STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435097	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Andes Senior Living	740 East Lake St Lake Andes, SD 57356

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49958 Based on observation, interview, and policy review, the provider failed to ensure dignity was maintained for two of three sampled residents (19 and 34) who had urinary catheter drainage bags that were not covered. Findings include: 1. Observation on 8/27/24 at 11:51 a.m. with resident 34 revealed: *He was in his wheelchair in the dining room with his urinary catheter drainage bag hanging under the wheelchair. *The urinary catheter drainage bag was not covered and contained visible urine. Observation on 8/29/24 at 8:43 a.m. with resident 34 revealed: *He was in the living room near the television with his urinary catheter drainage bag hanging under his wheelchair. *The urinary catheter drainage bag was not covered and contained visible urine. 2. Observation on 9/3/24 at 2:55 p.m. with resident 19 revealed: *He was in bed with a urinary catheter drainage bag hanging from the bed bar on the left side of his bed. *The urinary catheter drainage bag was not covered and half-filled with visible urine. *The urinary catheter drainage bag was visible from the hallway. 3. Interview on 9/03/24 at 3:00 p.m. with director of nursing (DON) B revealed: *She expected urinary catheter drainage bags to have been covered when under the resident's wheelchair or when hanging from the edge of the resident's bed. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Staff had been educated about covering urinary catheter bags. *Dignity covers were available for all catheters. 4. Review of the provider's revised 2023 Promoting/Maintaining Resident Dignity policy revealed: *It is the practice of this facility to protect and promote the resident's rights and treat each resident with respect and dignity . *All staff members are involved in promoting care to residents to promote and maintain resident dignity and respect resident rights. Review of the provider's October 19, 2022, Catheter Care Policy revealed the policy did not address covering the urinary catheter drainage bag.

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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. 45383 Based on record review, and interview, the provider failed to ensure one of one sampled resident (11) had documentation of a power of attorney for healthcare that would have allowed information to be released to the resident's friend. Findings include: 1. Review of resident 11's electronic medical record (EMR) revealed: *He had a brief interview for mental status (BIMS) score of 7 which indicated he had severe cognitive impairment. *He had a friend listed as a contact for care conferences and his emergency contact. *On 9/13/23 resident 11's friend had given verbal consent for him to receive an Influenza and a Respiratory syncytial virus (RSV) vaccination. *On 4/30/24 verbal education had been given to resident 11's friend regarding the increase in his Mirtazapine (an antidepressant) from 7.5 milligrams (mg) to 15 mg once daily at bedtime. -Resident 11's friend had verbalized understanding and had been ok with the increase. *On 5/14/24 at a care conference, resident 11's code status had been reviewed. Resident 11's friend was on board if hospice services had been required. Interview on 9/3/24 at 3:24 p.m. with social services director (SSD) E regarding power of attorney for healthcare/advanced directives revealed: *She would help residents with their advanced directive. *She had been unsure if there had been any written release of information for resident 11's emergency contact. *She agreed that his emergency contact had not been his POA and her agreement to care would not be necessary. Interview on 9/3/24 at 3:48 p.m. with SSD E regarding notification of resident 11's emergency contact revealed she had produced a document that allowed his emergency contact notification of his care conferences only. Interview on 9/3/24 at 3:58 p.m. with regional nurse consultant S and director of nursing B regarding releasing information to resident 11's emergency contact revealed: *They agreed they did not have the emergency contact listed as power of attorney for healthcare and that the emergency contact could not make medical treatment decisions for resident 11. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*They had not been aware releasing his information without the proper documentation in place may have been a HIPAA (health insurance portability and accountability act). Resident 11 was ill and was not interviewed regarding his friend as his emergency contact. Review of the provider's 2014 advanced directives policy revealed advanced directives included: *Advance Directives - such as a Durable Power of Attorney for Health Care document, Living Will, and POLST and other similar directives. *Plans for care when a sudden, life-threatening condition is diagnosed - such as a stroke, heart attack, pneumonia, or cancer. *Plans for care when a resident's health is gradually deteriorating - such as progression of Alzheimer's disease or other dementia; weight loss without an obvious medical cause; and worsening of congestive heart failure, kidney failure, or chronic lung disease. *Considering a palliative or comfort care plan or enrolling in a hospice program.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43021 Based on record review and interview, the provider failed to ensure the proper Medicare notices were completed and provided timely for three of three sampled residents (12, 38, and 39) prior to their discharge from Medicare Part A skilled services. Findings include: 1. Review of the Entrance Conference Worksheet completed by the provider on 8/27/24 revealed six residents were listed who had been discharged from Medicare Part A skilled services: *Five of those residents remained in the facility following their discharge from Medicare Part A. *One of those residents (39) was identified on the worksheet above as being discharged to home following his discharge from Medicare Part A. 2. Review of resident 39's CMS (Centers for Medicare and Medicaid Services) SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review form completed by business office manager (BOM) U on 8/29/24 revealed: *Resident 39's Medicare Part A Skilled Services Episode start date was 3/18/24. *His last covered day on Medicare Part A Service was 4/16/24. *The form's first question: Was a SNF ABN [Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage], Form CMS-10055 provided to the resident? was answered No with a handwritten explanation, Unknown. Was not in my job position at the time. *The form's second question: Was a NOMNC [Notice of Medicare Non-Coverage], Form CMS-10123 provided to the resident? Was answered Yes and and a copy of the form that was signed by resident 39 was provided. A request for resident 39's SNF ABN form was made on 9/4/24 at 5:54 p.m. from regional nurse consultant S and was not received by the end of the survey on 9/5/24 at 6:30 p.m. Review of the NOMNC form signed by resident 39 on 4/7/24 revealed: *The provider's name was above the title of the form. -The provider's address was not listed as required. -The provider's phone number was not listed as required. *The Effective Date Coverage of Your Current [left blank] Will End was completed with the date 4-10-24. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The type of services ending was left blank and should have been identified as skilled nursing. -The date of 4/10/24 was six days earlier than 4/16/24, his last covered day on Medicare Part A Service. Review of resident 39's electronic medical record (EMR) revealed: *He was admitted on [DATE] with Medicare Part A covering his stay. *On 4/17/24, after his Medicare Part A stay ended, he remained in the facility until 5/24/24. *He had skilled covered days remaining, continued to reside in the facility, and had not been discharged home on 4/16/24 as indicated on the Entrance Conference Worksheet. 3. Review of resident 12's CMS SNF Beneficiary Protection Notification Review form completed by BOM U on 8/29/24 revealed: *His Medicare Part A Skilled Services Episode start date was 4/8/24. *His last covered day on Medicare Part A Service was 5/9/24. *The form's first question Was a SNF ABN, Form CMS-10055 provided to the resident? was answered No with a written explanation, Unknown. Was not in my job position at the time. *The form's second question Was a NOMNC, Form CMS-10123 provided to the resident? Was answered Yes and and a copy of the unsigned form with the provider's notes was provided. A request for resident 12's SNF ABN form was made on 9/4/24 at 5:54 p.m. from regional nurse consultant S and was not received by the end of the survey on 9/5/24 at 6:30 p.m. Review of the NOMNC form for resident 12 revealed: *The provider's name was above the title of the form, but the provider's address or phone number was not listed as required. *The Effective Date Coverage of Your Current [left blank] Will End was completed with the date 5-6-24. -The type of services ending was left blank and should have been identified as skilled nursing. -The date of 5/6/24 was three days earlier than 5/9/24, his last covered day on Medicare Part A Service. *The form was not signed or dated to indicate when the notice was received. -The form contained the following handwritten notes: --mailed 5/1/24 [with his daughter's first and last name]. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--called 5/10/24, mailed again. --called, no response 5/22. Review of resident 12's EMR revealed: *He was admitted on [DATE] with Medicare Part A covering his stay. *His 4/15/24 Minimum Data Set (MDS) assessment recorded his brief interview for mental status (BIMS) score was nine, which meant he was moderately cognitively impaired. *On 5/10/24, after his Medicare Part A stay had ended, he remained in the facility. 4. Review of resident 38's CMS SNF Beneficiary Protection Notification Review form completed by BOM U on 8/29/24 revealed: *Her Medicare Part A Skilled Services Episode start date was 7/17/24. *Her last covered day on Medicare Part A Service was 7/31/24. *The form's first question: Was a SNF ABN, Form CMS-10055 provided to the resident? was answered Yes and a copy of the form that was signed by resident 38 was provided. *The form's second question: Was a NOMNC, Form CMS-10123 provided to the resident? Was answered Yes and a copy of the form that was signed by resident 38 was provided. Review of the SNF ABN form for resident 38 revealed: *The provider's name, address and phone number were not listed as required. *The resident had signed and dated the form on 7/30/24, which was a one-day notice, not the two-day notice required by 42 CFR [Code of Federal Regulations] 405.1200 (b)(1). Review of the NOMNC form for resident 38 revealed: *The provider's name was above the title of the form, but the provider's address and phone number were not listed as required. *The Effective Date Coverage of Your Current [left blank] Will End was completed with the date 7-31-24. -The type of services ending was left blank and should have been identified as skilled nursing. -The date of 7/31/24 was her last covered day on Medicare Part A Service. *The form was signed and dated by the resident on 7/30/24, which was a one-day notice, not the two-day notice required. