STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435038	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tekakwitha Living Center	6 E Chestnut Sisseton, SD 57262

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on interview, observation, document review, and policy review, the provider failed to ensure the staff followed proper sanitation and food handling practices regarding:*Handwashing and glove use standards were followed by dietary aide/cook I, dietary aide J, cook O, restorative supervisor N, and certified nursing assistant (CNA) H during one of one evening meal service and one of one lunch time service.*The steam tables in the north kitchenette were clean.*Dishwasher temperatures and sanitization levels were monitored and documented after each meal. Findings include:1. Interview on 1/20/26 at 2:40 p.m. with dietary aide/cook I in the kitchen revealed:*They had a dispenser of multi-range sanitizer that was premixed with water.*They used that sanitizer solution to clean the counters in the kitchen and the tables.*They did not test and did not have sanitizer testing strips to test the sanitation level of the sanitation solution. 2. Observation on 1/20/26 at 5:07 p.m. with dietary aide J in the north kitchenette revealed:*Dietary aide J was in the kitchenette, put on gloves, opened the door to the dining area, and pushed a cart that contained a big bowl of lettuce, styrofoam bowls, and salad dressing to the dining area. She then served the salad to the residents at their tables.*With those same gloved hands, dietary aide J grabbed a handful of lettuce with those dirty gloves and put it in a styrofoam bowl, put the salad dressing on it, and served it to a resident. *With those same dirty gloves hands, dietary aide J touched a resident's arm, the handle on the resident's wheelchair, the handle on the cart, and two more residents' arms, and then used those same gloves to grab a handful of lettuce, put it in the styrofoam bowl, put salad dressing on it, and served it to those residents.*She continued to serve the lettuce in the same manner throughout the dining service with those same gloves.*Restorative supervisor N removed the soups from the steam table, food particles were floating in the water in the steam table, and the water appeared dirty and hazy. 3. Interview on 1/20/26 with restorative supervisor N and dietary aide J revealed:*They were not sure how often the steam table needed to be cleaned.*Dietary aide J stated she thought it was done weekly, and the water was changed at that time. 4. Continued observation on 1/20/26 at 5:34 p.m. of dietary aide J in the east dining room revealed: *Dietary aide J put on gloves and pushed the cart that contained the big bowl of lettuce, styrofoam bowls, and salad dressing.*With those same gloved hands, she touched the resident's table, then grabbed a handful of lettuce, applied the salad dressing, and served it to the residents.*With those same gloved hands, she touched the handle on the cart when she pushed it to another table, touched a resident's arm, the handle on a resident's wheelchair, grabbed a handful of lettuce, put it in the styrofoam bowl, put the salad dressing on it, and served it to the residents. She continued in that fashion until all the residents were served the lettuce. 5. Observation on 1/20/26 at 5:36 p.m. of restorative supervisor N in the east kitchenette revealed:*She did not wash her hands before putting on a clean pair of gloves. She checked the temperature of the soup with a digital thermometer.*With those same gloved hands, she grabbed a wrap or a sandwich and put it on the resident's plate for them to eat, and then touched the ladle to put soup into a bowl. She did this throughout the dining and servicing process. 6. Observation on 1/20/26 at 5:43 p.m. of dietary aide/cook I in the east kitchenette revealed:*She had gloves on her hands. She pushed a cart with drinks on it, and served the drinks to the residents.*She removed her gloves, did not wash her hands, (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and put on a new pair of gloves, took out a slice of bread from the bread bag, and served it to a resident. 7. Interview on 1/21/26 at 8:30 a.m. with cook O in the kitchen revealed:*They used the sanitizer from the premixed dispenser to wipe off the counters in the kitchen, and they did not have testing strips to test the sanitation level of that solution.*She confirmed that, without the testing strips, she was unsure if the solution was at the appropriate sanitation level to sanitize the counters.*She stated, The manager before said it was fine [not to test the sanitation level].*Dietary staff were to wash their hands with soap and water when coming into the kitchen, before handling food, between handling certain foods, before putting gloves on, and after taking gloves off. 8. Observation on 1/21/26 at 12:03 p.m. of the north kitchenette steam table revealed there was dirty water and food floating in it. 9. Observation on 1/21/26 12:10 p.m. of the dining service in the north dining room revealed:*Dietary aide J and dietary aide/cook I had gloves on.