STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435110	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountain Springs Healthcare	2000 Wesleyan Blvd Rapid City, SD 57702

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and policy review, the provider failed to ensure:*Proper infection control practices had been followed for the cleaning and storage of nebulizer masks (a mask worn when using a nebulizer machine that converts liquid medication into an inhalable mist) for two of two sampled residents (21 and 79).*Proper infection control practices had been followed for cleaning of the Continuous Positive Airway Pressure (CPAP) machine (a device that uses air pressure to keep breathing airways open) for one of one sampled resident (16).*Proper infection control practice had been followed for cleaning and storage of oxygen equipment for three of three residents (16, 67, and 97) who required the use of oxygen. Findings included:1.Observation and interview on 9/16/25 at 2:07 p.m. with resident 21 in her room revealed: *A nebulizer machine (a machine that converts liquid medication into an inhalable mist) with an attached mask was lying on her bedside table. *The attached mask had a couple of small white spots on the inside. *Resident 21 stated she would receive her nebulizer treatment at night. *She stated the staff had not been cleaning the mask after her nebulizer treatments were completed. *She could not recall the last time the nebulizer mask had been cleaned following a treatment. 2. Review of resident 21's electronic medical record (EMR) revealed: *She was admitted to the facility on [DATE]. *Her 7/22/25 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated she was cognitively intact. *Her diagnoses included type 2 diabetes (a condition involving disruption in how the body regulates blood sugar), chronic respiratory failure with hypoxia (ongoing ability to maintain adequate oxygen levels), heart failure (a condition where the heart does not pump blood effectively), hypertension (high blood pressure), and pulmonary hypertension (high blood pressure that affects the lungs). *She had a 4/18/24 physician's order, Levalbuterol HCl Solution 1.25 MG/3ML (milligrams per 3 milliliters), 1 vial inhale orally via nebulizer at bedtime for SOB (shortness of breath)/wheezing. *There was no documentation for staff to clean or change her nebulizer mask. (continued on next page)

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*He did not have an order to change his nasal cannula or nebulizer mask on his TAR. 12. Observation on 9/17/25 at 9:47 a.m. of resident 97's room revealed: *There was a nasal cannula attached to a portable oxygen cylinder on the back of resident 97's wheelchair. *The nasal cannula was wrapped around the cylinder on the back of the wheelchair. *There was a plastic bag also hanging on the back of the wheelchair. *There was an oxygen concentrator near the head of the bed with a plastic bag hanging from the concentrator. *The nasal cannula that was attached to the concentrator was draped over resident 97's bed. 13. Observation and interview on 9/18/25 at 8:27 a.m. with resident 97 in her room revealed: *There was a nasal cannula draped over resident 97's oxygen concentrator with the nasal prongs touching the floor. *She was admitted to the facility for therapy to get strong enough to have surgery. *She was on oxygen before she was admitted to the facility but now, she required staff's assistance with her oxygen because she was unable to get out of bed or her chair without assistance. *She stated staff placed her nasal cannula on the oxygen concentrator that morning when she got out of bed. *She stated the staff usually just threw the nasal cannula on her bed or her recliner, but this morning had draped it over the oxygen concentrator. 14. Review of resident 97's EMR revealed: *She was admitted on [DATE]. *A BIMS assessment had not been completed. *She had a 9/15/25 physician's order for O2 at 1L per NC every shift. *She had a 9/15/25 physician's order to Change O2 tubing monthly at bedtime starting on the 15th and ending on the 15th every month. 15. Observation and interview on 9/17/25 at 3:39 p.m. with licensed practical nurse (LPN) H in resident 79's room revealed: *A resident's nebulizer mask and tubing were to be changed every two weeks, and it was to be dated when it was changed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The CPAP masks and tubing were to be rinsed with vinegar water weekly and allowed to air dry. *Nasal cannulas were to be changed monthly. *LPN H stated when the nasal cannulas and nebulizer masks and tubing were changed it was documented in the treatment administration record (TAR) in the resident's EMR. *She agreed that if the tasks of changing of the nasal cannulas and nebulizer masks were not documented on the resident's TAR there would be no way to verify, they had been changed. *LPN H verified the changing of resident 79's nasal cannulas, nebulizer mask and tubing were not able to be documented on the TAR as there was no order to complete that task. *Nasal cannulas and nebulizer masks were to be stored in plastic bags on the oxygen concentrator or portable cylinder when they were not in use. *LPN H stated after a resident was administered a nebulizer treatment the nebulizer mask was to be disassembled, rinsed with water, allowed to air dry and then stored in a plastic bag when not in use. *LPN H had documented she administered resident 79's nebulizer treatment as