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident 38's EMR revealed: *She was admitted on [DATE] with Medicare Part A covering her stay. *On 7/31/24, after her Medicare Part A stay had ended, she remained in the facility. 5. Interview on 9/4/24 at 10:11 a.m. with executive director (ED) A, in-person, and business office consultant (BOC) V, by phone, revealed: *BOM U had started her position on 4/28/24 but was currently out of the facility on leave. *BOM U was responsible for issuing the Medicare notices since July 2024, after BOC V had provided training on the Medicare notices which included the required two-day notice for the Medicare notices. *Both ED A and BOC V agreed the Medicare notices should have included the provider's name, address, and phone number above the title of the forms. *In reviewing resident 39's Medicare Part A stay and his NOMNC notice BOC V agreed: -He remained in the facility following his Medicare Part A's last covered day, 4/16/24. -He should have been given a SNF ABN notice. -The 4/10/24 date written on his NOMNC form was wrong and should have been 4/16/24. -She was not sure why resident 39's NOMNC form had the wrong date. *In reviewing resident 12's Medicare Part A stay and his NOMNC notice BOC V agreed: -He should have been given an SNF ABN notice. -The 5/6/24 date written on his NOMNC form was wrong and should have been 5/9/24. -She was not sure why resident 12's NOMNC form had the wrong date. *In reviewing resident 38's Medicare Part A stay and her Medicare notices BOC V agreed that her last covered day on Medicare Part A Service was 7/31/24. *Both ED A and BOC V agreed that resident 38 had not been given her Medicare notices at least two days before the end of her skilled services as required. On 9/4/24 at 11:36 a.m. a request for the provider's policy regarding the Medicare notices, including both the SNF ABN and NOMNC notices was made to ED A and he revealed that they had no policy regarding the required Medicare notices. 6. Review of the Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) Form CMS-10055 (2018) and Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123 provided to ED A on 9/4/24 at 11:36 a.m. revealed: (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Completing the SNF ABN . The SNF must include the SNF's name, address, and phone number, at a minimum. *When to Deliver the NOMNC .The NOMNC must be delivered at least two calendar days before Medicare-covered services end . *Heading -The name, address and telephone number of the provider that delivers the notice must appear above the title of the form. -Fill in the type of services ending, {home health, skilled nursing, comprehensive outpatient rehabilitation services, or hospice} and the actual date the service will end.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49958 Based on observation, interview, and policy review the provider failed to ensure privacy had been maintained for four of four sampled residents (35, 36, 38, and 139) who had adjoining rooms with a shared bathroom. Findings include: 1. Observation and interview on 8/27/24 at 12:28 p.m. with resident 35 revealed: *Resident 35 resided in room [ROOM NUMBER] which shared a bathroom with room [ROOM NUMBER]. *Both of those rooms' bathroom doors had been removed. *A shower curtain was hung in place of the door on resident 35's side of the room. *There was no curtain on the side of the bathroom shared with room [ROOM NUMBER]. *room [ROOM NUMBER] was being used to store resident equipment including a recliner, a bed, cardboard boxes, and linens. -Staff entered room [ROOM NUMBER] to access these items. *Resident 35 stated that she could not close the door because there was no door to close. 2. Observation on 8/27/24 at 1:34 p.m. and throughout that day with resident 36 in room [ROOM NUMBER] revealed: *The bathroom doors of the shared bathroom between resident rooms [ROOM NUMBERS] had been removed and a shower curtain had been hung in those doorways on both sides. *room [ROOM NUMBER] was being used as a conference room for the surveyors. *Resident 36 opened the curtain while seated on the toilet in that shared bathroom and asked the surveyors who they were and if she knew them. *When staff entered room [ROOM NUMBER] the surveyors could hear their conversations with resident 36 even with both curtains drawn. 3. Observation and interview on 9/3/24 at 10:17 a.m. with resident 36 in room [ROOM NUMBER] revealed: *Resident 35 opened the bathroom curtains between rooms [ROOM NUMBERS] and entered room [ROOM NUMBER] from room [ROOM NUMBER] during the surveyor's interview with resident 36. *Resident 36 stated, I don't like an audience. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Resident 35 then stood in the bathroom, where the surveyor could see her in the bathroom mirror, and listened to the surveyor's interview with resident 36. *The interview with resident 36 was ended and conducted at a later time. 4. Observation and interview on 9/3/24 at 4:09 p.m. with resident 38 revealed. *Resident 38 was now in room [ROOM NUMBER] which shared a bathroom with room [ROOM NUMBER]. -room [ROOM NUMBER] was being used to store resident equipment including a recliner, a bed, cardboard boxes, and linens. *There was a shower curtain hanging in the doorways on each side of the adjoining bathroom. -The curtain on room [ROOM NUMBER]'s side of the bathroom contained netting on the upper third of the curtain that allowed a direct line of sight into the bathroom and room [ROOM NUMBER]. *Staff entered room [ROOM NUMBER] four times during the surveyor's interview with resident 38 which was conducted in room [ROOM NUMBER]. -The surveyor had to stop the interview each time to allow for resident 38's privacy. 5. Observation and interview on 9/4/24 at 8:24 a.m. with resident 38 revealed: *The same curtain remained on the side between the bathroom and room [ROOM NUMBER]. *Resident 38 stated she was uncomfortable when she was in the bathroom because they come and go from room [ROOM NUMBER] and I never know when they are going to walk in there. *She stated, I am afraid someone is going to walk in on me when I am in the bathroom. 6. Observation and interview on 9/4/24 at 8:29 a.m. with director of nursing B revealed she: *Confirmed that the curtain between room [ROOM NUMBER] and the bathroom did not provide privacy for the resident in room [ROOM NUMBER] who used that bathroom. *She stated that the curtain needed to be changed. 7. Interview on 9/4/24 at 10:40 a.m. with executive director A regarding the use of shower curtains as doors on shared bathrooms revealed he: *Agreed the curtains did not provide complete privacy. *Stated the shared bathrooms were only shared female to female or male to male. *Confirmed that before the shower curtains, an accordion-style door was used that reached from the floor of the doorway to the top of the doorway. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Agreed that the curtain with the netting on top, did not provide adequate privacy as a person could see through the netting *Stated that bathroom doors were expensive. 8. Review of resident 36's electronic medical record revealed: *An 8/18/24 progress note (PN) that indicated, Resident very upset and scared. Resident from the other room [resident 139] that shares the bathroom came into her room and climb into her bed and would leave. Staff went down and finally assisted the resident and got her to go back into her room. 9. Review of resident 139's electronic medical record revealed: *An 8/18/24 PN indicated, Resident went from her bathroom that she shares into the other resident room and climb into the bed. Staff was informed and removed her back to her room. Other resident was frighten. *An 8/20/24 PN indicated Room change due to resident's behavior disrupting neighbor. She will have own room and bathroom. Resident kept going into other room next door . Resident moved due to behaviors of her going into her neighbors room and disturbing neighbor when she was using the bathroom. Resident neighbor was really upset by this and had found her laying in her bed. 10. Interview on 9/4/24 at 2:03 p.m. with DON B regarding the incident on 8/18/24 with resident 36 revealed she: *Confirmed that resident 139 had entered resident 36's room through the shared bathroom. -Resident 139 was moved to a private room. *Confirmed that the shared bathrooms were only between resident rooms [ROOM NUMBERS] and rooms [ROOM NUMBERS]. *Did not know when they began using the shower curtain instead of a retractable door. -The retractable doors have not been replaced since they broke. *Stated that they would not put males and females on opposite sides of the bathroom. *Confirmed that they did not have a policy regarding the use of the shower curtain or the shared bathrooms. *Confirmed she was aware of the resident's concerns regarding privacy. 11. Review of the provider's revised 2023 Promoting/Maintaining Resident Dignity policy revealed: *It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances residence quality of life . (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Maintain resident privacy. Review of the provider's undated A Resident [NAME] of Rights handbook revealed: *You have the right to privacy and confidentiality in the facility. This includes your accommodations .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45383 Based on observation, interview, and record review, the provider failed to ensure a clean and homelike environment was maintained for all 39 residents who resided at the facility. Findings include: 1. Observation on 8/27/24 at 12:10 p.m. revealed: *The heat register outside of resident room [ROOM NUMBER] was rusted and not cleanable. *The storage cove outside room [ROOM NUMBER] contained: -An oxygen concentrator. -An locked out Volaro lift. -A rolling desk chair. -A shelf contained: --Eight individual incontinent undergarments. --An open package of bathroom hygiene wipes. --An open package of incontinent undergarments. --A sheepskin blanket/bed pad. --A sign that indicated enhanced barrier precautions. Observation on 9/3/24 at 9:00 a.m. of the east hallway revealed there was a cloth chair that had a stain on the seat. Observation on 9/3/24 at 9:47 a.m. of the dining room revealed: *The west side Fujitsu air conditioning unit had 21 brown drip stains on it. *The east side Fujitsu air conditioning unit had four brown drip stains on it. *The vent next to that Fujitsu air conditioning unit had rust and a black substance on it. *There were 17 water-stained tiles on the ceiling of the dining room. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Andes Senior Living	740 East Lake St Lake Andes, SD 57356