*While getting a resident's order, dietary aide J touched the resident's arm with her gloved hand, she obtained the plate of food, and with those same gloved hands, she used the resident's silverware to cut up her food.*With those same gloved hands, dietary aid J received another plate of food, touched a resident's wheelchair handle, touched the top of the resident's glass, and cut up the resident's food. *While getting a resident's order, dietary aide/cook I touched a resident's chair with her gloved hands, received a plate of food, and served that to a resident.*Dietary aide I put a clothing protector on a resident and, with those same gloved hands, poured drinks for residents. *Cook O took off her gloves, did not wash her hands, used utensils to plate a resident's food, touched her hand to her pants, and then touched the plate. She stated, I do not have gloves, and received a pair of gloves from the nurse, did not wash her hands, put on those gloves, and used utensils to plate food. 10. Observation on 1/21/26 at 12:30 p.m. of the east dining room service revealed:*CNA H was standing at the steam table waiting to serve residents, she touched her hair, went over and got a resident's order, touched that resident's arm, obtained a plate of food, served it to the resident, and cut up the resident's food.*CNA H served a resident a plate of food, touched the table top, served another plate of food, did not wash her hands, put on a pair of gloves, and used her gloved hands to take chicken off the bone for a resident.*Cook O put on a pair of gloves, opened a cupboard door with those gloves, removed those gloves to get an apron, did not wash her hands, put on a pair of gloves, and plated food using utensils.*While plating food, cook O served a couple of residents their food, and without changing her gloves or performing hand hygiene, continued to plate other residents' food. *Dietary aide J came into the dining room, did not wash her hands, served residents their drinks and fruit cups, and touched a resident's arm, and continued to serve fruit cups and drinks to other residents. 11. Interview on 1/21/26 at 12:46 p.m. with cook O and dietary aide T in the east dining room revealed:*The steam table in the east kitchenette did not take water.*The CNAs were to clean and change the water in the steam table in the north kitchenette every two weeks, and it has just been done.*They did not have documentation that it had been cleaned. 12. Review of the provider's Chemical Sanitizing Dishmachine Temperature and PPM Log revealed:* INSTRUCTIONS: Please log WASH (140-160 degrees F [Fahrenheit]) and PPM [parts per million] test result when washing dishes after each meal, to ensure that the water temperature and sanitizer solution are properly controlled and monitored. The log should be filled in and. by those who are directly involved in the dishwashing process.*In October 2025, the wash temperature and the sanitization level were not documented 42 times.*In November 2025, the wash temperature and the sanitization level were not documented 41 times, and on 11/24/25, the wash temperature was 118 degrees.*In December 2025, the wash temperature and the sanitization level were not documented 20 times, and on 12/20/25, the wash temperature was 115 degrees, and on 12/28/25, the wash temperature was 118 degrees.*In January 2026, the wash temperature and the sanitization level were not documented 26 times. 13. Interview on 1/22/26 at 2:08 p.m. with administrator A revealed:*He expected the dishwasher temperature and sanitation level and the bucket sanitizer solution to be documented to ensure appropriate sanitation levels were reached when cleaning dishes and counters in the kitchen, and he agreed that with no documentation, it could (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	not be ensured that the dishes or counters were being sanitized appropriately, which could cause foodborne illness. 14. Review of the providers' undated Handwashing for Food Safety policy revealed:* Inadequate handwashing has been identified as a contributing factor to foodborne illness, especially when preparing raw meat and poultry. Hands can move germs that can cause illness found in raw meat and poultry, around the area you are preparing food, which can lead to foodborne illness. Washing our hands often is one of the best ways to stop the spread of harmful germs that can cause illness, including foodborne illness. 15. Review of the provider's undated dishwasher 2.0 Operator Procedures guide revealed:* Fill the machine with water using Fill Switch. If water temperature gauge has not reached 120 degrees F (49 degrees C [Celsius]) when the water level is just below overflow, drain water from the machine and continue to fill until proper temperature is attained.