having been administered on 9/17/25 at 1:02 p.m. *She stated after she administered resident 79's nebulizer she had rinsed his nebulizer mask, let it dry, and then reassembled the mask. She could not recall if he had a bag in his room that the nebulizer mask was stored in. *After LPN H observed resident 79's nebulizer mask medication chamber, which was one-fourth filled with a clear liquid she stated that he must not have finished his nebulizer treatment. *LPN H verified the nebulizer chamber attached to the mask was one-fourth filled with a clear liquid and the bottom one-third of the mask was hazy and the inside of the mask was rough to the touch, which was also documented as the condition of the mask on 9/17/25 at 11:43 a.m., prior to his last nebulizer having been documented as administered. *She stated she must not have cleaned it well after resident 79 was administered his 1:02 p.m. nebulizer treatment. *LPN H verified the tubing on the nebulizer mask was dated 8/16 and stated she would have considered resident 79's nebulizer mask as soiled and it should have been replaced. *LPN H verified resident 79's nasal cannula, which was draped across his bed was not store properly and stated it should have stored in a plastic bag, and she would consider it contaminated after laying on resident 79's bed and that would require the nasal cannula to be replaced. 16. Interview on 9/18/25 at 3:52 p.m. with director of nursing (DON) B revealed: *She expected nasal cannulas to be stored in a plastic bag when not in use. *If a nasal cannula became contaminated by touching the floor or other soiled surface, she expected (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff to replace the nasal cannula. *She verified the nasal cannulas on the beds, floor, wheelchair, and hairbrush would have all been considered contaminated and would need to be replaced. *Nasal cannulas were to be replaced monthly, and the replacement was to be documented in the resident's TAR. *CPAP mask and tubing were to be cleaned weekly with a vinegar and water solution and then hung to air dry. *The cleaning of the CPAP mask and tubing was to be documented in the resident's TAR. *DON B verified resident 16's CPAP mask and tubing had not been documented as having been cleaned for three weeks in a row during the month of August. *The provider did not have a CPAP policy. *She expected nebulizer masks to be disassembled, rinsed, and placed on a towel to airdry after each use. *The nebulizer tubing was not scheduled to be changed on a specific schedule, but after review of the description of resident 79's nebulizer mask she verified she would have considered his mask to be soiled, and it would have needed to be replaced. 17. Review of the provider's November 2018 Respiratory Care: Equipment Care and Handling policy revealed: *Respiratory equipment is handled in a manner that maintains good working order and promotes proper infection control. *General equipment change guidelines will be observed unless otherwise specified by regulation or physician's order: -a. Plastic bags are not used for storage, as they promote bacterial growth. *Nebulizers -Recommended Change Frequency PRN [as needed], Discard and replace if heavily soiled. -Storage & [and] Waste Empty &Discard in regular waste. Store hand held nebulizer in mesh bag, paper sack, or in compartment/container between each use. *Nasal Cannulas or Face Mask -Recommended Change Frequency PRN [as needed], Discard and replace if heavily soiled. -Store in mesh bag, paper sack, or in compartment/container between use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 11/24/21 Tabletop Compressor Nebulizer manufacturer's instructions revealed: *After each use, disassemble medicine cup into 3 sections. Wash in warm soapy water and rinse well. Wipe with a paper towel and allow to air dry. *It is important that the cleaning instructions are carefully followed to ensure optimal operation. *The disposable nebulizer T-Piece kit should be replaced after a long period of time of inactivity, or if it is obstructed by dry medication, dust, etc. With normal use, the disposable nebulizer T-piece kit should last 1 month. Review of the undated ResMed AirSense 10 manufacturer's instructions revealed: *You should clean the device weekly as directed. Refer to the mask user guide for detailed instructions for cleaning your mask. -1. Wash the water tub and air tubing in warm water using only mild detergent. Do not wash in a dishwasher or washing machine. -2. Rinse the water tub and air tubing thoroughly and allow to dry out of direct sunlight and/or heat. -3. Wipe the exterior of the device with a dry cloth.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, interview, and policy review, the provider failed to ensure:One of one observed certified medication aide (CMA) (F) had followed a physician's order for the administration of one of one sampled resident's (55) blood pressure medication.One of one observed registered nurse (RN) (E) had not split one of one sampled resident's (77) antipsychotic medication without first confirming this was an acceptable and safe practice.One of one observed RN (E) had documented the destruction of one of one sampled resident's (77) antipsychotic medication.One of one observed RN (E) had not documented that she had administered medications that were administered by one of one CMA (G). One of one observed CMA (G) had not administered medications to one of one sampled resident (77) that were prepared by one