STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435072	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seven Sisters Living Center	1201 Hwy 71 South Hot Springs, SD 57747

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 42558 Based on observation, interview, and record review, the provider failed to ensure two of two sampled residents (11 and 27) who received a specialized diet were served the correct portion sizes and nutritional values for one of three observed meal services. Findings include: 1. Observation on 7/23/24 from 11:45 a.m. through 12:35 p.m. of the memory care unit lunch meal revealed: *The menu for lunch that day consisted of spaghetti, a lettuce salad, and bread with an alternate meal of chicken and rice soup. *Residents 11 and 27 were served an approximate one-half cup round scoop of ground spaghetti centered in the middle of their plate. -No other food items were served with their meal. *Administrator A was present in the dining room and an unidentified aide notified him of their meal portions. -Resident 27's husband was visiting during the meal and administrator A offered more food items to which the husband responded he would wait and see if she ate the spaghetti first. -Resident 27 ate the spaghetti and a prepackaged cup of pudding the husband had offered. *Resident 11 showed little interest in eating her spaghetti. *By the end of the lunch meal, no further offers of food items were made to resident 11 or 27. Interview on 7/23/24 at 11:50 a.m. with resident 27's husband while he sat with her in the memory care dining room revealed: *He stated his wife had lost nearly 60 pounds since she had been sick with COVID-19 and her dementia had worsened. (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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He stated because of her weight loss and dementia her dentures no longer fit correctly, and she would have refused to wear her dentures even when they did fit. -He stated his wife liked eating soup, but it was rarely offered to her. -He stated she was able to eat soft foods without difficulty and had not understood why they gave her pureed food as she did not like it. Interview on 7/23/24 at 5:00 p.m. with registered dietitian (RD) D and administrator A regarding the above observed meal service revealed: *RD D stated she worked for the provider as a consultant. *RD D agreed the meal served to residents 11 and 27 was not visually palatable, accurate in portion size, or nutritionally balanced. *Administrator A agreed the full nutritional menu was not served to those residents. -He stated dietary cook R was hired within the last 90 days and he expected the dietary manager (DM E) to have ensured cook R had been educated on serving sizes and specialized diets. -He stated that DM E was newly hired around the same time as cook R and he (DM E) was working on obtaining his dietary manager's certificate. *Their expectation was for all the food groups listed on the menu, or a nutritionally equal substitute, was to have been served in the correct portion sizes. *They both confirmed they had not observed a meal service to ensure the meals were proportioned correctly and served appropriately. Interview on 7/24/24 at 1:30 p.m. with DM E revealed: *He stated he was hired as a cook in January of 2024 and became the DM around March of 2024. -He stated he had not worked as a DM in a long-term care facility before this employment and he was currently working on his dietary manager's certificate. *He stated the past DM had resigned in March of 2024 and the DM training he received from her was slim to none and lasted about four days in total. -She had shown him how to order supplies, complete the Minimum Data Set (MDS), and fill out the dietary staff schedules. -He stated he had no training on specialized diets, portion sizes, or the required education he needed to provide to his dietary staff. *He thought dietary cook R had been trained by dietary cook S on specialized diets and portion sizes. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 7/24/24 at 2:30 p.m. with dietary cook S revealed she: *Had worked as a cook for about one and a half years. -Had been trained on serving sizes by dietary cook T and had not received any formal training from a DM or a dietitian. *Stated she had trained cook R for nearly two weeks and had provided her with some training on plate presentation, serving sizes, recording temperatures, and specialized diets. *Was unable to identify the portion sizes for ground or pureed foods and stated she usually filled up a bowl until it would look like a four-ounce portion. -Stated there were no guides on portion sizes for specialized diets located in the kitchen. *Stated, Some people don't eat as much so we give smaller portions to them. -Was not aware if the dietitian had been notified of this practice. *Stated, We need more education on this (portion sizes). Interview on 7/24/24 at 2:40 p.m. with RD D regarding the above dietary staff interviews revealed: *She stated she was not aware the current DM and cooks had not been properly trained on portion sizes or dietary types and was not aware there were no serving guides available to staff. *She was not aware the cooks were serving smaller portions to those who did not eat well and had initiated a review of each resident's diet and food consistency orders. -She stated the only time residents should have been served smaller portions was if they had a specific order for smaller portions. *She agreed there was a need for further food service monitoring and dietary staff education. Review of resident 11's medical record revealed: *She received Hospice services and had a diagnosis of a major neurocognitive disorder due to Parkinson's disease with behavioral disturbance. -She had a brief interview for mental status (BIMS) of 99, which indicated she was severely cognitively impaired and was unable to participate in the assessment. *Her diet order was for an NDD3 (National Dysphagia Diet level 3) texture that omitted dry, hard, crispy foods. *She was to receive an Ensure nutritional supplement drink three times a day. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*On 01/23/2024, the resident weighed 117 lbs. On 07/20/2024, the resident weighed 95.5 pounds which was an -18.38 % weight loss. -A decrease of 10% or greater in 180 days was considered a significant weight loss. Review of resident 27's medical record revealed: *She was diagnosed with a major neurocognitive disorder due to Alzheimer's disease with behavioral disturbance, anxiety, depression, and hallucinations. *She had a BIMS of 04, which indicated she had a severe cognitive impairment. *Her diet order was for a regular diet as tolerated with mechanical texture, regular consistency, gravy on meat, pureed vegetables, and finger foods. -She also had an order for a nutritional supplement drink three times a day. *On 01/22/2024, the resident weighed 134 lbs. On 07/22/2024, the resident weighed 116 pounds which was an -13.43 % weight loss. -A decrease of 10% or greater in 180 days was considered a significant weight loss. Review of the provider's 2012 Weight Assessment and Intervention policy revealed: *The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents. -2. The Physician and the multidisciplinary team will identify conditions and medications that may be causing anorexia, weight loss, or increasing the risk of weight loss. For example: f. Increased need for calories and/or protein; i. Inadequate availability of food or fluids. Review of the provider's initial hire and annual dietary training revealed DM E, cook S, and cook R, had not received training on the following topics: Food Safety, Serving/Distribution, Leftovers, Time/Temp Controls, Nutrition/Hydration, and Sanitation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 42558 Based on observation, interview, record review, and policy review, the provider failed to ensure: *Proper hand hygiene, glove use, containment of soiled linen, and disinfection of a mechanical lift, by two of two staff (M and N) during one of one sampled resident's (46) mechanical lift transfer and personal hygiene care. *Proper hand hygiene, glove use, containment of soiled linen, and suprapubic catheter (connected through the abdomen to the bladder) care by one of one medication aide (Q) during one of two sampled resident's (1) catheter care observations. *Proper hand hygiene and glove use by two of two dietary aides (O and W) while assisting two of two residents (8 and 11) during two of three dining room observations. *Oxygen tubing was changed according to facility policy for two of four (43 and 51) sampled oxygen-dependent residents. *Cleaning and sanitization of five of six multi-use facility recliners and one of one couch located in the memory care unit. Findings include: 1. Observation on 7/23/24 at 10:29 a.m. with nurse aide (NA) M and certified nurse aide (CNA) N during a mechanical lift transfer and personal hygiene care of resident 46 revealed: *A multi-resident use mechanical lift was removed from the hallway and brought into resident 46's room. *NA M and CNA N sanitized their hands, applied clean gloves, and transferred resident 46 onto her bed using a sling attached to the mechanical lift. -Her open-backed skirt was partially wet with urine, was removed by NA M and placed directly onto the floor. *CNA N removed the resident's urine-soaked incontinence brief and cleansed the resident's genital and rectal areas. -Using those same gloved hands, he applied a barrier cream to the resident's rectal area first and then her genital skin folds. *NA M removed his gloves and without cleansing his hands he: -Opened the resident's closet door and obtained a clean incontinence brief and clothing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 7/24/24 at 4:55 p.m. with licensed practical nurse (LPN) K regarding NC tubing replacement revealed: *The NC tubing were replaced monthly and documented in the treatment administration record (TAR). *She was not able to find documentation in the TAR for NC tubing replacements for resident 43 or resident 51 nor able to produce the policy for NC tubing replacement. Interview on 7/25/24 at 8:33 a.m. with LPN L revealed she: *Thought that NC tubing replacements were documented in the TAR. *Was not able to find any documentation of NC tubing replacement for residents 43 or 51. Interview on 7/25/24 at 9:46 a.m. with LPN H revealed he: *Placed the tape on resident 8's nasal cannula with the date 7/1/24. *Assumed the tubing was replaced at the beginning of the month but was not certain. *Said the changes were notated in the TAR. *Was not able to find documentation for the nasal cannula changes for either of the above residents. *Was not able to produce a policy for when nasal cannula or oxygen tubing was to be changed. Interview on 7/25/24 at 11:59 a.m. with RN/ infection control coordinator U revealed she: *Was not sure when nasal cannulas or oxygen tubing was to be changed. *Did not know about any policy involving tubing changes. *Said that staff should not touch their face or hair prior to resident cares. *Said staff are trained annually on proper hand hygiene. Interview on 7/25/24 at 2:01 p.m. with assistant director of nursing (ADON)/ resident care manager (RMC) C revealed: *Her expectations were that staff would conduct proper hand hygiene and change oxygen tubing in accordance with the facility policy. (continued on next page)

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