*Free chlorine rinse should be 50 ppm or more. 16. Review of the provider's 4/24/24 Dishwasher for ADS (American Dish Service) AF-C policy revealed:* Operating Procedure:-[dishwasher service company] inspects Dishwasher machine monthly. They verify a minimum of 120 degrees F that gets cycled into the machine. If temperature drop below, notify maintenance.-Sanitizer levels are at a minimum of 100 PPM.-Refer to Manufacturer guidelines for daily start-up. 17. A sanitization bucket and steam table cleaning policies were requested and not received before exiting the facility.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on Certification and Survey Provider Enhanced Reports (CASPER) data review, staff schedule review, timecard review, and interview, the provider failed to ensure Payroll Based Journal (PBJ) (information of the provider's daily staffing hours for the care of the residents) data was accurately completed before submission to the Center for Medicare and Medicaid Services (CMS) for four of four federal fiscal quarters (Quarter 1, 2025; Quarter 2, 2025; Quarter 3, 2025; and Quarter 4, 2025). Findings include:1. Review of the PBJ data submitted to CMS for the four quarters listed above revealed:*The following items were triggered:-Failed to submit data for the quarter.-One star staffing rating.*The following items were suppressed due to no nursing hours being reported:-Excessively low weekend staffing.-No RN hours.-Failed to have licensed nursing coverage 24 hours per day. 2. Review of the provider's October, November, and December 2025 employee staffing schedules and timecards revealed they had licensed nursing coverage 24 hours per day and eight continuous hours of RN coverage. 3. Interview on 1/20/26 at 1:49 p.m. with administrator A regarding Payroll Based Journal (PBJ) staffing data and reporting revealed:*He knew the PBJ hours were not getting reported.*He confirmed the staffing schedules were correct and they had met the requirements for PBJ staffing*The former health information manager (HIM) was responsible for submitting the staffing data *That employee stopped working for the facility in October 2024.He was told by his supervisor there would be some training on that in the future.He agreed the PBJ hours were not being completed as required. 4. Interview on 1/22/26 at 11:26 a.m. with regional director L regarding PBJ staffing data and reporting revealed:*He was aware the PBJ hours were not being completed.*The HIM person who was entering the PBJ hours had resigned about a year ago *after the HIM resigned, the PBJ education for reporting was passed on to the former administrator.The former administrator did not complete the education to complete the PBJ reporting by the time she resigned in December 2025.*Regional director L stated there was a PBJ education packet for administrator A to complete so he could input the PBJ hours.*Regional director L confirmed the PBJ staffing hours had not been submitted, as required, for the past four quarters. A policy for PBJ hours reporting was requested on 1/21/26 at 2:30 p.m. and the administrator stated there was no such policy in the facility.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interview and policy review, the provider failed to deliver mail daily to ten of ten residents (10, 14, 15, 18, 24, 30, 31, 35, 37, and 38) within twenty-four hours after it was delivered to the nursing home by the local post office. Findings include: 1. Interview on 1/22/26 at 10:00 a.m. during the resident group meeting revealed:*Residents (10, 14, 15, 18, 24, 30, 31, 35, 37, and 38) stated they did not get their mail daily.*Mail was not delivered on Saturdays because there was no one to pass it out.*Activities director M usually delivered the mail to the residents during the weekdays. 2. Interview on 1/22/26 at 11:30 a.m. social services director C revealed she expected residents to be delivered mail on Saturdays. 3. Interview on 1/22/26 at 11:43 a.m. with activity director M revealed on Saturdays, the charge nurse would get the mail, and then she would pick it up on Mondays and deliver it to the residents because she did not work on Saturdays. 4. Review of the provider's May 2017 Mail and Electronic Communication policy revealed Mail and packages will be delivered to the resident within twenty-four (24) hours of delivery on premises or to the facility's post office box (including Saturday deliveries).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observations, interviews, and policy review, the facility failed to ensure proper storage and disposal of expired medications in one of one medication room and one of one medication cart that had expired medications and treatments.*One of one medication room and One of One medication cart (north) had expired medications and treatments. Findings Include:1. Observations on 1/22/26 at 11:00 a.m. with Licensed Practical Nurse (LPN) G in the Medication Room revealed expired medications and treatments.