of one RN (E).One of one observed RN (D) had followed the manufacturer's instructions for use of an inhaler that was self-administered by one of one sampled resident (97).Findings include:1. Observation and interview on 9/18/25 at 7:30 a.m. with CMA F, preparing resident 55's medications for administration revealed: The resident's 4/15/25 physician's order for Metoprolol Succinate (a high blood pressure medication) had included the following parameters for administering that medication: hold [the medication] if SBP [systolic blood pressure-the pressure in the arteries when the heart contracts] is less than 110. CMA F administered the above medication to resident 55 and then took the resident's blood pressure. The resident's blood pressure was 142/73. The systolic number (142) was greater than 110. CMA F stated, [the resident's] blood pressure is usually high. I didn't see it [the parameter information below the medication order]. She confirmed she had not followed the physician's order for administering resident 55's blood pressure medication. 2. Observation on 9/18/25 at 9:05 a.m. of RN E preparing resident 77's medications for administration revealed:a. RN E reviewed the resident's medication administration record (MAR) to prepare the resident's morning medications for administration. Those medications included a packet of topical pain reliever gel and 2.5 milligrams (mg) of olanzapine (an atypical antipsychotic medication). RN E pulled a 5.0 mg olanzapine medication card out of the med cart for resident 77. The resident had orders to take 5 mg of olanzapine at bedtime. RN E split the 5.0 mg olanzapine tablet to make 2.5 mg without first contacting a pharmacist or the resident's medical provider to ensure it was appropriate to have done that. She discarded the other half of that 5.0 mg tablet into a medication destruction container, but she had failed to document that destruction. b. Continued observation of RN E and CMA G during that same medication pass revealed:CMA G was standing outside of resident 77's room, a short distance away from RN E. Resident 77 had COVID-19 and was in isolation in her room. CMA G offered to put on personal protective equipment (gown, gloves, and face mask) to enter the resident's room and administer the above medications.RN E handed CMA G the Biofreeze packet and the medication cup with the olanzapine inside of it. She instructed CMA G to apply the Biofreeze to the resident's back. RN E initialed on resident 77's medication administration record (MAR) that she had administered those medications, but she had not administered them.3. Interview on 9/18/25 at 9:07 a.m. with RN E revealed it was beyond her scope of practice to have determined it was acceptable to have split resident 77's olanzapine. She also had not accounted for the other half of the 5.0 mg olanzapine tablet that she had destroyed. She was also expected to have administered the above medications because she had prepared them. She should not have delegated that task to CMA G.4. Interview on 9/18/25 at 9:15 a.m. with CMA G regarding the above medication administration revealed that she should not have administered any medications that she had not prepared herself. 5. Observation on 9/18/25 at 9:30 a.m. of RN D preparing resident 97's inhaler for administration revealed:RN D carried the inhaler and a cup of water into the resident's room. She handed the resident her Trelegy Ellipta inhaler and resident 97 self-administered one puff according to the physician's order. RN D handed the resident the cup water. Resident 97 swallowed some of the water before setting the cup down on her bedside table.Review of the Trelegy Ellipta inhaler instructions for use (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and interview on 9/18/25 at 10:30 a.m. with RN D revealed Step 6. Rinse your mouth with water after you have used the inhaler and spit the water out. Do not swallow the water. RN D confirmed she had not properly instructed resident 97 regarding how the resident should have used her inhaler. 6. Interview on 9/18/25 at 2:30 p.m. with director of nursing (DON) B regarding the above observations revealed:Licensed nurses and CMAs were expected to review the entire physician's order, including any instructions, before administering a resident's medication. Resident 97's inhaler order should have included instructions regarding the use of water in conjunction with her inhaler. Staff who prepared residents' medications for administration were expected to be the same staff who administered those medications. Medications were not expected to have been split without first consulting a medical provider or pharmacist. The destruction of any medication was expected to have been documented. 7. Review of the provider's January 2025 Medication Administration General Guidelines policy revealed,Medication Administration: 1. Medications are administered in accordance with written orders of the prescriber .2. Obtain and record any vital signs as necessary prior to medication administration.If breaking tablets was necessary to administer the proper dose: Medication Preparation-4.a. The administration of partial tablets is clearly identified or highlighted on the resident's MAR.5. The person who prepares the dose for administration is the person who administers the dose.Documentation: 1. The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given.8. Review of the provider's January 2024 Disposal of Medications, Syringes, and Needles Disposal of Medications policy revealed: 3. Documentation of non-controlled medication may be completed on a medication administration record (MAR), a medication disposition log or form (or record provided for that purpose) and shall be retained as per federal privacy and state regulations.9. Review of the provider's January 2023 Medication Administration Oral Inhalations policy revealed, 15. For steroid inhalers, provide resident with cup of water and instruct him/her to rinse mouth and spit water back into cup.