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observations made on 9/4/24 throughout the day from 8:00 a.m. through 6:00 p.m. revealed the individual room air conditioners in rooms 1, 2, 6, 8, 9, 11, and 12 had accumulated dust on the air return grates. Observation on 9/4/24 at 4:30 p.m. of the dining room revealed the air return vent on the east side of the dining room was rusty and uncleanable. 49958 Observation on 9/4/24 at 4:48 p.m. revealed: *A piece of weather stripping from the bottom of the exterior door was propped against the wall outside room [ROOM NUMBER]. *Resident rooms [ROOM NUMBER]'s doors were missing several portions of the door paneling. -There was exposed wood with sharp edges on the outside hinge side of those doors. *The toilet plumbing in room [ROOM NUMBER] had a green [NAME] and was an uncleanable surface. -A portion of the toilet caulking was missing. *The bathroom door in room [ROOM NUMBER] had been removed and at least 20 holes remained in the wall. -There was peeling paint on the bathroom door framing. *There was no threshold between the laminate flooring in room [ROOM NUMBER] and the carpet in the hallway. -An uncleanable gap remained in that flooring transition area. *Doors and door frames to resident rooms 20, 21, 22, 25, 26, 27, and 28, had peeling paint and were uncleanable surfaces. *The linen closet door next to resident room [ROOM NUMBER] had peeling paint and was an uncleanable surface. *The bathroom sink faucet in resident room [ROOM NUMBER] was green with a [NAME] and was not a cleanable surface. *The hallway ceiling light outside room [ROOM NUMBER] contained unidentifiable debris. *The bathroom outside of the director of nursing office contained the following uncleanable surfaces: -The bathroom door was peeling. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The mirror had several areas of reflective surface missing. -The disposable menstrual products machine was rusted. -The sink faucet and toilet plumbing were white and green with water stain residue. -The paper towel dispenser was cracked in the front and there was an unidentified tan substance in the crack. *The metal ceiling tile frames starting near the south doors headed towards the front door were stained or rusted a dark orange color. *There were at least 15 ceiling tiles between the nurse's station and front door that were stained with a dark orange substance. *The baseboard molding between the living room and hallway was torn and the drywall was exposed. 2. On 9/5/24 at 6:15 p.m. the survey team met with executive director (ED) A and director of nursing (DON) B for an exit conference and reviewed the environmental observations. ED A and DON B provided no disagreement or comment. 3. Review of the provider's undated A Resident [NAME] of Rights handbook revealed, You are entitled to a quality of life. A facility must provide care and an environment that contributes to your quality of life including: A safe, clean, comfortable and homelike environment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45383 Based on observation, interview, record review, and policy review the provider failed to ensure the care plans for two of two sampled residents (19 and 139) reflected their current needs: *Resident 139's care plan did not include fall and elopement interventions. *Resident 19's care plan did not include enhanced barrier precautions (EBP) (use of gown and gloves while providing contact care) due to his open wounds and his indwelling catheter. Findings include: 1. Observation on 8/27/24 at 8:52 a.m. of resident 139 while she was lying in her bed revealed: *Her bed had been in a lowered position. *A fall mat was on the floor next to the bed. Review of resident 139's electronic medical record (EMR) revealed: *She had been admitted on [DATE]. *On 8/29/24 she had been identified as a fall risk. *On 8/29/24 she had been identified as an elopement risk. -An order had been obtained for a Wanderguard (a door alarming bracelet). Review of resident 139's current care plan revealed: *There had not been any indication for the use of the fall mat to have been used next to her bed. *There had not been any indication that she had been using a Wanderguard due to her elopement risk. 49958 2. Observation on 9/3/24 at 9:55 am of resident 19 in his room revealed: *He had a urinary catheter drainage bag hanging from the left side of his bed. *There was no sign to indicate EBP was to be used when providing care to resident 19. *There were gloves, but no gowns or eye protection were in the room or outside the door. Observation and interview on 9/3/24 at 10:32 a.m. with certified medication aide (CMA) I revealed she: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Was taking resident 19's vitals. *Was not wearing a gown or gloves. *Stated that she provided medication to resident 19, took his vitals, and applied a cream to his legs. *Confirmed that resident 19 was off all precautions as of today. *Stated, I only wear gloves when applying a cream, but I don't need a gown. Observation and interview on 9/3/24 at 11:26 a.m. with certified nursing assistant (CNA) M and CNA N revealed. *They transferred resident 19 with a mechanical stand aid. *CNA M and CNA N were not wearing gowns or gloves. *CNA N stated they did not need to wear a gown when providing care to resident 19. Review of resident 19's electronic medical record (EMR) revealed: *He was admitted on [DATE]. *Admission documentation indicated five open wounds being treated. *On admission there was a physician's order for an indwelling urinary catheter. *There had not been any indication in resident 19's current care plan that EBP was required or when it was required. Observation and interview on 9/3/24 at 3:28 p.m. with director of nursing B revealed: *She confirmed that the sign for EBP was not inside the door above the light switch in resident 19's room where she had expected it to be. *She confirmed there were no gowns or eye protection present in resident 19's room or outside the door. *It was her expectation that gowns, gloves, and eye protection be worn when providing care for residents with wounds and indwelling urinary catheters. On 9/5/24 at 6:15 p.m. the survey team met with executive director (ED) A and DON B for an exit conference and reviewed the area of the citation proposed. ED A and DON B provided no disagreement or comment. Review of the provider's October 2017 Person Centered Care Plan policy revealed: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*It did not include the provider's letterhead or facility name. *COMPREHENSIVE PERSON-CENTERED CARE PLANS: 1. Developed within 7 days after completion of the comprehensive MDS [Minimum Data Set] Assessment. 2. Contains measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs . * The overall person-centered care plan should be oriented towards: . managing risk factors.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45383 Based on observation, interview, record review, and policy review the provider failed to ensure care plans were revised to reflect the current care needs of two of two sampled residents (22 and 38) related to: *Resident 22 who had a central venous catheter (CVC) he used for dialysis treatments. *Resident 38 who checked her blood sugars and self-administered insulin. Findings include: 1. Observation on 8/29/24 at 12:46 p.m. of resident 22 while seated in his wheelchair revealed he had a central venous catheter (CVC) he used for dialysis treatments. Review of resident 22's care plan revealed: *I have End Stage Renal disease and require dialysis. *I go to dialysis on Monday, Wednesday & Friday @ 1000, make sure I have had my meal and medications before I go, I take a sack lunch to dialysis. *Monitor Bruit and thrill, redness or swelling at site every shift. Nursing. *Notify my MD of any shunt problems: no bruit, bleeding, port problems, symptoms of infection, abnormal labs, persistent symptoms of fluid retention (peripheral edema, weight gain, neck vein distention, orthopnea, elevated B/P, tachycardia or tachypnea). Interview on 9/5/24 10:30 a.m. with Minimum Data Set (MDS) coordinator D regarding resident 22's care plan revealed: *She had not revised his care plan to remove the checking for a bruit and thrill of his fistula. *She agreed that resident 22 had CVC to receive his dialysis treatment and would not have required the checking for a bruit and thrill of his fistula. 49958 2. Interview on 8/29/24 at 10:49 a.m. with resident 38 revealed: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She stated that she resided there because of complications with her diabetes. *She tested her blood glucose (sugar) levels four times a day, and gave herself injections of insulin. *She stated her blood sugars are all over the place. -She clarified that she had some blood glucose levels that were low and some blood glucose levels that were high when she checked them. *It was her goal to return to a community living environment. Review of resident 38's electronic medical record (EMR) revealed: *She was admitted on [DATE]. *She had a Brief Interview for Mental Status (BIMS) score of 15 which indicated she was cognitively intact. *Her diagnosis included type 1 diabetes mellitus, anxiety disorder, celiac disease, mild intellectual disabilities, oppositional defiant disorder, and adverse effect of insulin and oral hypoglycemics [antidiabetic] drugs, subsequent encounter. *A 7/11/24 physician order for blood glucose monitoring before meals and at bedtime. *A 7/11/24 physician order for Novolog Injection Solution 100 unit/ML [milliliter] per sliding scale. *A 7/15/24 medication self-administration safety screen that had been initiated but not completed. *An 8/17/24 progress note stated, Resident checked her blood sugar independently and gave herself her insulin appropriately. *An 8/27/24 progress note that stated, resident did own testing and giving of insulin. *There was no physician order for medication self-administration. *The resident care plan did not indicate that resident 38 checked her blood sugars or self-administered her insulin. On 9/5/24 at 6:15 p.m. the survey team met with executive director (ED) A and director of nursing (DON) B for an exit conference and reviewed the accuracy of care plans. ED A and DON B provided no disagreement or comment. Review of the provider's October 2017 Person Centered Care Plan policy revealed: *It did not include the provider's letterhead or facility name. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Person centered care planning is an on-going process which actively encourages the resident and/or the resident's representative to be an active participant in the care planning process and addresses the development and implementation of individualized person care. *Reviewed and revised annually, quarterly, with significant change in status and as needed. * The overall person-centered care plan should be oriented towards: . managing risk factors.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45383 Based on record review, interview, observation and policy review, the provider failed to ensure: *One of one sampled resident (11) had been re-weighed after a nine-pound weight loss within 13 days. *One of one sampled resident (38) had been accurately assessed for self-administration of medication. Findings include: 1. Review of resident 11's electronic medical record (EMR) revealed: *On 8/8/24 a weight of 165 pounds had been documented. *On 8/21/24 a weight of 156 pounds had been documented. *There was no documentation found that resident 11 had been reweighed due to that 5.45% weight loss in 13 days. Interview on 9/3/24 at 3:19 p.m. with certified nursing assistant (CNA) N regarding a change in a resident's weight revealed: *She would have informed her charge nurse of the weight change and then she would reweigh the resident. Interview on 9/4/24 at 3:26 p.m. with regional nurse consultant S, director of nursing B, and assistant director of nursing C regarding re-weighing residents revealed: *They had some issues with their scales. *All residents would have been weighed weekly on their bath days. *They agreed that there had been no documentation of resident 11 refusing to be weighed. *They agreed that resident 11 had not been reweighed once a 9-pound weight loss had been identified from his last recorded weight. Review of the provider's October 2021 Weight and Height Measurement policy reveled: *If resident has gained or loss three or more pounds resident needs to be reweighed with nurse supervision. If nurse has verified weight change nurse must notify physician and nursing leadership. 2. Interview on 8/29/24 at 10:49 a.m. with resident 38 revealed: (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*She stated that she resided there because of complications with her diabetes. *She tested her blood glucose levels four times a day and gave herself injections of insulin. *She stated her blood sugars are all over the place. -She clarified that she had some blood glucose levels that were low and some blood glucose levels that were high when she checked them. *It was her goal to return to a community living environment. Review of resident 38's electronic medical record (EMR) revealed: *She was admitted on [DATE]. *She had a Brief Interview for Mental Status (BIMS) score of 15 which indicated she was cognitively intact. *Her diagnosis included type 1 diabetes mellitus, anxiety disorder, celiac disease, mild intellectual disabilities, oppositional defiant disorder, and adverse effect of insulin and oral hypoglycemics [antidiabetic] drugs, subsequent encounter. *A 7/11/24 physician order for blood glucose monitoring before meals and at bedtime. *A 7/11/24 physician order for Novolog Injection Solution 100 unit/ML [milliliter] per sliding scale. *A 7/15/24 medication self-administration safety screen that had been initiated but not completed. *An 8/17/24 progress note stated, Resident checked her blood sugar independently and gave herself her insulin appropriately. *An 8/27/24 progress note that stated, resident did own testing and giving of insulin. *There was no physician order for medication self-administration. On 9/5/24 at 6:15 p.m. the survey team met with executive director (ED) A and director of nursing (DON) B for an exit conference and reviewed the accuracy of assessment for self-administration of medication. ED A and DON B provided no disagreement or comment. Review of the providers revised 2023 Medication Self Administration Safety Screen and/or Self Administration of Nebulizer Evaluation policy revealed: *Evaluation and approval for self administration of medication will be based on The Medication Self Administration Safety Screen and/or Self Administration of Nebulizer Evaluation. *The Medication Self Administration Safety Screen will be completed prior to the resident initiating self administration of medications . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*A physician's order will be obtained indicating which medications the resident may self administer and with or without supervision.

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49958 Based on interview and record review the provider failed to ensure care and services according to accepted standards of clinical practice regarding blood sugar monitoring, interventions, and notification to the resident's physician for four of seven diabetic residents (3, 20, 22, and 38) that experienced blood sugar levels outside of the normal range. Interventions and timely follow-up to those blood sugars was not consistently identified in their records. Finding include: Notice: Notice of immediate jeopardy was given verbally and in writing on 9/5/24 at 11:55 a.m. to executive director (ED) A and director of nursing (DON) B of the immediate jeopardy related to F684 when the provider failed to ensure quality of care regarding hypoglycemic (lower than standard blood sugar level range) and hyperglycemic (higher than standard blood sugar level range) risks for diabetic residents. On 9/5/24 at 11:55 a.m. ED A and DON B were asked for an immediate removal plan. Plan: On 9/5/2024, diabetic residents #3, #20, #22, and #38 who receive insulin will be managed with the glycemic management protocol given by the medical directors' guidelines. Nurses (RN and LPN) as well as medication aides have been educated on hypoglycemia and hyperglycemia protocols. Nurses are to contact each individual residents' provider in event of a low or high blood sugar reading. Nurses were educated to document interventions for low or high blood sugar within the resident's EMR. Nurses have been educated on the importance of following each individual resident's guidelines given by the resident's medical provider to properly manage diabetes. On 9/5/2024, nursing staff education was completed by the DON and ADON to ensure those who are currently working are providing appropriate glycemic care and the steps to follow in the event of a low or high blood sugar reading. Glycemic management protocol instructs that the nurse on duty will contact the residents' provider during clinical hours or their hospital on-call provider after business hours. All nurses and medication aides not on shift will be educated prior to them coming on shift. On 9/5/2024, all nurses and medications aides were educated on glycemic management protocols. All those not on shift will be educated prior to them coming on shift. Any concerns will be reported to the charge nurse, director of nursing, infection preventionist, and/or administrator immediately and addressed in facility QAPI. On 9/5/24 at 5:16 p.m. ED A provided their final plan for the removal of the immediate jeopardy. On 9/5/24 at 5:45 p.m. the provider's removal plan was accepted by the survey team. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 9/5/24 at 6:15 p.m. the survey team reviewed the provider's documentation for the removal of the immediate jeopardy and determined the immediacy was removed. After the removal of the immediate jeopardy, the scope and severity of the citation level was H. 1. Interview on 8/29/24 at 10:49 a.m. with resident 38 revealed: *She stated that she resided there because of complications with her diabetes. *She tested her blood glucose (sugar) levels four times a day and gave herself injections of insulin. *She stated her blood sugars are all over the place. -She clarified that she had some blood glucose levels that were low and some blood glucose levels that were high when she checked them. *It was her goal to return to a community living environment. Interview on 9/3/24 4:09 p.m. with resident 38 about her blood sugar levels on 9/2/24 revealed she: *Stated, I wasn't feeling the best, I was really sleepy. *Could not recall if she ate her breakfast that day, however, she stated, I slept through lunch and when they finally woke me up my blood sugar was 46. *Stated it was close to supper time so they brought me supper to my room and I ate it even though I didn't want it. *Did not know her blood sugar was low but recalled feeling shaky. *Recalled, They checked it [her blood sugar] about 3 hours later. *Stated, They said they tried to wake me overnight but I didn't budge. -There was no overnight blood sugar or attempts to wake her documented. *Stated she got really bad migraines and had one around 11 o'clock that night after her blood sugar was low. Review of resident 38's EMR revealed: *She was admitted on [DATE]. *She had a Brief Interview for Mental Status (BIMS) score of 15 which indicated she was cognitively intact. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*Her diagnosis included type 1 diabetes mellitus, anxiety disorder, celiac disease, mild intellectual disabilities, oppositional defiant disorder, and adverse effect of insulin and oral hypoglycemics [antidiabetic] drugs, subsequent encounter. *A 7/11/24 progress note indicated, Events leading up to admission: resident's blood sugar dropped to an extremely low level, leading her to end up in the emergency room *A physician order for Novolog Injection Solution 100 UNIT/ML [milliliter] (Insulin Aspart) Inject as per sliding scale: -71 - 150 = 0; -151- 200 = 3; -201 - 250 = 5; -251 - 300 = 7; -301 - 350 = 9; -351 - 400 = 11. -Greater than 400 Call MD [medical doctor]. -subcutaneously three times a day. -There was no guidance or order for what to do when the glucose level was lower than 71. *A physician order for Glucose Oral Tablet Chewable 4 GM [grams] (Dextrose (Diabetic Use)) Give 4 tablet by mouth as needed for Hypoglycemia. *On 7/16/24 at 6:58 a.m. a blood sugar of 57 mg/dL had been recorded. -Glucose Oral Tablets were not administered. *On 7/16/24 at 11:19 a.m. a recheck blood sugar of 414mg/dL had been recorded. -This was 4 hours and 21 minutes later. -There was no documentation the physician was notified. *On 8/14/24 at 10:00 a.m. a blood sugar of 51 mg/dL had been recorded. -Glucose Oral Tablets were not administered. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Andes Senior Living	740 East Lake St Lake Andes, SD 57356