* Tuberculin Purified Protein Derivative (PPD) solution vial was ordered from the pharmacy on 10/27/25. The vial cap was removed and open with no open date. With no open date marked on box or vial, the opened vial should be discarded.2. Observation on 1/22/26 at 11:25 a.m. of the North Medication Cart revealed expired medications.* Resident 3's Novolog expired on 1/15/26 and had 1/3 of the used medication vial remaining and per the open date and written expiration date on the vial was expired.* Stock bottle of Senna Plus expired in November 2025 with approximately half of the bottle (500 tabs) remaining.* Stock Liquid Pain Relief expired in December 2025 with approximately half of the bottle remaining.2. Interview with Licensed Practical Nurse (LPN) G at 1/22/26 at 11:35 a.m. revealed:* The medications should have expiration dates on them when they were opened and discarded. The night shift staff are who usually go through and check the expiration dates.* The medications should have been checked by the nursing staff to ensure they do not expire prior to giving them to a resident.* If the medication was expired, it should be pulled from use and reordered.3. Interview with Director of Nursing (DON) B on 1/22/26 at 2:18 p.m. revealed:* Her expectation was that medications were checked for expiration dates prior to giving the medication and pulled from the medication cart if expired.4. Review of the providers' Medication Storage in the Facility policy revealed:* Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.* H. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal (See Section IE: DISPOSAL OF MEDICATIONS AND MEDICATION-RELATED SUPPLIES), and reorder from the pharmacy (SEE IC3: ORDERING AND RECEIVING NON-CONTROLLED MEDICATIONS FROM THE DISPENSING PHARMACY) if a current order exists.* Expiration Dating (Beyond-use dating) D. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 1. The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration (NOTE: the best stickers to affix contain both a date opened and expiration notation line). The expiration date of the vial or container will be [30] days unless the manufacturer recommends another date or regulations/guidelines require different dating (See APPENDIX 29 - MEDICATIONS WITH SHORTENED EXPIRATION DATES).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and policy review, the provider failed to ensure proper infection control practices were followed for:*Cleaning one of one ice maker located outside of the kitchen.*Cleaning the refrigerator in one of one family room. Findings include: 1. Observation on 1/20/26 at 1:00 p.m. of the ice machine outside of the kitchen revealed that it was not clean. There was a dirty light green powder like substance on the outside corners of the machine above the level of the ice dispenser that fell off the machine during ice dispensing. There was heavy water spotting on the splash guard and visible rust on the metal grate above the water drain.2. Observation on 1/21/26 at 9:35 a.m. of the mini refrigerator in the family room there was a four-ounce serving of ice cream on the refrigerator's top shelf that had melted and spilled onto all the shelves in the refrigerator.3. Interview on 1/22/26 at 11:00 a.m. with housekeeper K revealed that she had been employed at the facility for less than a year. When asked if cleaning the family room refrigerator or ice machine was her responsibility, she did not think it was her responsibility. When asked how she knew what her responsibilities were as a housekeeper, she replied that there was a notebook with an outline of the daily responsibilities. She then provided a copy of the outline.4. Interview on 1/22/26 at 11:20 a.m. with licensed practical nurse (LPN) G revealed that she was not sure who's responsibility it was to clean the family room refrigerator or the ice machine. She thought that it were either maintenance or housekeeping.5. Interview on 1/22/26 at 12:30 p.m. with maintenance lead D revealed that he had been employed at the facility for less than a year and was the housekeeping supervisor. He reported that he did not receive much training on his responsibilities. He reported that housekeeping staff were responsible for cleaning the family room refrigerator, but he did not think they were responsible for cleaning the ice maker. He stated that the responsibility of maintenance was to just blow off the dust on the top of the ice maker.6. Interview and observation on 1/22/26 at 12:55 p.m. with director of nursing (DON) B revealed that she was unsure who's responsibility it was to clean the ice maker. She reported that she was not sure if it was the responsibility of the CNAs or housekeeping to clean the family room refrigerator. When she observed the ice maker, the appearance did not meet her expectations of cleanliness. She expected the surfaces to be clean, the grates to be clean and not rusted, and the dirt/debris on the outside corners to be clean.7. Review of the provider's undated housekeeping checklist revealed that number 4. Clean ice machine daily. Initial Sheet. Number 16. Check room fridge temps and chart daily (Clean and defrost TLC [Tekakwitha Living Center] fridges as needed.8. Review of the provider's February 2025 Infection Control and Prevention policy revealed a purpose of To establish comprehensive guidelines for preventing and controlling infections within the facility, protecting the health and safety of residents, staff and visitors. and principles of infection control were to Adhere to evidence-based practices for infection control.