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, record review, and policy review, the provider failed to ensure:The Emergency Kit (E-Kit, a secured storage container stocked with specific medications that were used for a resident during an unplanned medical emergency) controlled medications (medications regulated by the government due to their potential for abuse or addiction) had been routinely accounted for.Narcotic administration and narcotic counts for two of three sampled residents (31 and 98) were accurately documented, and any discrepancies in those counts had been identified and reconciled. The destruction of one of one sampled resident's medication (98) was documented and accurately accounted for after it was not administered.Findings include:1. Observation inside medication room (1) and interview on 9/17/25 at 4:20 p.m. with medical records/certified medication aide (CMA) T revealed: The medication refrigerator in that room contained an E-Kit. There was a numbered, plastic tag on the outside of the E-Kit that was broken to remove the medications from inside that box. A list of medications inside that E-Kit was affixed to the outside of that E-Kit. That E-Kit had contained insulin pens. There was a second secured storage container inside that same refrigerator. The following controlled substances that belonged to residents 11 and 77 were inside it: three ABH (Ativan, Benadryl, and Haldol) topical dispensers. There was also an unlabeled bottle of unopened liquid Ativan inside its original box within the second storage container. Medical records/CMA T stated the above bottle of Ativan was part of the E-Kit, but it was too big to store inside the E-Kit. He was not sure if the contents of that Ativan bottle were regularly accounted for. Administrations from the ABH dispensers for residents' 77 and 11's were accounted for each day on their individual narcotic sheets. Interview on 9/17/25 at 4:30 p.m. with director of nursing (DON) B regarding E-Kit accountability revealed that if the plastic tag on the above E-Kit was broken and insulin was removed, the removal was documented on the inventory sheet inside the E-Kit. That completed sheet was then faxed to the pharmacy provider. The pharmacy provider restocked the E-Kit and placed a different numbered tag on it. There was no process for regularly monitoring the tag number to know if any of the E-Kit contents had been removed without notifying the pharmacy, but DON B had thought the likelihood of insulin being diverted (the illegal redirection of prescription drugs for unauthorized use) was probably low. Continued interview with DON B regarding the above Ativan that was a part of, but not inside of the E-Kit, revealed there was also no process for accounting for the contents of that bottle. She agreed that if the Ativan bottle had been improperly accessed or removed from the refrigerator, it would have been difficult to identify that it was diverted. She thought the likelihood of Ativan diversion was higher than insulin diversion. 3. Review of the provider's January 2025 Emergency Pharmacy Service and Emergency Kits (E-Kits) policy revealed no mention that any emergency medications were to be stored outside of the E-Kit. 4. Review of resident 31's 8/19/25 through 8/25/25 oxycodone (a federally regulated narcotic pain medication) narcotic reconciliation sheet (page 21) and resident 31's August 2025 medication administration record (MAR) and interview on 9/18/25 at 2:30 p.m. with DON B revealed:The above reconciliation sheet was divided into the following columns: the date the medication was administered, the time the medication was administered, the administration dose, the signature of the person who had administered the medication, and the quantity of remaining tablets after the medication was administered.There were numbered lines for each time a medication was removed from a medication card for administration. The reconciliation sheet showed that on 8/19/25, there were eight 5-milligram (mg) tablets of oxycodone. On 8/20/25, two tablets were removed for administration, on 8/21/25, one tablet was removed for administration, and on 8/22/25, two tablets were removed for administration. That left three remaining oxycodone tablets. Resident 31's MAR supported that each of those oxycodone tablets had been administered.The date, time, dose, and signature on line 6 of that sheet were missing, but a 2 was written on that line for the quantity of tablets that were remaining. Line 7 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountain Springs Healthcare	2000 Wesleyan Blvd Rapid City, SD 57702

