STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435079	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
United Living Community	405 First Ave Brookings, SD 57006

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 47416 Based on record review, interview, and policy review, the provider failed to provide bed-hold notices to the resident or resident's responsible party at the time of transfer to a hospital and ombudsman notification for four of four sampled residents (6, 4, 25 and 27). Findings include: 1. Review of resident 6's electronic medical record (EMR), revealed: *On 12/04/23, she had been transferred to the hospital at the request of her family representative due to her becoming shaky and she could not stand on her own. *There was no written notification to the resident or her responsible party regarding the Bed Hold policy, and no documented notification to the Ombudsman that resident 6 had been sent and admitted to the hospital. 32332 2. Review of resident 4's EMR revealed: *On 2/29/24 at 10:30 p.m. resident 4 fell outside the restroom by the nurses' station. *He reported back pain. *Emergency medical services (EMS) was called and he remained on the floor while the staff waited for the ambulance. *Resident 4 was taken to the hospital and remained there until he returned on 3/2/24. *There was no documentation the resident or his responsible party had received information about the bed-hold policy. 3. Review of resident 25's EMR revealed: *On 9/25/23 at 5:37 p.m. the hospital called to inform the nurse that resident 25 had a critical value blood glucose of 835. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435079	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Ecare (an online health service) called soon after with orders to send her to the emergency room . *A phone call was made to her husband who gave permission to send her to the hospital. *Resident 25 was transferred by ambulance to the hospital and remained there she returned on 9/29/23. *There was no documentation the resident or her responsible party had received information about the bed-hold policy. 49958 4. Review of resident 27's EMR revealed: *A health status progress note (PN) on 3/21/24 at 11:52 a.m. indicated the resident .transferred to the ER [emergency room] for further evaluation. Resident left [facility name] at 1130 via ambulance. *A PN on 3/21/24 at 1152 a.m. indicated her son was notified of the resident's transfer to the ER. *A PN on 3/22/24 at 4:04 p.m. indicated she had returned to the facility. *A PN on 4/7/24 at 12:30 p.m. indicated her son . agree to transport patient to the hospital for evaluation. *A PN on 4/10/24 at 1:44 p.m. indicated she had returned to the facility. *There were no documentation the resident or her responsible party had received information about the bed-hold policy. 5. Interview on 5/23/24 at 10:22 a.m. with social service designee (SSD) C revealed: *The bed-hold information was located in the welcome book. *Residents signed an Admission Acknowledgement form, that acknowledged receipt of the Welcome Handbook upon admission. *She was not aware if a written form had been completed at the time of transfer. *She did not know it was her responsibility. 6. Interview on 5/23/24 at 10:52 a.m. with administrator A revealed: *She would have expected the nurse to notify the family verbally at the time of transfer and the social worker to follow up regarding the resident's return to the facility during a hospitalization . *A bed hold should have been completed at the time of transfer. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She stated, We are not completing a written bed-hold form. 7. Review of the provider's undated Holding Bed Space policy revealed: *Upon admission and when a resident is transferred for hospitalization or for therapeutic leave, a representative of the Social Services Department will provide information concerning our bed hold policy. *When emergency transfers are necessary, the facility will provide the resident or representative (sponsor) with information concerning our bed-hold policy. (Copy of Bed Hold Policy is mailed to resident or resident representative.)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 47416 Based on interview, observation, record review and policy review, the provider failed to ensure one of one sampled resident (115) was accurately assessed for appropriate and safe self-administration of a nebulized (converted from liquid to mist) medication. Findings include: 1. Interview on 05/21/24 at 09:25 a.m. with resident 115 revealed she: *Had a medication that was given through a nebulizer (neb) machine. *Was left alone by staff during her neb treatments. *Stated she had never been educated on using the neb machine and could not turn it on or off. *Would take the mask off before the neb treatment was done. *Wanted to self-administer her neb treatment. Observation and interview on 5/22/24 at 10:02 a.m. with registered nurse (RN) K while providing a neb treatment for resident 115 revealed: *She placed liquid Ipratropium (a med to open airways in the lungs) and Budesonide (a med to prevent swelling) in the neb reservoir, started the neb machine and placed the mask on resident 115's face. *She stated that she would set a timer on her watch for ten minutes and return to assist the resident and left the room. *She did not know if the resident had an orderto self-administer the neb treatment. *She was not sure of the facility policy on resident self-administration of medications. *Review of the resident 115's electronic medical record (EMR) revealed: *An order on 05/13/24 for Budesonide (one vile via neb two times a day) and on 05/16/24 for Ipratropium (one vile by mouth three times a day). *There was no order for the self-administration of the Ipratropium or Budesonide . *There was no assessment to determine if she was able to self-administer the neb treatment safely. *Her care plan did not include her self-administration of the neb treatment. 