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, the provider failed to have a qualified infection preventionist for the facility.Findings include: 1. Interview on 1/22/26 at 12:25 p.m. with director of nursing (DON) B revealed that she was in charge of the facility's infection prevention program but had not completed an approved infection preventionist (IP) course. She reported that she had been working on the IP course but had not found the time to complete it. She confirmed that she oversaw the facility's infection prevention program during the last recertification survey and had not completed the IP course then either.2. Review of the provider's infection control program binder revealed that the provider did not have an infection preventionist.

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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 observation, interview, document review, record review, and policy review, the provider failed to protect the resident's rights and ensure a resident's advance directive code status (an individual's desire to be resuscitated with cardiopulmonary resuscitation (CPR), specific limited interventions, or not resuscitated (DNR) if their heart stopped) wishes were identified accurately in the medical record for two of seventeen sampled residents (3 and 16). Findings include:1. Observation, interview, and document review on [DATE] at 4:18 p.m. with registered nurse (RN) E at the nurse's station revealed:*Resident paper charts that had a heart with a stethoscope logo on the outside of the chart indicated the resident's code status was a full code, so then CPR would have been performed. If a paper chart did not have that logo, it indicated the resident was a DNR, so CPR would not have been performed.*Resident 3's paper chart had the heart with the stethoscope logo on it.* Resident 3 had an advance directive in his paper chart that was signed on [DATE] that indicated he wanted CPR.*RN E would not have performed CPR on resident 3 because she knew he was a DNR, and he was admitted to hospice on [DATE].*She stated that someone who did not know resident 3 well may have performed CPR on him because that is what his chart indicated with the logo on it and the [DATE] advance directive. She stated, It must not have been updated.*In resident 3's paper chart, behind his full code advance directive, there was a living will (a document that specifies a resident's preferences about measures that are used to prolong life when there is a terminal prognosis) signed on [DATE] that indicated he was to be a DNR.*Resident 16's paper chart did not have the heart with the stethoscope logo on it.*RN E opened residents 16's chart and found an advance directive that indicated CPR should be performed, so she stated she would do CPR.*Upon further review, the advance directive that was in resident 16's chart belonged to a resident who had been discharged . Resident 16's advance directive was found on the backside of another page in his chart and indicated he was a DNR.*She verified that having the wrong resident's advance directive in his chart could have caused an error, and CPR could have been performed when it should not have been. 2. Review of resident 16's electronic medical record revealed:*His [DATE] BIMS score was 9, which indicated he had moderate cognitive impairment.*On [DATE], he had orders for DNR.*He had a diagnosis of congestive heart failure (your heart can not pump enough blood to meet your body's needs, causing blood and fluid to back up)(CHF). 3. Observation on [DATE] 8:55 a.m. outside of resident 3's room revealed there was a heart with a stethoscope logo posted on the wall next to his name. 4. Interview on [DATE] at 9:18 a.m. with licensed practical nurse (LPN) G revealed that if resident 3's heart stopped, she would have performed CPR because the logo posted by his name indicated he was a full code. 5. Review of resident 3's electronic medical record revealed:*His [DATE] brief interview for mental status (BIMS) score was 12, which indicated he had moderate cognitive impairment.*On [DATE], he had orders to be admitted to hospice on [DATE].*On [DATE], he had orders for DNR/DNI.