STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435114	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diamond Care Center	901 N Main Ave Bridgewater, SD 57319

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on Certification and Survey Provider Enhanced Reports (CASPER) data review, staff timecard and pay stub review, facility assessment review, and interview, the provider failed to have licensed nursing coverage for 24-hours per day in the facility for four of four federal fiscal quarters (Quarter 1, 2024, Quarter 2, 2025, Quarter 3, 2024, and Quarter 4, 2024).Findings include:1. Review of the Payroll Based Journal (PBJ) (information of the provider's daily staffing hours for the appropriate care of the residents) data for Quarter 1 (October, November, and December 2024) revealed:*There was no 24-hour nursing coverage documented for seventeen days (October 1, 3, 4, 5, 6, 7, 8, 12, 13, 16, 17, 21, 22, 25, 26, 27, and 31) in October 2024.*There was no 24-hour nursing coverage documented for twenty days (November 4, 5, 8, 9, 10, 11, 14, 15, 16, 18, 19, 21, 23, 24, 25, 26, 27, 28, 29, and 30) in November 2024.*There was no 24-hour nursing coverage documented for eighteen days (December 1, 3, 4, 6, 7, 8, 12, 13, 14, 17, 19, 21, 23, 24, 26, 27, 28, and 29) in December 2024. 2. Review of the PBJ data for Quarter 2 (January, February, and March 2025) revealed:*There was no 24-hour nursing coverage documented for sixteen days (January 1, 4, 5, 6, 10, 11, 14, 17, 18, 19, 21, 22, 23, 28, 30, and 31) in January 2025.*There was no 24-hour nursing coverage documented for twelve days (February 2, 6, 7, 8, 15, 16, 18, 20, 25, 26, 27, and 28) in February 2025.*There was no 24-hour nursing coverage documented for seventeen days (March 1, 2, 6, 10, 11, 12, 15, 16, 19, 21, 22, 23, 25, 28, 29, 30, and 31) in March 2025. 3. Review of the PBJ data for Quarter 3 (April, May, and June 2024) revealed the provider failed to submit data for the quarter. 4. Review of the PBJ data for Quarter 4 (July, August, and September 2024) revealed:*There was no 24-hour nursing coverage documented for sixteen days (July 4, 5, 6, 7, 10, 11, 12, 13, 14, 16, 19, 20, 21, 22, 30, and 31) in July 2024.*There was no 24-hour nursing coverage documented for fifteen days (August 2, 3, 4, 10, 13, 14, 18, 19, 20, 21, 22, 23, 24, 29, and 31) in August 2024.*There was no 24-hour nursing coverage documented for eighteen days (September 1, 4, 5, 6, 10, 13, 14, 15, 19, 20, 21, 22, 23, 24, 25, 26, 27, and 28) in September 2024. Review of the provider's staff timecards and pay stubs revealed licensed nursing coverage for 24-hours per day could not be verified for Quarter 1, 2024, Quarter 2, 2025, Quarter 3, 2024, and Quarter 4, 2024. Review of the provider's updated January 2025 facility assessment regarding licensed nursing coverage revealed:*One to three licensed nurses providing direct care were needed for each shift.*An RN (registered nurse) or LPN (licensed practical nurse) was needed for each shift.*The director of nursing (DON) RN was to work full time day shifts. Interview on 9/11/25 at 2:08 p.m. with administrator A revealed:*She was responsible for submitting the PBJ information.*She had not submitted the PBJ data for the third quarter.*The DON was a full-time interim (temporary) employee.*She could not verify that there was licensed nursing coverage for 24-hours a day for the dates listed in the PBJ report.