2. Interview on 05/23/24 at 11:03 a.m. with RN I revealed: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* There was no order for resident 115 to self-administer any medications. *Resident 115 had not been educated on using the nebulizer. *Self-administration was not included in resident 115's care plan. *She would have expected all education to have been conducted and documented in the resident's record. Review of the providers February 2021 Self-Administration of Medication policy revealed: *3. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and their care plan. The decision that a resident can safely self-administer medications is reassessed periodically based on changes in the resident's medical and /or decision-making status.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 47416 Based on observation, interview, record review, and policy review, the provider failed to ensure resident care plans were revised to reflect the current needs for three of twenty-one sampled residents as follows: *Three of three sampled residents (6, 50, and 54) who had VirtuSense VSTAlert motion detection systems installed in their rooms. *One of one sampled resident (50) who had a side rail on her bed. Findings include: 1. Observation on 5/23/24 at 10:25 a.m. of resident 6's room revealed a VST motion sensor located on the far wall that had been directed at the residents' bed. 2. Review of resident 6's electronic medical record (EMR) revealed: *An order dated 05/17/24 indicated Resident may use VST monitor per order received on 5/3/24. *There was no documentation of the use of the VST monitor in the resident care plan. *There was no consent documentation for the use of the VST monitor. 49958 3. Observation on 5/20/24 at 2:27 p.m. of resident 50's room revealed: *A side rail on the left side of her bed. *A VST motion sensor located on the far wall that had been directed at the residents' bed. 4. Interview on 5/21/24 at 8:51 a.m. with an unidentified nurse revealed: *Resident 50 used the side rail to reposition herself. *The VST motion sensor alerted the nurses by phone when the resident attempted to get out of bed. 5. Review of resident 50's EMR revealed: *An order dated 12/28/23 indicated Facility has added a bed monitor to patient room. *A fall progress note (PN) dated 1/4/24 at 4:10 p.m. indicated the resident fell in her room. -Interventions added to care plan: use VST monitor. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--This intervention had not been added to her care plan. *There was no documentation of the use of the side rail in her care plan. 6. Interview on 5/22/24 at 1:08 p.m. with director of nursing (DON) B revealed: *An order for the VST monitor for resident 50 was added by the Hospice physician on 1/3/24. -It had not been added to her medication administration record (MAR) or her care plan. --The family is aware however we just didn't document it. *She would have expected the VST monitoring to have been added to the MAR and the care plan, and the resident's or resident's representative's consent to have been obtained and documented. *She stated the side rail documentation for resident 50 had not been completed because the family wanted it so she could move in the bed. *She would have expected a quarterly side rail assessment for resident 50 to have been completed, a physician's order to have been obtained, and the side rail to have been added to her care plan. 7. Observation and interview on 5/22/24 at 12:46 p.m. with resident 54 while in her room revealed: *A VST motion sensor located on the far wall directed at her bed. -The sensor system announced resuming when the resident stepped near her bed. *The resident stated, who said that? -She indicated she did not know where the noise came from. 8. Review of resident 54's EMR revealed: *A PN dated 3/31/24 at 11:42 p.m. indicated The resident's VST alarm is not working tonight. *There was no documentation of the use of the VST monitor in her care plan. 9. Interview on 5/22/24 at 3:40 p.m. with administrator A revealed: *The VST system was used for fall prevention for residents at the highest risk of falls. *She confirmed a physician's order and the resident's representative's consent should have been obtained and the use of the VST monitoring system should have been added to the care plan. * They did not have a specific policy regarding the VST monitoring system. Review of the providers' 2016 Proper Use of Side Rails policy revealed, The use of side rails as an assistive device will be addressed in the resident care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the providers' undated Care Plan Policy revealed: *The purpose of the care plan is to provide a centralized coordination of the services that will be provided to each resident, based on his or her individual needs, abilities, and preferences. *The care plan should address, but is not limited to the following: -Fall history and/or risk.