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-There was no documentation of interventions related to the low blood sugar level or that the physician was notified. *On 8/14/24 at 11:11 a.m. a recheck blood sugar of 123 mg/dL had been recorded. -This was 1 hour and 11 minutes later. *On 8/18/24 at 8:05 p.m. a blood sugar of 410 mg/dL had been recorded. -There was no documentation the physician was notified. *On 8/20/24 at 4:47 p.m. a blood sugar of 407 mg/dL had been recorded. -There was no documentation the physician was notified. *On 8/30/24 at 11:29 a.m. a blood sugar of 49 mg/dL had been recorded. -Glucose Oral Tablets were not administered. *On 8/30/24 at 4:11 p.m. a recheck blood sugar of 415 mg/dL had been recorded. -This was 3 hours 42 minutes later. -There was no documentation the physician was notified. *On 9/2/24 at 5:10 p.m. a blood sugar of 46 mg/dL had been recorded by registered nurse (RN) Z. -Glucose Oral Tablets were not administered. *On 9/2/24 at 8:28 p.m. a recheck blood sugar of 216 mg/dL had been recorded. -This was 3 hours and 18 minutes later. On 9/4/24 at 6:21 p.m. a blood sugar of 38 mg/dL had been recorded. -Glucose Oral Tablets were not administered. -There was no documentation of interventions related to the low blood sugar level or that the physician was notified. *On 9/5/24 at 5:00 a.m. a blood sugar of 402 mg/dL had been recorded. -There was no documentation the physician was notified. 2. Review of resident 22's EMR revealed: *He was admitted on [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*His Brief Interview for Mental Status (BIMS) score was 15 which indicated he was cognitively intact. *His diagnosis included type 2 diabetes mellitus, end-stage renal disease, dependence on renal dialysis, and chronic vascular disease. *Insulin aspart solution inject as per sliding scale: -If 0-70 milligrams (mg) per deciliter (dL) = follow hypoglycemia protocol; -71-150= 0. -151-200= 2; -201-250= 4; -251-300= 6; -301-350= 8; -351+= 10 call MD, -Subcutaneously four times a day related to Diabetes Mellitus. *On 7/27/24 at 8:00 p.m. a blood sugar of 351 mg/dL had been recorded. *On 7/28/24 at 8:00 p.m. a blood sugar of 374 mg/dL had been recorded. *On 7/29/24 at 8:00 p.m. a blood sugar of 359 mg/dL had been recorded. *On 7/30/24 at 5:00 p.m. a blood sugar of 355 mg/dL had been recorded. *On 8/28/24 at 8:00 p.m. a blood sugar of 354 mg/dL had been recorded. *There was no documentation the physician was notified on 7/27/24, 7/28/24, 7/29/24, 7/30/24, nor 8/28/24. 3. Review of resident 3's electronic medical record (EMR) revealed: *She was admitted on [DATE]. *Her Brief Interview for Mental Status (BIMS) score was 15 which indicated she was cognitively intact. *Her diagnosis included type 2 diabetes mellitus, hepatic failure, and chronic kidney disease. *A physician order for Humalog Injection Solution (Insulin Lispro) Inject as (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	per sliding scale: -0 - 200 = 0; -201 - 250 = 3 units; -251 - 300 = 6 units; -301+ = 9 units, -subcutaneously three times a day. *There were no parameters for when the physician was to have been notified. *On 5/21/24 at 9:07 p.m. a blood sugar of 414 mg/dL had been recorded. *On 5/23/24 at 4:34 p.m. a blood sugar of 439 mg/dL had been recorded. *There was no documentation the physician was notified on 5/21/24 nor 5/23/24. 4. Review of resident 20's EMR revealed: *She was admitted on [DATE]. *Her Brief Interview for Mental Status (BIMS) score was 7 which indicated she was severely cognitively impaired. *Her diagnosis included type 2 diabetes mellitus, metabolic encephalopathy, cerebral infarction due to embolism and dementia. *A physician order for Humalog Injection Solution (Insulin Lispro) Inject as per sliding scale: -151 - 200 = 2 units; -201 - 250 = 4 units; ; 251 - 300 = 6 units; -301 - 350 = 8 units; -351 -400 = 10 Units; -401 - 500 = Call MD. -subcutaneously with meals. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*On 8/5/24 at 4:18 p.m. a blood sugar of 402 mg/dL had been recorded. -There was no documentation the physician was notified. 5. Interview on 9/4/24 at 10:06 a.m. with director of nursing (DON) B and regional nurse consultant (RNC) S revealed: *There was no written facility policy on hypoglycemia management or diabetic care. *There were [Providers Name] Standing Orders. -A copy of the standing orders was provided to the survey team. *A written request was provided for an interview with RN Z -RN Z was not available before the end of the survey. 6. Review of the [Providers Name] Standing Orders revealed: *There were 4 documents provided each with a different illegible physician's signature. *They had not been reviewed by the current DON. -They had been reviewed by the previous DON on 3/22/23. *These standing orders may be used at the discretion of the licensed Nurse. They are to be used only for the length of time specified, and then be replaced by a routine physician's order if additional use is indicated. *Glucose Gel 15, 40%Gel Tube, PRN [as needed] low Blood Sugar/per nurse assessment, Hypoglycemia. *Glucagon, 1mg [milligram] IM [intramuscularly], PRN Low Blood sugar, Unresponsive, Hypoglycemia. *May perform a one touch blood glucose on any resident to R/O [rule out] hypo or hyperglycemia. Interview on 9/5/24 at 8:25 a.m. with assistant director of nursing (ADON) C on the process for following up on low or high blood sugars revealed: *She confirmed that the doctor was to be notified when a resident had a low or high blood sugar reading. -The process depended on if the event occurred on the day shift or the night shift and who the doctor was. --During the day, if it was urgent the physician assistant at the clinic should have been called by phone. --If it was a less serious issue a fax should have been sent. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*Any time a physician was contacted we would document it. When we contact the medical doctor we will put in a progress note. *She did not know the facility policy on low blood sugars. -She stated, as a nurse, if it [a blood sugar reading] was in the 30's or 40's or something we would need to do something right away and contact the medical doctor. If in the 70's I would assess the resident and see if she was having breakfast soon. *When asked specifically about a blood sugar of 46 she stated, I would get them some carbs like peanut butter, a sandwich, or juice and check it [the blood sugar] again in 15 minutes. *She confirmed that the medical doctor should have been notified. *She stated, If it [a blood sugar of 47] was on the night shift we would wait til morning to contact the medical doctor. *She confirmed that the blood sugar, interventions, and notification to the physician by call or a fax sent, and a recheck of the blood sugar should have been documented in the resident's record. Interview on 9/5/24 at 9:45 a.m. with ADON C revealed she defined hypoglycemia as a range between 60-70 but that she would assess the symptoms because a person could feel hypoglycemic at 100 if they are used to their blood sugars being in the 600's. Interview on 9/5/24 at 1:48 p.m. with ED A and Chief Operating Officer AA regarding the diabetic care of insulin-dependent residents revealed they both agreed that notifications had not been made to residents' physicians according to their physician's orders and that interventions were missing from resident's electronic medical record. Interview on 9/5/24 at 5:29 p.m. with executive director A and DON B revealed the only time a physician was notified of a high or low blood sugar was on the documents provided. Review of the documents provided by ED A and DON B revealed: *Resident 20's physician had been notified of high blood sugars on 7/21/24 at 7:20 a.m. and again at 11:40 a.m. *There was no documentation that residents 3, 22, or 38's physicians had been notified of the 18 blood sugar levels outside of the normal range.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 49958 Based on interview, staff schedule review, and payroll record review, the provider failed to ensure a registered nurse (RN) was scheduled for eight consecutive hours for two of four weekends in May 2023. Findings include: 1. Interview on 9/4/24 at 3:03 p.m. with executive director A regarding the required eight hours of RN coverage on a daily basis revealed he: *Was responsible for filing the payroll-based journal (PBJ) reports. -He began submitting the facility's payroll-based journal information starting with Quarter 3 of 2024. *Had been aware they did not have an RN working in the facility on 5/7/24, 5/27/24, and 5/28/24. *Stated they always had a nurse in the building, but not always an RN on weekends. 2. Review of the provider's staff schedule and payroll record for May 2023 revealed they did not have RN coverage on the following dates: *Sunday 5/7/24. *Saturday 5/27/24. *Sunday 5/28/24.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 45383 Based on record review, interview, and policy review the provider had failed to ensure one of one sampled resident (139) had as needed (PRN) lorazepam (antianxiety medication) order renewed for use beyond 14 days. Findings include: 1. Review of resident 139's electronic medical record (EMR) revealed: *On 8/15/24 an order for lorazepam 0.5 milligrams (mg) orally to be given every six hours as needed for anxiety. *On 8/18/24 an order for lorazepam 2 mg per milliliter (ml) to be given 0.5 mg every six hours as needed for anxiety. *On 8/20/24 an order for lorazepam 0.5 mg to be given 0.25 mg every 12 hours as need for anxiety. *All orders had been active until 9/4/24. 2. Interview on 9/4/24 at 3:34 p.m. with regional nurse consultant S, director of nursing B, and assistant director of nursing C regarding resident 139's prn lorazepam revealed: *They had not been aware that all three lorazepam orders had not been renewed. *They all had agreed that the three as needed orders for lorazepam were not current. *They obtained a new order on 9/4/24 for resident 139 for lorazepam 2 mg/ml give 0.25 mg orally every six hours as needed for anxiety. 3. Review of the provider's January 2022 PRN Psychotropic Medication Process revealed: *To ensure that the resident's medication regimen is managed to promote or maintain the resident's highest practicable mental, [physician] and psychosocial well-being. *To ensure the utilization of PRN psychotropic medication(s) only when needed to treat specific diagnosed condition(s) and monitor the resident's use of PRN psychotropic medications in an effort to assist with stabilizing or improving the resident's outcome, quality of life and functional capacity. *All PRN Anti-Psychotic medications will be limited to 14-days and will not be renewed unless the prescriber directly examines the resident for appropriateness of the medication and documents the rational in the medical record prior to the nurse accepting and processing the order.