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated on 8/23/25, oxycodone was removed for administration at 4:40 p.m., but there was no documented dose or a signature of the person who had removed that oxycodone. A 1 was written on that same line for the quantity of remaining tablets. Resident 31's MAR indicated there was no oxycodone administered on that date. There was a discrepancy between the narcotic reconciliation sheet and the MAR.DON B stated that on 9/12/25, the above accountability error was brought to her attention by the pharmacy provider during an on-site visit. DON B had contacted licensed practical nurse (LPN) M, who had worked on 8/23/25. LPN M stated she had administered two oxycodone tablets to resident 31 on 8/23/25, but she had failed to document those administrations on the MAR. She had not fully completed lines 6 and 7 of the reconciliation form. There was no documentation in resident 31's electronic medical record (EMR), on her MAR, or on the reconciliation sheet to explain that reconciliation error.4. Review of resident 31's 8/25/25 through 8/28/25 oxycodone narcotic reconciliation sheet (page 22) and resident 31's August 2025 MAR and continued interview with DON B revealed:The narcotic reconciliation sheet showed that on 8/25/25, there were 30 oxycodone tablets. Between that date and 8/28/25, six oxycodone were documented as having been removed for administration to resident 14. Line 6 on that sheet showed 24, the amount of remaining oxycodone tablets the resident should have had after those administrations. Resident 31's MAR supported that six oxycodone were administered.Beneath the 24 on line 6 of the reconciliation sheet was the number 23 with a circle around it. Under that, there was a line through the remainder of the page and the words, Sent home 8/28/25. Further down the page, the quantity of oxycodone tablets that were released to the resident or their responsible party was 23. That form was signed by DON B.DON B was not able to explain the discrepancy between the number of oxycodone tablets resident 31 should have had at the time of her 8/28/25 discharge (24) and the number of oxycodone tablets that were released (23).5. Review of resident 98's 8/27/25 through 8/30/25 diphenoxylate (opioid pain reliever)-atropine (used to prevent abuse of a medication) narcotic reconciliation sheet (page 15) and resident 98's August 2025 MAR and interview on 9/18/25 at 2:40 p.m. with DON B revealed:The physician's order for diphenoxylate-atropine was: Give 2 tablets by mouth four times daily for 3 days. Those medication administrations were scheduled for 6:00 a.m., noon, 5:00 p.m., and 11:00 p.m. Line 3 of the reconciliation sheet showed that on 8/28/25 at 9:08 a.m., two of the above tablets were removed for administration. That left 18 remaining tablets.Line 4 of the sheet showed that on 8/28/25 at 9:08 p.m., two of the tablets were removed for administration. There was a line drawn through the 16 in the Quantity Remaining column, and a 15 with a circle around it was written beside it. Resident 98's MAR documentation on 8/28/25 indicated she was administered her 6:00 a.m. dose of the above medication and refused the noon dose. Her 5:00 p.m. dose was held (not administered) due to illness, and the 11:00 p.m. dose was refused. DON B had no explanation why the 16 had been drawn through and replaced with a 15. The narcotic sheet supported the removal of two medications for administration, so the medication count should have been 16. Since those medications were not administered, the remaining medication quantity should have been 16. There was no documentation to support that the same two medications had been destroyed after they were held and not administered to the resident. 6. Review of the provider's January 2025 Emergency Pharmacy Service and Emergency Kits (E-Kits) policy revealed:6. The emergency kit, along with the list of contents posted on the outside of the kit, is maintained at a designated locked area that is easily accessible in an emergency. 14. d. The provider pharmacy may require additional forms or procedures to aid in controlled substance accountability as appropriate per state regulation.Review of the provider's January 2025 Medication Administration General Guidelines policy revealed: 1. The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given.Review of the provider's January 2024 Disposal of Medications policy revealed: Procedures: 2. If a controlled medication is unused, refused by the resident or not given for any reason, the disposal is documented on the accountability record on the line representing that dose with the required signatures.Review of the provider's January 2025 Medication Storage policy revealed:[15. Controlled drugs should be reconciled at the time of final disposition.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure two of two sampled residents (79 and 84) were assessed for the ability to safely self-administer medications, and had a physician's order to self-administer medications according to the provider's policy.Findings include:1. Observation and interview on 9/17/25 at 9:54 a.m. with resident 84 in her room revealed:*There was a plastic cup used for medication administration on her over-the-bed table.*There were pills in the plastic cup.*There were no staff present in her room or within eyesight of resident 84 or the medications.*Resident 84 stated that staff had left her morning medications on her over-the-bed table so she could take them slowly with breakfast because some of the medications upset her stomach.Observation and interview on 9/18/25 at 8:43 a.m. with resident 84 in her room revealed:*There was a plastic cup used for medication administration on her over-the-bed table.*There were four pills in the plastic cup.*Resident 84 stated she was waiting for her breakfast to arrive to take her medication.