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49958 Based on observation, interview, and policy review the provider failed to ensure food items were appropriately labeled, stored, handled, prepared, and served in a safe and sanitary manner in one of one kitchen and one of four kitchenettes for the following: *One of one commercial refrigerator that contained food items that were not labeled, dated, or discarded by the use-by date, *One of one commercial freezer that contained food items that were not labeled or dated. *One of one kitchen and one of four kitchenettes that contained dry food items that were not labeled or dated. *Appropriate glove use and hand hygiene by cook G while preparing food. *Appropriate glove use and hand hygiene by dietary aide F and by unlicensed assistive personnel (UAP) H while handling food. Findings include: 1. Observation on [DATE] at 1:11 p.m. of the kitchen revealed: *A commercial refrigerator contained: -One container of pickles that was not covered or dated. -One jar of barbecue sauce that was opened and not dated. -One bottle of ranch dressing marked as opened on [DATE]. --There was no expiration date found. -A container labeled broccoli broth use by ,d+[DATE]. -A sliced onion in a plastic bag that was not labeled or dated. -A flour tortilla labeled use by [DATE]. -A package of deli pepper jack cheese labeled use by [DATE]. -A tub of palmetto cheese spread labeled use by date [DATE]. -Two heads of lettuce in a plastic bag that had browned in areas. -Several stacks of sliced cheese, wrapped in plastic wrap, one with what appeared to be a spot of mold, that were not labeled or dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Two apple pies on a tray covered with plastic that were not labeled or dated. *A commercial freezer contained: -At least 10 packages of opened frozen meat items that were not labeled or dated. *Two open bags of puffcorn that were not dated. *An open bag of shredded coconut labeled sell by date [DATE]. -There was no open or use-by date. *An open bag of cereal that was not labeled or dated. 2. Observation on [DATE] at 2:1p.m. in the 500-hall kitchenette revealed: *A package of what appeared to be French Toast in the freezer that was not labeled or dated. *A bottle of liquid that appeared to be pancake syrup that was not labeled or dated. *Three containers of dry cereal that were not labeled or dated *An open plastic bag of what appeared to be pancake mix dated ,d+[DATE]. 3. Observation and interview on [DATE] at 3:51 p.m. with cook G revealed he: *Wore gloves to place raw chicken on a pan, removed those gloves, seasoned the chicken- without washing his hands, and then put on a new pair of gloves. *Checked the temperature of the lasagna while wearing those gloves, removed those gloves, and without washing his hands put on a new pair of gloves and then touched the ready-to-eat garlic bread with those gloved hands. 4. Observation on [DATE] 10:38 a.m. with dietary aide F in the main kitchen revealed: *While wearing gloves, he opened the walk-in cooler door, took two containers from the cooler, and set them on the cart. *With those same gloved hands, he picked up a lid to a coffee pot, set it on the counter, filled it, picked up a lid, and screwed it on the coffee pot. *With those same glove hands he delivered the cart to the kitchenette on Morningview hallway and came back to the main kitchen. *He continued to move between the main kitchen and the Morningview kitchenette while he touched several surfaces and resident food items (silverware, BBQ sauce, straws, beverage cans and water glass rims) with those same gloved hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*At 11:18 a.m. he removed those gloves, did not wash his hands and put on a new pair of gloves and again touched several surfaces and resident food items (utensils, buns, plates, and cupboards) while he served lunch. *He picked up a clipboard and documented resident meal intakes with those same gloves on. *At 11:50 a.m. he removed those gloves and did not wash his hands. 5. Interview on [DATE] at 11:52 a.m. with dietary aide F regarding glove use and handwashing revealed he stated: *Gloves are to be worn whenever handling food or beverages. *If he left the serving area and changed gloves, he would wash his hands before putting on the new gloves. 6. Observation on [DATE] at 11:18 a.m. with UAP H revealed: *She wore gloves while serving a resident meal plate in the 500-hall dining room, without changing those gloves she took a bottle of ketchup out of the refrigerator, then served the next plate while wearing those same gloves. *While wearing those same gloves she left the dining room and delivered a meal tray to resident room [ROOM NUMBER]. *She returned to the serving area, removed those gloves, did not wash her hands, put on a new pair of gloves and delivered a meal tray to resident room [ROOM NUMBER]. *She removed those gloves as she walked to the serving line, discarded them in the trash, did not wash her hands and put on a new pair of gloves. *She then stated, We don't have to, but I like to wear gloves when I serve food. 7. Interview on [DATE] at 9:00 a.m. dietary manager (DM) D regarding glove use, hand hygiene, and food storage, handling, preparation, and serving revealed: *Food items were labeled with a black marker that indicated an intake date. *The manufactured date was the date used for the expiration date. *Prepared or leftover food was to have been labeled with a sticker that identified the food, the date it was placed in the refrigerator, and the date it should have been discarded. *She would have expected expired food to have been thrown away. *Dry cereal, once removed from the box, should have been labeled with a sticker indicating what kind of cereal it was, and when it was to have been discarded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She would have expected gloves to have been worn when touching ready-to-eat foods. *She stated gloves needed to be changed when moving on to a new task. *She would have expected staff to wash their hands when they arrived at work, before starting a task, before putting on gloves, after removing gloves, and when their hands were soiled. *Gloves were not to have been worn while delivering food to residents at the table or to their rooms. *Hand sanitizer should have been used in the dining room between each task. 