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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. **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 for resident consumption were appropriately labeled and stored in a safe and sanitary manner for the following: *Three of five freezers that contained food items that were not labeled or dated. *One of one resident refrigerator that contained food items that were not labeled, dated, or discarded by the use-by date. 1. Observation on 8/27/24 at 8:15 a.m. of the lower-level food storage area revealed: *A freezer labeled Freezer 1 contained two bags of fruit that were opened and not labeled or dated. *A freezer labeled Freezer 2 contained: -One bag of waffles that was open and not dated. -One bag of French Toast that was opened and not dated. -Three bags of frozen omelets that were not labeled or dated. -Garlic bread that was open and not dated. *An unlabeled freezer contained two bags of frozen vegetables that were open and not labeled or dated. 2. Observation on 8/27/24 at 10:49 a.m. of the resident refrigerator located in the therapy room revealed: *What appeared to be fruit in a plastic container dated 8/16/24. -The date indicated the food had been in that refrigerator for 11 days. *Yogurt labeled [NAME] 8/16/24. -The date indicated the food had been in that refrigerator for 11 days. *An open container of coffee creamer dated 7/30/24. -The date indicated the food had been in that refrigerator for 28 days. *A plastic bag with breaded meat labeled with resident 38's name that was not dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Interview on 9/4//24 at 10:18 a.m. with dining services manager F revealed: *She confirmed that there were unlabeled food items in the freezers and resident refrigerator. *Food items were to have been labeled with a black marker or a piece of tape that indicated a date received and an opened date. -The black markers smudge and wipe off and the tape falls off. *They have food labels that do not stick to the packages. *She was in the process of implementing a re-bagging system. *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 items in the freezer to be labeled and dated. *She would have expected items in the resident refrigerator to have been labeled, dated, and to have been thrown away after 7 days. -The kitchen and activities staff are responsible for monitoring the resident refrigerator. 4. Review of the provider's undated Food Storage Policy revealed: *It did not have an approval date by the medical director or governing body. *Date marking should be visible on all high-risk foods. *Leftover food must be used within7 days or discarded . *Frozen Foods: All foods should be covered, labeled and dated. Review of the provider's November 16, 2018, Outside Food and Food Storage policy revealed: *Foods or beverages brought in from the outside will be labeled with the resident's name, room number and dated by nursing with the current date the item(s) was brought to the facility for storage. * .will be dated when accepted for storage and discarded after 48 hours.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 43021 Based on observation, interview, record review, policy review, and job description review the provider failed to ensure the facility was operated and administered by executive director (ED) A and director of nursing (DON) B, in a manner that ensured the safety and overall well-being of all 39 residents in the facility. Those areas included: *Maintaining an effective infection control program that included following appropriate infection control procedures for the prevention and management of COVID-19 infections which included: -The implementation of appropriate precautions, including enhanced barrier precautions. -Ensuring staff demonstrated the proper use of personal protective equipment. -Hand hygiene after caring for infected residents. *Ensuring quality of care regarding hypoglycemic and hyperglycemic risks for four of seven insulin-dependent diabetic residents (3, 20, 22, and 38) which included interventions and physician notification according to blood glucose parameters set by the resident's physician. *Ensuring the facility was safe, clean, comfortable, and had a homelike environment. Resident rooms and other common use areas maintained in a manner to ensure the homelike environment. *Maintaining a resident's personal privacy with toileting for three residents (35, 36, and 38) who had adjoining rooms with a shared bathroom. *Ensuring a registered nurse worked for at least eight consecutive hours a day on three dates (5/7/24, 5/27/24, and 5/28/24). *Implementing an effective performance improvement plan (PIP) and quality assurance program. Findings include: 1. Observations, interviews, record reviews, and policy reviews throughout the course of the survey, conducted from 8/27/24 through 8/29/24 and from 9/3/24 through 9/5/24, revealed ED A and DON B had not ensured the safe management and overall well-being of all the residents who lived in the facility. This was evidenced by there was a widespread system breakdown to ensure the facility had implemented: *An effective infection control program that included staff education, monitoring, and communication to prevent facility-acquired COVID-19 infections. *A diabetic care program regarding hypoglycemic and hyperglycemic risks with appropriate interventions and physician notifications. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*An effective environmental program to ensure the facility was safe, clean, comfortable, and had a homelike environment. *An effective Quality Assurance and Performance Improvement (QAPI) program. Interview on 8/27/24 at 1:25 p.m. with ED A and DON B regarding their COVID-19 Outbreak policy revealed they had not followed their policy by not addressing resident room assignment for shared rooms based on a case-by-case analysis of the presence of risk factors for increased likelihood of transmission of COVID-19 infection. Interview on 9/4/24 at 10:11 a.m. with ED A revealed he started his position at the facility on 7/1/24, and was transitioning from another ED position within the same corporation ' s network. Interview on 9/5/24 at 1:48 p.m. with ED A and Chief Operating Officer AA regarding the diabetic care of insulin-dependent residents revealed they both agreed that notifications had not been made to residents' physicians according to their physician's orders and that interventions were missing from resident's electronic medical record. Review of the provider's 11/15/23 Executive Director - LNHA [Licensed Nursing Home Administrator] job description signed by ED A on 5/29/24 revealed: *Job Summary identified: -Directs the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations. -Follow all established policies and procedures . to assure that quality resident care and an effective operation can be maintained. *Essential Job Functions included: -Lead facility QA [Quality Assurance] committee and ensure compliance with regulations for state of operation. -Oversee and conduct regular rounds to monitor delivery of nursing care, operation of support departments, cleanliness and appearance of the facility, . and ensure resident and tenant needs are being addressed. -Ensure . all staff is appropriately trained, and a high level of interdepartmental teamwork is maintained. -Ensure the building and grounds are appropriately maintained and that equipment and work areas are clean, safe, and orderly, and any hazardous conditions are timely addressed. Review of the provider's 11/15/23 Director of Nursing (DON) job description signed by DON B on 3/11/24 revealed: (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*Job Summary stated The primary purpose of your job position is to plan, organize, develop, and direct the overall operation of our nursing service department in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility . *Essential Job Functions included: -Plan, develop, organize, implement, evaluate, and direct the nursing service department, as well as its programs and activities, in accordance with current rules, regulations, and guidelines that govern the skilled nursing and long-term care facility. -Develop, maintain, and periodically update written policies and procedures that govern the day-to-day functions of the nursing service department. -Develop methods for coordination of nursing services with other resident services to ensure the continuity of the residents' total regimen of care. -Audit documentation for errors or inconsistencies and make necessary changes to prevent further errors. Refer to F583, F584, F684, F727, F867, and F880.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 49958 Based on record review, interview, and policy review the provider failed to ensure complete and accurate documentation had been entered in the resident records for four of twenty (20, 22, 34, and 38) sampled residents. Findings include: 1. Review of resident 20's electronic medical record (EMR) revealed: *The physician was to be notified for blood sugars greater than 401. *A blood sugar reading above 401 was documented 8/5/24. -There was no documentation to indicate that the physician had not been notified. 2. Review of resident 22's EMR revealed: *The physician was to be notified for blood sugars greater than 351. *Five blood sugar readings above 351 were documented between 7/27/24 and 8/28/24. -There was no documentation to indicate that the physician had not been notified. 3. Review of resident 34's EMR revealed: *A 9/5/24 progress note stated Held care conference for [resident 20's name] today but no answer from poa [power of attorney]. Resident will remain a DNR/DNI [do not resuscitate/do not intubate] Code status and be here for long term care. -Resident 34's EMR contained information referring to the wrong resident. 4. Review of resident 38's EMR revealed: *An 8/1/24 physician fax communication regarding resident 4's nitroglycerin order. *Her care plan states Ensure [resident 8's name] is aware/compliant with the facilities smoking policy. -Resident 38's EMR contained information referring to the wrong resident. *The physician was to be notified for blood sugars greater than 400. *Five blood sugar readings above 400 were documented between 7/16/24 and 9/5/24. -There was no documentation to indicate that the physician had been notified. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Andes Senior Living	740 East Lake St Lake Andes, SD 57356