*There were no staff present in resident 84's room to be sure she took her medications.2. Review of resident 84's electronic medical record (EMR) revealed:*She was admitted on [DATE].*She had a 7/9/25 Brief Interview of Mental Status (BIMS) assessment score of 12, which indicted she was moderately cognitively impaired.*The 7/9/25 progress note documented one of the reasons for admission to the facility was that she was non-compliant with taking her medications.*Resident 84 did not have a physician's order to self-administer medications.*There was no medication self-administration assessment to determine if resident 84 was able to safely self-administer her medications in her EMR.3. Interview on 9/18/25 at 9:33 a.m. with director of nursing (DON) B revealed that resident 84 had not been assessed to determine if she was safe to self-administer her medications.4. Observation and interview on 9/17/25 at 11:43 a.m. with resident 79 in his room revealed:*There was an assembled nebulizer (a device that converts liquid medication into an inhalable mist) mask wrapped around the handle of resident 79's bedside table.*The nebulizer mask had a clear liquid substance remaining in the chamber.*Resident 79 stated he received his nebulizer treatment three to four times per day.*Staff would set up his nebulizer treatment and then some staff stayed in the room while he took the medication, and others would leave the room.*He would hang the nebulizer mask on the handle on his bed side table when he had completed his nebulizer treatment.5. Interview on 9/17/25 at 3:39 p.m. with licensed practical nurse (LPN) H revealed:*She had administered resident 79's nebulizer after lunch on 9/17/25.*At times she would remain in the room while resident 79 was being administered his nebulizer medication, but other times she would go out into the hallway while he was receiving his nebulizer medication.*LPN H verified there was a clear liquid remaining in the chamber of the nebulizer mask.*She stated resident 79 must not have finished his nebulizer. She documented in his EMR as having administered the medication after lunch.6. Review of resident 79 EMR revealed:*He was admitted on [DATE].*He had a BIMS assessment score of 11, which indicated he was moderately cognitively impaired.*Resident 79 had a 9/11/25 physician's order for Ipratropium-Albuterol Solution [a medication used to open the air passages in the lungs to make it easier to breathe] 0.5 -2.5 (3) MG/3ML [milligrams per 3 milliliters] 3 ml inhale orally three times a day for pneumonia for 7 Days.*There was no physician's order for resident 79 to self-administer medications.*There was no medication self-administration assessment to determine if resident 79 was able to safely self-administer his medications.7. Interview on 9/18/25 at 3:52 p.m. with DON B revealed:*If a resident asked to self-administer their medications the interdisciplinary team (IDT) would assess that resident to determine if they could safely self-administer their medications.*If it was determined by the IDT team that the resident was able to safely self-administer their medications, there would need to be a physician's order in place prior to the resident being able to self-administer medications.*There were no residents who had a self-administration assessment and physician's order for self-administration of medications in the (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility at that time.*She verified leaving medications at bedside for a resident to take on their own would have been self-administration of those medications.*She verified leaving a resident's room while the resident was receiving a nebulizer treatment would have been considered self-administration of the nebulizer.8. Review of the provider's September 2017 Self-Administration of Medications policy revealed:* If the resident desires to self-administer medications, the Self Medication Evaluation is completed. This evaluation is completed before the resident is able to self-administer.* If it is determined the resident may self-administer medications, the nurse:-a. Obtains a physician's order for self-administration for the specific medication(s).-b. Initiates the Self-Medication Administration Care Plan.Review of the provider's January 2025 Medication Administration policy revealed:* Residents are allowed to self-administer medications when specifically authorized by the prescriber, the nursing care centers' Interdisciplinary Team (IDT), and in accordance with procedures for self-administration of medications and state regulation.* The resident is always observed after administration to ensure that the dose was completely ingested.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure accurate documentation of the resident's wishes involving their advance directives (a legal document that expresses a person's health care wishes if they become unable to speak for themselves)/code status (specifies the type of emergent treatment a person wishes to receive if their heart or breathing would stop) for one of one sampled resident (5).Findings include:1. Review of resident 5's medical record revealed:*She was admitted on [DATE].*Her [DATE] Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact.*There was a banner display in her electronic medical record (EMR), which indicated that she did not want CPR (cardiopulmonary resuscitation, an emergency procedure to provide chest compression and often rescue breathing to preserve brain function and maintain blood circulation).