8. Interview on [DATE] at 3:10 p.m. with registered dietitian E, by email, , regarding food handling, glove use, and hand hygiene revealed: *I expect that staff will use gloves whenever handling ready-to-eat foods that are not going to be cooked further. *They should be washing hands before putting [on] the gloves. *Hand washing needs to be done frequently and often between tasks and after breaks . *I expect dining room staff to wash [their] hands prior to serving. -I don't expect them to wear gloves when serving meals unless they are touching a ready to eat item like a roll or bun. Review of the provider's 2017 Food Receiving and Storage policy revealed: *Dry foods that are stored in bins will be removed from original packaging, labeled and dated (use by date). *All food stored in the refrigerator or freezer will be covered, labeled and dated (use by date). Review of the provider's 2017 Preventing Foodborne Illness- Employee Hygiene and Sanitary Practices policy revealed: *Employees must wash their hands: whenever entering or re-entering the kitchen; before coming into contact with any food surfaces; during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks . *The use of disposable gloves does not substitute for proper hand washing. Review of the provider's 2009 Personal Protective Equipment - Gloves policy revealed: *Wash your hands after removing gloves or use alcohol hand rinse if appropriate. 45683

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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. 32332 Based on observation, interview, and policy review, the provider failed to ensure: *Licensed practical nurse (LPN) O and certified nursing assistant (CNA) P had performed hand hygiene and glove use according to the provider's policy during a dressing change for sampled resident (164). *Registered nurse (RN) K had performed hand hygiene and glove use according to the provider's policy during a nebulizer treatment with resident (115). Findings include: 1. Observation and interview on 5/22/24 at 12:30 p.m. with LPN O and CNA P during a dressing change for resident 164 revealed: *LPN O entered the resident's room and into the bathroom. *Then CNA P entered the room. *Both LPN O and CNA P put on gloves without washing their hands. *LPN O: -Removed the soiled wound dressings from the residents buttock and removed her gloves. -Put on clean gloves without washing her hands. -Placed some paper towels at the head of the bed. -Placed the resident's new dressings on top of those paper towels and opened the dressings. -Took her gloves off and put clean gloves on without washing her hands or using hand sanitizer. -With those gloved hands she reached into her pocket, removed a pen and dated the new dressings with the pen. *LPN O placed two new dressings on resident 164's buttock. *CNA P had assisted with repositioning the resident, the bedding, clothes, and incontinence brief. -She removed her soiled gloves and without washing her hands she put clean gloves on. *A large bottle of hand sanitizer was on top of the medication cabinet in the room. *LPN O and CNA P confirmed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There was hand sanitizer available for use in the room. -They should have used hand sanitizer or soap and water each time they changed their gloves. 2. Interview on 5/24/24 at 1:00 p.m. with the RN infection preventionist I and RN staff development coordinator L regarding the above observed lack of hand hygiene revealed the staff had received repeated hand hygiene education. 3. Observation and interview on 5/22/24 at 10:02 a.m. with RN K while providing a nebulizer treatment for resident 115 revealed: *She did not perform hand hygiene before taking the nebulizer equipment out of the packaging. *She did not perform hand hygiene before putting gloves on or after taking them off. *She admitted she did not perform hand hygiene and stated she should have sanitized her hands before touching the equipment. Review of the provider's January 2023 Nebulizer Treatments policy revealed: * Procedure: 1. Wash or sanitize hands. Review of the provider's Handwashing/Hand Hygiene Policy revealed: *All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. *All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. *Hand hygiene products and supplies (sinks, soap, towels, alcohol-based rub) would be readily accessible and convenient for staff use to encourage compliance with hygiene policies. *Wash hands with soap and water for the following: -When the hands were visibly soiled; and -After contact with a resident with infectious diarrhea. -Before and after coming on duty. -After personal use of the toilet or conducting your hygiene. *Use an alcohol-based hand rub containing at least 62% alcohol or soap and water for the following situations such as: -Before and coming on duty. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435079	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER United Living Community		STREET ADDRESS, CITY, STATE, ZIP CODE 405 First Ave Brookings, SD 57006	

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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 - Some	-Before and after direct contact with residents. -Before preparing or handling medications. -Before and after handling invasive devices such as a catheter and IV access sites. -Before handling used dressings and contaminated equipment. -Before moving from a contaminated body site to a clean body site during resident care. -After contact with blood or bodily fluid. -Before assisting residents with eating. *Hand hygiene is the final step after removing and disposing of protective equipment. *The use of gloves does not replace hand washing or hand hygiene. *Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.