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Five blood sugar readings below 60 were documented between 7/16/24 and 9/5/24. -There was no documentation to indicate interventions were provided or that the physician had been notified. Refer to F684. 5. Interview on 8/29/24 at 4:00 p.m. with executive director (ED) A revealed that the only policy the facility had related to the accuracy and privacy of electronic medical records was the Resident's Access to Protected Health Information (PHI)/Medical Record policy provided. Interview on 9/4/24 at 10:06 a.m. with director of nursing (DON) B and regional nurse consultant (RNC) S revealed: *There was no written facility policy on hypoglycemia management or diabetic care. *There were [Name of provider] Standing Orders. -A copy of the standing orders was provided to the survey team. Review of the [Name of provider] Standing Orders did not indicate when a physician was to be notified of a high or low blood sugar. Interview on 9/4/24 at 2:46 p.m. interview with director of nursing (DON) B revealed: *She confirmed that resident 4's fax communication was in resident 38's EMR *She stated, Oh that is not okay. *Confirmed that this might be considered a violation however stated that only staff and surveyors would be able to see that. Interview on 9/5/24 at 8:25 a.m. and again at 9:45 a.m. with assistant director of nursing (ADON) C on the process for following up on low or high blood sugars revealed: *She confirmed that the doctor was notified when a resident had a low or high blood sugar reading. *Any time a physician is contacted we would document it. When we contact the medical doctor we will put in a progress note. *She defined hypoglycemia [a low blood sugar] as a range between 60-70. Interview on 9/5/24 at 5:29 p.m. with ED A and DON B revealed the only time a physician was notified of a high or low blood sugar was on the documents provided. Review of the documents provided by ED A and DON B revealed resident 20's physician had been notified of high blood sugars on 7/21/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Review of the provider's April 14, 2003, Resident's Access to Protected Health Information (PHI)/Medical Record policy revealed: *It included the letterhead of another corporation. -It did not include the provider's letterhead or facility name. *The policy did not address the accuracy of the resident record. On 9/5/24 at 6:15 p.m. the survey team met with ED A and DON B for an exit conference and reviewed the accuracy of documentation. ED A and DON B provided no disagreement or comment.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 43021 Based on interview and policy review, the provider failed to implement an effective quality assurance process improvement (QAPI) program that focused on identifying and improving systemic problems. Findings include: 1. Interview on 9/5/24 at 4:44 p.m. with executive director (ED) A revealed: *Regarding their QAPI Program: -The committee met monthly with the medical director in attendance. -They had developed a performance improvement plan (PIP) for falls which included reviewing interventions that were put in place. *Regarding their infection prevention & control program and their 5/6/24 COVID-19 Outbreak policy: -He agreed that they were currently experiencing a COVID-19 outbreak in the facility. -He was aware that they had allowed residents with confirmed COVID-19 infection to share a room with residents that did not have that respiratory pathogen, increasing the likelihood of the transmission of COVID-19 infections. -He thought they were doing what was best for the residents by allowing the residents who were not infected to remain in the room with a resident with confirmed COVID-19 infection as they had been exposed to that respiratory pathogen. -He agreed that they had not followed their COVID-19 Outbreak policy and stated it was our mistake. *Regarding their diabetic care program for insulin-dependent diabetic residents: -He was not aware of the lack of physician notification according the blood glucose parameters ordered by the resident's physician. -He was not aware of the lack of interventions documented in the resident's electronic medical record. 2. Review of the provider's 5/23/23 Quality Assurance and Performance Improvement Plan (QAPI)/Quality Assessment and Assurance (QAA) policy revealed: (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*The Purpose of QAPI was a systematic approach for improving quality of life, quality of care, and services we provide to our residents. We take a proactive approach to continually improve the way engage and care for our residents, caregivers, . so that we may realize our vision to provide a homelike environment to our residents . To do this, all employees will participate in ongoing QAPI efforts which support our mission . *The scope of the QAPI program encompasses all segments of care and services, including customer service, care management, clinical quality, quality of life, resident choice and effective care transitions. *The facility Executive Director and Director of Nursing are designated as the governing body of the nursing home QAPI program. They are responsible for: *Developing a culture that involves input from facility staff, residents, families, and other care partners. *To develop leadership and facility wide training on QAPI, ensuring staff have time, equipment, and training as needed. Refer to F582, F584, F658, F684, F758, F812, F880 and F944.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45383 Based on observation, interview, record review, and policy review the provider failed to ensure the management COVID-19 cases with 12 of 12 sampled residents (5, 6, 8, 10, 19, 20, 29, 31, 32, 33, 38, and 89) implement appropriate precautions, and prevent further transmission of the disease, including ensuring staff demonstrated the proper use of personal protective equipment (PPE) (e.g. N95 face masks and gowns), and proper hand hygiene between residents to prevent the spread of COVID-19 infection. Findings include: Notice: On 8/27/24: *At 11:30 a.m., immediate jeopardy was identified related to the prevention and control of resident COVID-19 infections at F880. *At 1:25 p.m., notice of immediate jeopardy was provided verbally and in writing to executive director (ED) A, director of nursing (DON) B, and regional nurse consultant (RNC) S. An immediate jeopardy removal plan was requested at that time. The survey team exited the building at 2:00 p.m. Plan: On 8/27/2024, all covid positive residents were moved in with other covid positive residents. All negative residents are grouped with well residents with no signs symptoms of covid. Other negative residents with known exposure including resident #6, #38, and resident #8 in the presumptive area with other presumptive residents. Staff have been educated on the importance of keeping all positive residents on isolation for 10 days. Staff are to redirect if they want to come out of their room. On 8/27/2024, staff education was completed by the DON and RN Nurse Specialist to ensure all staff who are currently working and are providing care to positive and presumptive residents, knew how to properly DONN and DOFF PPE. PPE is put on prior to entering positive and presumptive rooms. This includes removing the gloves and gown inside the room and performing hand hygiene. The removal of the eye protection and mask happens outside the room. Masks and eye protection are discarded. Hand hygiene is performed again. All those not on shift will be educated prior to them coming on shift. On 8/27/2024, All staff currently on shift were educated on properly wearing an N95 mask. All those not on shift will be educated prior to them coming on shift. On 8/27/2024, All staff currently on shift were educated on proper hand hygiene after DOFFING PPE prior to assisting another resident. All those not on shift will be educated prior to them coming on shift. Any concerns will be reported to the charge nurse, director of nursing, infection preventionist, and/or administrator immediately and addressed in facility QAPI. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/27/24: *At 7:45 p.m. ED A provided their final plan for the removal of the immediate jeopardy through an email submission. *At 8:33 p.m. the provider's removal plan was reviewed and accepted by the survey team. On 8/28/24: *At 8:00 a.m. the survey team entered the facility to observe and review the provider's documentation related to their removal plan of the immediate jeopardy. Based on observations and documentation review the survey team could not remove the immediacy as the removal plan had not been fully implemented. *At 10:30 a.m. a meeting was held by the survey team with ED A, DON B, and RNC S regarding the removal plan had not been fully implemented and the immediacy had not been removed. The survey team exited the building at 10:45 a.m. On 8/29/24: *At 8:30 a.m. the survey team entered the facility to observe and review the provider's documentation related to their removal plan of the immediate jeopardy. *At 10:10 a.m. the survey team's observations and review of the provider's documentation for the removal of the immediate jeopardy determined the immediacy was removed. After the removal of the immediate jeopardy, the scope and severity of the citation level was H. 1. Observation on 8/27/24 at 8:37 a.m. of resident 10 and 20's door revealed: *The residents had been on isolation precautions, but the door is wide open. *Resident 10 was on isolation until 9/1/24. Observation on 8/27/24 at 8:39 a.m. of 19 and 32's door revealed: *The residents had been on isolation precautions. *Resident 19 was on isolation until 9/1/24. Observation on 8/27/24 at 8:56 a.m. of assistant activities T revealed: *She had applied gloves without performing hand hygiene. *Her N95 had not been worn with the straps separated to ensure a tight seal. Observation on 8/27/24 at 9:00 a.m. of unidentified staff revealed: *They had applied gloves without performing hand hygiene prior to glove use. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*Staff had applied full personal protective equipment (PPE) with her gloved hands touched the garbage can and went to another room and opened the door. *Removed her PPE and did not perform hand hygiene. -She then touched her hair and walked down the hallway with her goggles on. *Activities assistant T walked out of a isolation room with her gown on and took the garbage into the soiled utility room. *All observed staff continued to wear the same N95 mask after leaving an isolation room. Observation on 8/27/24 at 9:15 a.m. of unidentified staff leaving resident 5 and 33's room revealed: *They had removed their gowns but had the same N95 on while going to a non-COVID-19 room. *No hand hygiene by staff before applying gloves *She had out her gown on and touched her hair with her gloved hands and entered another room. Observation on 8/27/24 at10:00 a.m. of housekeeping aide W wiping down tables in the dining room with his N95 mask is just below his lower lip and not under his chin. 2. Review of the facility record of residents that had been on isolation revealed: *On 8/22/24: -Resident 33 had tested positive for COVID-19. -Resident 5 was resident 33 ' s roommate and had tested negative. --On 8/24/25 resident 5 tested positive for COVID-19. -Resident 10 tested positive for COVID-19. --On 8/26/24 resident 20 had tested positive for COVID -19. *On 8/22/24 resident 31 had tested positive for COVID-19 and her roommate resident 38 had tested negative but remained in the same room. *On 8/23/24 resident 89 had tested positive for COVID-19 and her roommate resident 8 had been (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	negative and remained in the same room. *On 8/24/24 resident 29 had tested positive for COVID-19 and her roommate resident 6 had been negative and remained in the same room. *On 8/24/24 a progress note had been made regarding Telephone call to resident 6's representative and informed her that resident is on quarantine for 10 days due to residents room mate is covid positive. 3. Review of resident 6, 8, 32, and 38's electronic medical record (EMR) revealed there had not been any documentation indicating information was provided to them or their responsible party regarding the risk of residents remaining in the same room with their positive roommates. 