-There was a [DATE] physician's order for DNR (do not resuscitate). *Her advance directive, which was signed on [DATE] and had been scanned into the EMR, indicated that she did want CPR. 2. Interview on [DATE] at 11:06 a.m. with resident 5 revealed:*She had changed her advance directive on [DATE].*She confirmed that she did want CPR. 3. Interview on [DATE] at 11:41 a.m. with licensed practical nurse (LPN) H about how staff would know a resident's code status revealed:*There were two places to find a resident's code status.-They kept a binder with the signed forms indicating residents' wishes at the nurses' station.-In the EMR, code status was indicated on a banner display and in physician orders.*If the paper form and the physician's order did not agree, she would follow the physician's order. 4. Interview on [DATE] at 11:46 a.m. with director of nursing (DON) B about the advance directive process revealed:*When an advance directive form is received, the binder in the nurse's station should be updated with that form to accurately reflect the residents' wishes.*The physician should be contacted for an order to reflect that code status.*She confirmed that resident 5's advance directive form indicated that she did want CPR.*She agreed that the physician should have been contacted for a new order to reflect the accurate code status for resident 5, and the EMR should have been updated. 5. Review of the provider's [DATE] Advance Directive policy revealed:* It is the policy of this facility that residents have the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.* During the admission process, written information is given to the resident/representative regarding the resident's right to make decisions concerning medical care, including the right to request, refuse, and/or discontinue medical or surgical treatment, to participate in or refuse to participate in experimental research and the right to formulate an advance directive. This includes the right to revoke these decisions at any time.* During the admission process, the facility identifies if the resident has an advance directive or medical orders related to life sustaining treatment. If the resident does, a copy is requested and kept in the resident's medical chart, accessible to the physician and care staff.* During the development of the initial comprehensive assessment and care plan, quarterly, annually, when significant changes in condition occur, or at the resident's request, discussion and documentation of the resident's choices regarding future health care occurs. A review of the advance directive.is included in the discussion.* The resident's comprehensive care plan is reviewed and updated routinely in order to incorporate the resident's choices regarding these rights into treatment, care and services.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, policy review, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.19.1 October 2024, the provider failed to ensure that one of one sampled residents (13) Minimum Data Set (MDS) (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) assessment was accurately coded for the area of active diagnoses.Findings include:1. Review of resident 13's electronic medical record (EMR) revealed:*She was admitted on [DATE].*Her 7/23/25 Brief Interview for Mental Status (BIMS) assessment score was 12, which indicated she had moderate cognitive impairment.*She had a 4/8/25 diagnosis of bipolar disorder (a chronic mental health condition characterized by extreme mood swings), anxiety disorder (a chronic mental health condition characterized by excessive and persistent worry, fear, and nervousness), and depression.*She had no physician orders related to bipolar disorder.*There was no documentation to support the diagnosis of bipolar disorder. 2. A request for documentation related to and supporting the diagnosis of bipolar disorder was submitted to director of nursing (DON) B on 9/18/25 at 7:45 a.m.-The facility was unable to provide documentation to support that diagnosis during the survey. 3. Interview on 9/18/25 at 11:46 a.m. with DON B about resident 13's diagnosis of bipolar disorder revealed, We have searched through everything and cannot find out how or why it got in her chart. 4. Interview on 9/18/25 at 1:58 p.m. with MDS coordinator, registered nurse (RN) C, about the diagnosis of bipolar disorder revealed:*She did not remember adding the diagnosis.*She did not know where the diagnosis came from and could not find any documentation to support it.*She stated, It was an error on the admission MDS. 5. The provider did not have an MDS policy to review. 6. Review of the Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.19.1 October 2024 page I-7 revealed:* I: Active Diagnoses in the Last 7 Days (cont.)-Item Rationale--Health-related Quality of Life---Disease processes can have a significant adverse effect on an individual's health status and quality of life.--Planning for Care---This section identifies active diseases and infections that drive the current plan of care.--Steps for Assessment---There are two look-back periods for this section:----Diagnosis identification (Step 1) is a 60-day look-back period.----Diagnosis status: Active or Inactive (Step 2) is a 7-day look-back period (except for Item I2300 UTI, which does not use the active 7-day look-back period).---1. Identify diagnoses: The disease conditions in this section require a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60 days.