:27 p.m. with director of nursing (DON) B revealed resident 30 had not had a self-administration of medications assessment completed. 5. Interview on 7/24/25 at 12:45 p.m. with administrator A and DON B revealed:*No residents in the facility had been assessed to safely self-administer medications.*DON B expected LPN I would have remained in resident 30's room to monitor the administration of the nebulizer medication, if he was not assessed to safely administer them.*She confirmed by LPN I not remaining in resident 30's room during the administration of the nebulizer, resident 30 was self-administering his nebulizer medication. Review of the provider's 10/8/12 Medication Self-Administration policy revealed:* An individual Resident may self-administer drugs if the interdisciplinary team (IDT) has determined that this is a safe practice.* If a resident requests to self-administer drugs, the IDT is responsible for determining if it is safe for the Resident to do so before the Resident may do so.* Documentation of the self-administration plan should be done in the Resident's care plan.* The facility may require that drugs be administered by the nurse of medication aide until the IDT has had an opportunity to obtain information necessary to assess the Resident's ability to self-administer drugs. ,

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:Number of residents cited:Based on observation, interview, record review, and policy review, the provider failed to ensure: *Medication labels matched the current physician orders for one of one randomly observed resident (28) according to the provider's policy. Findings include: *Medications with shortened expiration dates [medications that, after opening, expire prior to the manufacturer's expiration date] were labeled properly and disposed of after having outdated for one random resident (18) in one of two medication carts, (Maple/Aspen cart) and a provider stock medication in one of one medication room. 1. Observation and interview on [DATE] at 8:21 a.m. with certified medication aide (CMA) N during medication pass revealed:*Resident 28's artificial tears eye drops (medication for dry eyes) medication administration order (MAR) read, Artificial Tears (dextran 70- hypromellose) eye drops (Dextran 70-hypromellose) - 1 drop Opthalmic [related to the eye] Four Times a Day, and the pharmacy medication label read one drop to both eyes four times per day as needed.-The MAR did not indicate which eye the artificial tears eye drops were to be administered into.-The MAR order indicated the artificial tears were scheduled to be administered four times per day while the pharmacy label indicated the artificial tears were to be administered four times a day as needed.*CMA N indicated she gave the artificial tears in both of resident 28's eyes because resident 28 had always told her to put it in both of her eyes.*CMA N verified there was no direction on the MAR to indicate which eye the artificial tears were to be administered into, and the directions on the pharmacy label and in the MAR did not match.*RN clinical care coordinator F asked resident 28 which eye she was to receive the artificial tears into and resident 28 stated she received in both of her eyes. Interview and record review on [DATE] at 8:30 a.m. with registered nurse (RN) clinical care coordinator F revealed:*She verified the artificial tears order on resident 28's MAR did not indicate which eye the drops were to be administered into and the MAR instructions for administration did not match the pharmacy label instructions.*She verified the pharmacy label should have reflected the accurate administration instructions in order to complete the medication administration checks prior to administration of a resident's medication.*RN clinical care coordinator F retrieved the original physician's order for the administration of the resident's artificial tears, which indicated the artificial tears were to be administered into both eyes four times daily. Interview on [DATE] at 9:23 a.m. with CMA N revealed:*She had been a CMA at this facility for about one month.*She was a CMA prior to beginning her CMA position at this facility.*She had not noticed resident 28's MAR did not include which eye the artificial tears were to be administered into because she trusted the training she was provided by the nurses, and that was to administer resident 28's artificial tears into both eyes. -Additionally resident 28 had always told her that she received the artificial tears in both eyes.*If she would have noticed resident 28's MAR for artificial tears did not contain which eye the medication was to be administered into she would have asked the nurse to clarify the order. 2. Observation and interview on [DATE] at 10:40 a.m. of the medication room with RN clinical care coordinator F revealed:*Inside the refrigerator in the medication room was an opened vial of tuberculin solution (an injectable medication used to test for tuberculosis).*There was no date documented on the vial or the box the tuberculin solution was stored in to indicate when the vial was opened or when it use-by date after opening.*RN clinical care coordinator verified the tuberculin solution was open, and did not contain a date to indicate when it was opened or when it expired.*She stated the tuberculin solution was to be destroyed 30 days after the vial was opened, but she was unable to determine when the 30 days would have been because there was no date to indicate when the vial was opened.*She stated the tuberculin solution was used last week to test one staff member that was unable to have his blood drawn for the Gold test (a laboratory test for tuberculosis) that the facility routinely used. 3. Observation and interview on [DATE] at 11:40 a.m. of the Maple/Aspen medication cart with licensed practical nurse (LPN) K revealed:*Resident 18's latanoprost (medication used to treat increased pressure in the eye) eye drops were documented as opened on [DATE] and did not have an used-by date after opening identified on the bottle or box the eye drops were stored in.*LPN K confirmed that resident 18's latanoprost contained an opened date of [DATE], and that there was not an used-by date after opening indicated on the bottle or box that contained the bottle of latanoprost.*She was not sure how long latanoprost was able to be used for after opening before it needed to be destroyed.*She indicated there was a reference related to medications with shortened expiration dates in the narcotic binder on each medication cart.*The narcotic binder for the Maple/Aspen cart was not on the medication cart at that time for her to