*He had diagnoses of left femur fracture (broken hip), a stage four pressure ulcer (skin and/or underlying tissue injury from prolonged pressure that was open with full thickness skin and tissue loss. Bone, tendon, or muscle may be visible) to his sacral region (buttocks), osteomyelitis of his vertebrae and sacral region (infection of the bones of his spine), and CHF. 6. Interview on [DATE] at 1:53 p.m. with director of nursing (DON) B revealed:*The social worker completed the advance directive forms with the resident or family.*If there was a change to a resident's advance directive, the nurse was to notify either the DON or social worker, and said, There is a lapse at times [sometimes it was missed and not updated].*She stated that resident 3's advance directive should have been updated on his chart, and the logos by his room and chart should have been removed when his code status changed to a DNR and verified that resident 3 could have received CPR in error.*She stated that the discharged resident's advance directive should not have been in resident 16's chart (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and verified that resident 16 could have received CPR in error. 7. Review of the provider's [DATE] Advance Directive policy revealed:* Advance directives will be respected in accordance with state law and facility policy.* Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record.* The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive.* Changes or revocations of a directive must be submitted in writing to the Administrator. The Administrator may require new documents if changes are extensive. The Care Plan Team will be informed of such changes and/or revocations so that appropriate changes can be made in the resident assessment (MDS) and care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435038	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tekakwitha Living Center	6 E Chestnut Sisseton, SD 57262

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, document review, and record review, the provider failed to provide adequate supervision to a dental appointment for one of one sampled resident (4) who had severe cognitive impairment and was at high risk for falling. Findings include:1. Interview on 1/21/26 at 11:17 a.m. with resident 4's granddaughter/power of attorney revealed:*A few months ago, a nursing home staff member called her and told her that her grandmother had a dental appointment in fifteen minutes.*She was unaware of that appointment and was not going to be able to meet her there.*She asked the staff member to reschedule it instead.*She received a phone call from the dental clinic asking her why her grandmother was at the appointment by herself.*Resident 4 rode the community transportation by herself and was dropped off at the dental clinic, where she was by herself for 45 minutes.*She was very upset that resident 4 went by herself to that appointment because of resident 4's cognitive impairment.*She talked to the previous administrator about the incident. 2. Interview and form review on 1/22/26 at 1:53 p.m. and 3:37 p.m. with director of nursing (DON) B revealed:*She verified that resident 4 was sent to that appointment by herself.*She stated that resident 4 should not have gone to the appointment by herself, and she expected the appointment to have been cancelled unless they had staff to take her.*Resident 4's granddaughter typically took her to her appointments.*Upon admission, in the admission packet, they have families/residents sign a Specialty Doctor's Appointments form. Resident 4 was admitted prior to the forms being implemented and did not have one signed.*The 10/7/25 form stated: In the event that [resident] needs to go to a specialty doctor's appointment, (which this means any appointment besides when his/her primary care physician comes to the facility to do regulatory check-ups), that you understand your loved one needs to be accompanied by family or friend at the appointment. This applies when your loved one's cognitive impairments make it unsafe for resident to go on his/her own to the appointment and/or if information given to resident at said appointment will not be able to be retained. The facility will work with you to line up these special appointments so that said person can go with and/or meet at that appointment. If you are unable to meet your loved one at said appointment understand that the clinic may cancel the appointment and you acknowledge there is a risk then for injury or information not to be relayed correctly. [There was a space for signatures.]*They did not have a policy regarding taking residents to appointments. 3. Review of resident 4's electronic medical record revealed:*She was admitted on [DATE].*Her 12/2/25 Brief Interview for Mental Status (BIMS) score was 3, which indicated she had severe cognitive impairment.*Her 8/13/25 Morse Fall Scale indicated she was at high risk for falling.