4. Interview on 8/27/24 at 9:23 a.m. with DON B regarding isolation of resident's revealed: *If one resident had tested positive for COVID-19 they would isolate the roommate with them at the same time. *She would have informed the negative resident of the risk of staying in the room with their COVID-19 positive roommate. Interview on 8/27/24 at 10:17a.m. with DON B regarding the notification of the roommate and family of the COVID-19 positive roommate revealed that information would have been documented in a progress note. 5. Review of the provider's May 2024 COVID-19 Outbreak policy revealed: *In the nursing home, place a resident with confirmed COVID infection in a single-person room, when possible. The door should be kept closed (if safe to do so). Ideally, the resident should have a private bathroom, if possible. If a single-person room is not available, only residents with the same respiratory pathogen should be housed in the same room. *When a two or more resident(s)/tenant(s) who are currently in the facility tests positive, all staff must wear N95 throughout the facility until there are less than three positive residents in isolation. See guidance on one or two resident(s)/tenant(s) when less than three positive. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*N95, gown, eye protection, and gloves are required in the presumptive and positive resident's/tenant's rooms. When staff member foes from a presumptive or positive room to a well room, they must doff their PPE and change the N95 to a surgical mask. When a staff member goes from a positive to a presumptive room, they must change their PPE and N95. 49958 6. Observation on 8/27/24 at 7:56 a.m. revealed: *A sign at the front door stating masks were required. *There was no hand sanitizer at the front door. *The wall-mounted hand sanitizer outside resident room [ROOM NUMBER] did not work. 7. Interview on 8/27/24 at 8:05 a.m. with director of nursing (DON) B revealed that there were 10 COVID-19-positive residents in the facility. 8. Observation on 08/27/24 at 09:18 a.m. revealed: *The Lysol wipes container outside room [ROOM NUMBER] was open with the wipe pulled up through and draped over the edge. *An unidentified staff member pushed the medication cart down the hall from room [ROOM NUMBER] to room [ROOM NUMBER] while wearing a gown, n-95 mask, and gloves. -She parked the cart outside room [ROOM NUMBER] and went into room [ROOM NUMBER]. -She then exited room [ROOM NUMBER] without the gown or gloves. -She removed her mask with her ungloved hands, discarded it in the trash can, opened the drawer of the cart that contained personal protective equipment (PPE), took a new mask, and put that mask on. Observation on 8/27/24 at 10:41 a.m. with activities assistant T revealed: *She exited room [ROOM NUMBER] wearing an N-95 mask and her glasses. -A resident in room [ROOM NUMBER] was COVID-19-positive. *She did not change her mask or sanitize her glasses with no shield. *She pushed the water cart down the hall. *She lowered her N-95 with ungloved hands, wiped her face with a tissue, placed that tissue in her pocket, raised her mask, donned a gown, and entered room [ROOM NUMBER] wearing the same mask and glasses with no shield. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	She exited room [ROOM NUMBER], removed her gloves and gown, disposed of them in the trash can inside room [ROOM NUMBER]'s door, went back into the room, pushed the cloth curtain aside, washed her hands, moved the curtain again with her hands, touched her mask and then continued down the hall. 9. Observation on 8/28/24 at 8:56 a.m. with resident 5 and activities director (AD) G revealed: *Resident 5 was COVID-19-positive. *He exited his room with his walker, identified himself to the surveyor, and stated he was headed to breakfast. *He walked past the nurse's station and went to a table near the window in the dining room. *There are three other residents seated in the dining room. *He hollered Give me some Juice, and AD G gave him juice and coffee. *AD G assisted resident 5 with his watch with ungloved hands, without completing hand hygiene left the area, returned with a maroon insulated cup, set it on the nurse's station, and continued to assist residents in the dining room. Observation on 8/28/24 at 09:05 a.m. with dining services manager F revealed: *She approached resident 5 and told him he needed to return to his room because people were sick. *She picked up his coffee cup with an ungloved hand and told AD G resident 5 could not be in the dining room. *She handed that coffee cup to an unidentified staff who left the dining room with resident 5. Interview on 8/28/24 at 9:08 a.m. with AD G revealed she: *Confirmed that she assisted resident 5 with his beverages and watch in the dining room. *Last received training about COVID-19-positive residents last week sometime, but could not recall when. -The training was a verbal briefing on the use of PPE and separating COVID-19-positive residents. *Stated that to find out who was positive she would have to look in point click care each day. -So I just avoid going into their room. *Thought resident 5 was off precautions, because they change so quick. Interview on 8/28/24 at 9:11 a.m. with certified nursing assistant (CNA) K revealed: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*The names on the nameplate outside resident rooms [ROOM NUMBER] did not accurately reflect the residents in those rooms. *Some residents had changed rooms yesterday and some had changed rooms today. Observation on 8/28/24 at 9:40 a.m. with CNA N revealed she: *Put on a gown outside of room [ROOM NUMBER], and was unable to find gloves or goggles outside of room [ROOM NUMBER]. -room [ROOM NUMBER] was marked Isolation. *Located gloves and a face shield in a PPE cart outside of room [ROOM NUMBER], continued to put on her PPE, and entered room [ROOM NUMBER]. *Exited room [ROOM NUMBER] with a stand lift, removed her gloves and mask, performed hand hygiene, put on a new N-95 mask, parked the stand lift outside room [ROOM NUMBER] without sanitizing it, and returned to the nurse's station. Observation on 8/28/24 at 9:41 a.m. outside resident room [ROOM NUMBER] revealed: *A blue stand lift pad draped over the top of the PPE cart touching the box of gloves and hand sanitizer. -room [ROOM NUMBER] was marked Isolation. Interview on 8/28/24 at 09:48 a.m. with CNA N revealed: *Residents in room [ROOM NUMBER] are in isolation but did not have COVID-19. *She confirmed that the names on the nameplate outside room [ROOM NUMBER] did not accurately reflect the residents who were in room [ROOM NUMBER] at that time. *She last received education on COVID-19 precautions sometime last week after we had positive residents. -The training included a pamphlet on how to use PPE properly. -It was a refresher and there was a sign-in sheet. 10. Observation and interview on 8/29/24 at 12:48 p.m. with dining services aide Y revealed: *She wore a surgical mask which hung by one ear. It did not cover her mouth. *She stood in the doorway between the kitchen and the dining room. *She spoke with another staff member. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Some	*She could not recall receiving education about wearing a mask. *When asked if masks were required in the kitchen during a facility COVID-19 outbreak she stated, They say I am supposed to, but I don't think I have to if no one else is around. B. Based on observation, interview, record review, and policy review the provider failed to ensure enhanced barrier precautions (EBP) were appropriately implemented and carried out for two of two residents (34 and 19) identified as those who should have EBP. Findings include: 1. Observation and interview on 8/27/24 at 12:39 p.m. with resident 34 revealed: *There was a sign inside the door above the light switch that indicated enhanced barrier precautions (EBP). *There was a urinary catheter drainage bag hanging under resident 34's wheelchair. *He stated that the staff wear gloves when assisting with his urinary catheter bag. *He confirmed that the staff do not wear a gown or eye protection when assisting with his care. *No gowns or eye protection was in the room or outside the door. Observation and interview on 9/3/24 at 3:21 p.m. with certified nursing assistant (CNA) L and CNA N regarding care provided for resident 34 revealed: *CNA L stated gowns were kept outside of resident 34's door. *CNA N stated gowns were kept on the backside of the door. *CNA N confirmed that there were no gowns outside of resident 34's room or on the backside of that door. Observation and interview on 9/3/24 at 3:24 p.m. with resident 34's daughter revealed: *There were no gowns on the back of the door. *Resident 34's daughter confirmed that staff did not wear gowns when transferring resident 34 or providing his care. Review of resident 34's electronic medical record (EMR) revealed: *He had a physician's order for an indwelling urinary catheter. *The resident care plan indicated that EBP was required. 2. Observation on 9/3/24 at 9:55 am with resident 19 revealed: *He had a urinary catheter drainage bag hanging from the left side of his bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435097	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Andes Senior Living	740 East Lake St Lake Andes, SD 57356

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*There was no sign to indicate EBP was to be used when providing care to resident 19. *No gowns or eye protection was in the room or outside the door. Observation and interview on 9/3/24 at 10:32 a.m. with certified medication aide (CMA) I revealed she: *Was taking resident 19's vitals. *Was not wearing a gown or gloves. *Stated that she provided medication to resident 19, took his vitals, and applied a cream to his legs. *Confirmed that resident 19 was off all precautions as of today. *Stated, I only wear gloves when applying a cream, but I don't need a gown. Observation and interview on 9/3/24 at 11:26 a.m. with CNA M and CNA N revealed. *They transferred resident 19 with a mechanical stand aid. -CNA M and CNA N were not wearing gowns or gloves. *CNA N stated they did not need to wear a gown when providing care to resident 19. Review of resident 19's electronic medical record (EMR) revealed: *He was admitted on [DATE]. *Admission documentation indicated five open wounds being treated. *On admission there was a physician's order for an indwelling urinary catheter. Observation and interview on 9/3/24 at 3:28 p.m. with director of nursing B revealed: Observation and interview on 9/3/24 at 3:28 p.m. with director of nursing B revealed: *She confirmed that the sign for EBP was not inside the door above the light switch in resident 19's room where she had expected it to be. *She confirmed there were no gowns or eye protection present in resident 19's room or outside the door. *It was her expectation that gowns, gloves, and eye protection be worn when providing care for residents with wounds and indwelling urinary catheters. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Some	*She confirmed there were no gowns or eye protection present in resident 34's room or outside the door. *It was her expectation that gowns, gloves, and eye protection be worn when providing care for residents with wounds and indwelling urinary catheters. Review of the provider's May 6, 2024, Enhanced Barrier Precautions Policy revealed: *It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. *Enhanced barrier precautions (EBP) referred to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. * An order for enhanced barrier precautions will be obtained for residents with any of the following: Wounds . urinary catheters .

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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 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 45383 Based on employee file review the provider failed to ensure that seven of seven sampled employees (B, C, J, P, Q, X, and Y) had been educated on the quality assurance and performance improvement process of the facility. Findings include: 1. Review of employee B, C, J, P, Q, X, and Y's files revealed there was no documentation they had not received the mandatory quality assurance and performance improvement education per the regulation for an extended survey.