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:Number of residents cited:Based on observation, interview, and manufacturer's manual review, the provider failed to assess the safety for one of one sampled resident's (10) side rail to be sure it was fastened securely to the bed and for possible risk of entrapment. Findings include: 1. Observation and interview on 7/22/24 at 2:47 p.m. with resident 10 in his room revealed:*He had a black upside-down U-shaped side rail on the left side of his bed.*It was located about halfway between the foot and the head of his bed.*The D shaped opening at the top of the side rail measured eight inches wide by four and a quarter inch high.*He stated he used the side rail to reposition himself while he was in bed.*He had been educated on how to use the side rail by staff.*He had an electronically adjustable bed. 2. Review of resident 10's electronic medical record revealed:*He was admitted on [DATE].*His 5/8/25 Brief Interview for Mental Score (BIMS) assessment score was 14, which indicated he was cognitively intact.*His 7/23/25 care plan indicated:- I require assistance with my ADL's [activities of daily living] related to a history of falls, physical limitations, depression, incontinence, and antidepressant use.- I use a bed cane [side rail] to reposition in bed.*The 4/22/25 Negotiated Risk-Side Rail assessment reflected, Update maintenance to install the side rail device. Maintenance installs side rails per manufacturer guideline and compatible with bed/mattress. Maintenance will complete quarterly checks of the side rail for ongoing appropriate installation and secure fit. Maintenance will be advised if side rails need to be removed, if the become loose, or if there are any other apparent concerns with physical installation of the device. 3. Interview on 7/23/25 at 12:03 p.m. with director of nursing (DON) B revealed:*The provider did not have a policy related to side rails.*She referred to the provider's 8/13/12 Restraint policy when the provider's side rail policy was requested. 4. Continued observation and interview on 7/23/25 at 12:20 p.m. with resident 10 in his room.*He had chosen and purchased the side rail, that his son-in-law installed on the.*The side rail had been on his bed for about four to five months.*To get out of bed he would use the side rail to lean his back against, then he pulled himself forward to the other side of the bed.*At times he would push against the side rail while he was seated on the bed to get out of bed.*The side rail could be moved towards the foot and the head of the bed.*Resident 10 stated that at times the strap that secured the side rail to the bed would loosen, as it was at that time, which made it possible to move the side rail around on the bed. 5. Interview on 7/23/25 at 3:27 p.m. with physical therapist H revealed:*Resident 10 was currently working with physical therapy due to an increased number of falls.*Resident 10 was independent with getting in and out of bed.*She had not witnessed how resident 10 used the side rail to get in and out of bed.*She was not aware of where the side rail was attached to the bed, that it was loose, or how resident used the side rail.*He had been educated by therapy to use the head of the bed adjustments to assist himself into a seated position in the bed to make the transfers out of bed easier for him.*The therapy department had not completed an assessment on resident 10 for entrapment risks or his side rail. 6. Interview on 7/23/25 at 4:20 p.m. with certified medication aide (CMA) O revealed:*Resident 10 used the side rail to get in and out of bed by pulling on the side rail to sit himself up.*He was independent with getting in and out of bed.*She had not noticed resident 10's side rail being loose.*If she had noticed it was loose she would notify maintenance to have it secured.*She was aware of the risks of entrapment related to side rail use but did not feel resident 10 was at risk related to his side rail.*She indicated it was the provider's protocol to have a resident or resident's representative sign a release of liability if they requested the use of a side rail. 7. Interview on 7/23/25 at 3:27 p.m. with plant manager E revealed:*He oversaw maintenance for the facility.*The therapy department was responsible for the installation of bed rails. *Resident 10 had purchased his own bed rail on his bed, but plant manager E was not sure who completed the installation of the bed rail on resident's bed.*He completed bed rail checks when he did the routine room checks.-He checked the tightness of the bed rail, and clearance of the bedrails on the adjustable beds.*He had not taken measurements in the zones of entrapment or completed an entrapment assessment for resident 10's side rails. 8. Interview on 7/24/25 at 12:45 p.m. and continued interview at 1:40 p.m. with administrator A and DON B revealed:*Facility staff had not installed resident 10's side rail onto his bed. The DON entered his room to find it already installed on 4/22/25.*An entrapment assessment had not been completed for resident 10 related to the side rail.*She did not consider that side rail a risk of entrapment because of resident 10's cognition.*No measurements had been taken to assess for entrapment risk related to his side rail.*The provider did not have a formal process or policy to assess for entrapment risk.*When