---Medical record sources for physician diagnoses include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/problem list, and other resources as available. If a diagnosis/problem list is used, only diagnoses confirmed by the physician should be entered.---2. Determine whether diagnoses are active: Once a diagnosis is identified, it must be determined if the diagnosis is active. Active diagnoses are diagnoses that have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered inactive diagnoses.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the provider failed to ensure that one of one sampled resident (13), who had a categorical convalescent period of 100 days (referring to a person recovering from an illness or operation) preadmission screening and resident review (PASRR) (a federally mandated program that screens individuals to ensure that those with a serious mental illness (SMI) or an intellectual or developmental disability (ID/DD) receive appropriate care in the correct setting), was rescreened when resident 13 stayed in the facility for over 100 days. Findings include:1. Record review of resident 13's electronic medical record (EMR) revealed:*She was admitted on [DATE].*Her initial preadmission screening from the hospital dated 4/7/25 indicated that she did not have a serious mental illness or developmental disability, and she had been approved for a period of 100 days.-The expectation was that the facility would rescreen the resident within the 100-day period for which she had been approved.*There was no documentation in the EMR to indicate that resident 13 had received any subsequent PASRR screening. 2. Documentation of all PASSR screenings for resident 13 was requested from director of nursing (DON) B on 9/18/25 at 7:45 a.m.-The facility was unable to provide documentation during the survey showing they had completed any PASRR screening for resident 13 after the initial screen on 4/8/25. 3. Interview on 9/18/25 at 11:46 a.m. with DON B revealed:*Social services director (SSD) S was responsible for completing the residents' PASRR screenings.-SSD S was not onsite during the survey.*She had reached out to SSD S to discuss the PASRR screening for resident 13.*SSD S had agreed that additional PASRR screening should have been completed for resident 13. 4. Review of the provider's 1/1/25 PASRR Process Policy and Procedure revealed:* Upon admission to the facility the Admissions Coordinator, Medical Records Director or designee validates a PASRR Level I is included in the admission paperwork. If there is no PASRR Level I, the Medical Records Director or designee contacts the hospital to obtain.* If a Level II Evaluation is indicated the Social Worker validates, within a timely period, that a LMHP [licensed mental health provider] is scheduled to evaluate.* Once the Level II Evaluation is complete, the Social Services Director will give to the Medical Records Director to be placed in the EHR [electronic health record]. * Social Services Director may keep a tracking log. If used, this log should include the following:-Resident admit date -PASRR I in the chart-Positive PASRR I has a referral for evaluation-Date the Level II evaluation is completed-Date the Level II is placed in the chart-Date an invalidation is placed in chart.* Follow up as needed per Federal PASRR rules. 5. Review of the 9/25 South Dakota Medicaid [NAME] and Policy Manual, Preadmission Screening and Resident Review (PASRR) revealed:* Federal Requirements- The PASRR process requires that all individuals applying to Medicaid-certified nursing facilities be given a preliminary assessment to determine whether they might have SMI or ID/DD. This is called a Level I screen. Those individuals who test positive at a Level I are then evaluated in depth, called Level II PASRR. The findings of this evaluation result in determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care.* Level I Process- Categorical Determination- Abbreviated Level II --This abbreviated process of PASRR is permitted because the individual meets certain categorical criteria. When an individual meets the criteria for one of these categories, it means that the evaluation of their SMI and/or ID/DD is not necessary at that time. However, the determination of meeting level of care for the nursing facility is still required. Some categories are time limited, meaning that the individual may be subject to a full PASRR Level II evaluation following admission.-- The current South Dakota categorical options are:--- The physician identifies the need for convalescent care following a hospitalization for a duration of less than 100 days. Requires documentation by a medical provider supporting the convalescent stay.* Resident Review/Status Change Process- Short Term/Categorical Concludes--When a categorical decision or short-term approval concludes, federal law requires that PASRR be involved to determine whether continued (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing facility care is appropriate if the provider believes that the individual's stay should extend beyond the authorized period.--- The nursing facility must submit a new Screening Form to Maximus, marking Resident Review.--- This must be completed by or before the last approved day after admission to the nursing facility.* Nursing Facility Responsibilities- To avoid non-payment for Medicaid recipients, nursing facilities have the responsibility to:-- Ensure that if a Short Term/Categorical stay needs to be renewed, the new PASRR is fully processed prior to the ending approval date.