*Her diagnoses were left femur fracture (hip fracture), dementia (a group of symptoms affecting memory, thinking, and social abilities), major depressive disorder (a serious, long-lasting mood disorder that goes beyond normal sadness), and anxiety disorder (a feeling of worry, fear, or unease about future events or a perceived threat).*A 10/4/25 progress note stated, Resident is alert with confusion noted.TABs/bed alarm/chair alarm [(a fall prevention device that alarms to notify staff of the resident's movement, such as standing)] on, as she is a high fall risk.*A 10/21/25 progress note stated, Resident left at 0900 for dental appt. at [dental clinic] via community transit and arrived back 1130.*Review of her 9/12/25 care plan revealed:- [Resident 4] has the potential to be physically aggressive r/t [related to] Dementia.- When [resident 4] becomes agitated: Intervene before agitation escalates; Guide away from source of distress.*[Resident 4] is able to identify her family but not other residents or staff and can follow one-word instructions.*[Resident 4] needs supervision and assistance with all decision making.*[Resident 4] uses psychotropic (drugs that affect brain activities associated with mental processes and behavior) medications Quetiapine for Behavior management.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and policy review, the facility failed to complete a Trauma Informed Care assessment for one of one sampled resident (5) after they have experienced a loss of a loved one. Findings Include: 1. Interview on [DATE] at 3:55 p.m. with resident 5 noted that after each question asked during the interview, she would have discussed her husband passing away. The following statements were said:* I should have died before him* This is his shirt that he used to wear* I have to keep busy to not think about him.2. Observation on [DATE] at 11:10 a.m. of resident 5's wound care revealed she continued to reiterate sentiments for her husband passing away and how sad she was he was not here with her.3. Interview and chart review for resident 5 on [DATE] at 11:25 a.m. with director of nursing (DON) B confirmed she did not have a Trauma Informed Care completed and the Social Services Designee was responsible for completing the Trauma Informed Care assessments.4. Interview and chart review for resident 5 on [DATE] at 1:10 p.m. with Social Services designee (SSD) C revealed she could not find Trauma Informed Care on resident 5. She stated, I must have missed that one. She said she completed this on admission and as needed but completed the mood assessment quarterly within the MDS.5. Review of the providers [DATE] Trauma Informed Care policy revealed:* Purpose: To ensure facilities deliver care and services which meet professional standards, use approaches which are culturally competent, account for resident's expedience and preferences, and address the needs of trauma survivors.* Trauma Survivors - Military veterans, survivors of disasters, survivors of abuse, history of homelessness, history of imprisonment, and traumatic loss of a loved one.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview, the provider failed to employ a full-time, qualified registered dietitian or dietary manager who met the requirements to serve as the director of food and nutritional services. Findings include:1. Interview on 1/20/26 at 1:23 p.m. with dietary aide/cook I and restorative supervisor N revealed:*The facility did not have a dietary manager.*Restorative supervisor N was working as the dietary cook, she had been a cook there prior to her current role.*The previous dietary manager worked there for a few years, and after she quit, a certified nursing assistant (CNA) took over for a few weeks, but did not want to do it anymore, and went back to working as a CNA. *The administrator ordered food for the kitchen; they just wrote down for him what was needed. 2. Interview on 1/21/26 at 8:30 a.m. with cook O revealed:*She confirmed there was no dietary manager to oversee the process of the kitchen.*She would go to administrator A if there were issues.*She was not a certified dietary manager (CDM).*She completed the ServSafe training.*The regular registered dietitian (RD) was out on maternity leave.-There was a RD covering for her during her leave, and she was there a few weeks ago, wrote a few things down, and then left. 3. Interview on 1/22/26 at 8:45 a.m. and 2:08 p.m. with administrator A revealed:*Their previous dietary manager left her position on 1/7/26, after being in that role for a few weeks.-The dietary manager before her, left her position on 8/19/25.*They had the dietary manager position posted.*When asked who could answer dietary questions, he stated, I guess that would be me.*He was not a CDM.*Consultant RD was not full-time and came to the facility monthly.*Their regular registered dietitian (RD) was out on maternity leave, and another dietitian was covering for her.