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 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. Based on Certification and Survey Provider Enhanced Reports (CASPER) data review, staff timecard and pay stub review, facility assessment review, and interview, the provider failed to ensure a registered nurse (RN) was in the facility for eight consecutive hours daily for four of four federal fiscal quarters (Quarter 1, 2024, Quarter 2, 2025, Quarter 3, 2024, and Quarter 4, 2024).Findings include:1. Review of the Payroll Based Journal (PBJ) (information of the provider's daily staffing hours for the appropriate care of the residents) data for Quarter 1 (October 2024 - December 2024) revealed:*There was no eight-hour nurse coverage documented for seven days (October 12, 13, 19, 20, 25, 26, and 27) in October 2024.*There was no eight-hour nurse coverage documented for thirteen days (November 2, 3, 8, 9, 10, 16, 24, 25, 26, 27, 28, 29, and 30) in November 2024.*There was no eight-hour nurse coverage documented for eleven days (December 1, 7, 8, 15, 21, 22, 23, 24, 27, 28, and 29) in December 2024. 2. Review of the PBJ data for Quarter 2 (January 1 2024- March 31 2025) revealed:*There was no eight-hour nurse coverage documented for seven days (January 1, 4, 12, 18, 19, 25, and 26) in January 2025.*There was no eight-hour nurse coverage documented for seven days (February 2, 6, 7, 8, 9, 16, and 23) in February 2025.*There was no eight-hour nurse coverage documented for six days (March 2, 15, 19, 22, 23, and 29) in March 2025. 3. Review of the PBJ data for Quarter 3 (April 1 2024- June 30 2024) revealed the provider failed to submit data for the quarter. 4. Review of the PBJ data for Quarter 4 (July 1 2024 - September 30 2024) revealed:*There was no eight-hour nurse coverage documented for five days (July 5, 6, 19, 20, and 21) in July 2024.*There was no eight-hour nurse coverage documented for three days (August 2, 18, and 31) in August 2024.*There was no eight-hour nurse coverage documented for six days (September 1, 14, 19, 20, 21, and 22) in September 2024. Review of the provider's staff timecards and pay stubs revealed that registered nurse (RN) coverage for eight consecutive hours a day for seven days a week could not be verified. Review of the provider's updated January 2025 facility assessment regarding RN coverage revealed:*One to three licensed nurses providing direct care were needed for each shift.*An RN or LPN (licensed practical nurse) was needed for each shift.*The director of nursing (DON) RN was to work full time day shifts. Interview on 9/11/25 at 2:08 p.m. with administrator A revealed:*She had applied for an RN waiver, but it had been denied.*She was responsible for submitting the PBJ data report.*She had not submitted the PBJ data for the third quarter. *She could not verify that there was RN coverage eight consecutive hours a day for seven days a week during the dates triggered.*The DON was a fulltime interim (temporary) employee.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on Certification and Survey Provider Enhanced Reports (CASPER) data review, staff timecard and pay stub review, and interview, the provider failed to ensure Payroll Based Journal (PBJ) (information of the provider's daily staffing hours for the appropriate care of the residents) data was submitted to the Centers for Medicare and Medicaid (CMS) for one of four federal fiscal quarters (Quarter 3, 2024). Findings include: 1. Review of the PBJ data submitted to CMS for Quarter 3, 2024 revealed no PBJ data had been submitted to CMS for the time period of April 1, 2024 through June 30, 2024.*The following metrics were suppressed for invalid data:-Excessively Low Weekend Staffing.-No registered nurse (RN) hours.-Failed to have licensed nursing coverage 24 hours per day. Review of the staff timecards and pay stubs revealed licensed nursing coverage for 24-hours a day and RN coverage for seven days a week could not be verified. Interview on 9/11/25 at 2:08 p.m. with administrator A revealed:*She was responsible for submitting the PBJ data report to CMS.*She had not submitted the PBJ data for the third quarter.*She could not verify that there was licensed nursing coverage for 24-hours a day for Quarter 3, 2024.*She could not verify that there was RN coverage eight consecutive hours a day for seven days a week during Quarter 3, 2024.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and policy review, the provider failed to monitor refrigerator temperatures to ensure safe food storage for six of six sampled residents (13, 14, 20, 29, 30, and 31) with refrigerators in their rooms.Findings include: 1. Observation and interview on 9/9/25 at 2:55 p.m. with resident 31 in her room revealed:*She had a refrigerator in her room.*She stated she had not had it for very long, but there is nothing in it that could spoil.*There was no temperature gauge inside the refrigerator or a temperature monitor log to record its temperatures. 2. Observation on 9/9/25 at 8:33 a.m. in resident 29's room revealed his refrigerator did not have a temperature gauge inside it or a temperature monitor log to record its temperatures. 3. Observation on 9/9/25 at 8:44 a.m. in resident 14 and 30's shared room revealed their refrigerators did not have a temperature gauge inside them or a temperature monitor log to record their temperatures. 4. Observation on 9/11/25 at 6:35 p.m. in resident 20 and 13's shared room revealed their refrigerators did not have a temperature gauge inside them or a temperature monitor log to record their temperatures. 5. Interview on 9/11/25 at 9:53 a.m. with environmental services supervisor L revealed:*She was the head of housekeeping and laundry.*She checked the residents' refrigerators on Mondays and Thursdays for cleanliness and outdated items.*She confirmed that none of the resident refrigerators had temperature gauges to monitor their temperatures. 6. Interview on 9/11/25 at 10:17 a.m. with dietary manager E revealed:*She checked the residents' refrigerators for outdated items twice a week.*She was not aware that the refrigerators did not have temperature gauges, but thought they should have. 7. Review of the provider's revised 7/2025 Refrigerator policy revealed:* This policy will ensure proper handling, serving, and storage of any food items brought into our community from all outside sources.* 4. Food or beverage items may be stored in facility pantries, refrigerators or freezers, or [the] resident's personal room refrigerators, if applicable.* All cooked or prepared food brought in for a resident and stored in the facility's refrigerator or [a resident's] personal room refrigerator will be dated when accepted for storage and discarded after 72 hours/3 days. No home-prepared food items that are canned or preserved will be permitted.* 5. Facility refrigerators will have a temp log completed daily.* a. Refrigerator temps should be between 36-46 degrees and freezer temperatures should be 0 or below.* b. If the temperature is out of range adjust the fridge or freezer, recheck the temp in 4 hours and document action taken at the bottom of the page and log in maintenance service requests.

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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 certified nursing assistants (CNAs) did not administer a resident's topical (applied to the body) medications and self-administered medications were documented for one of (one) sampled resident (1) who self-administered medications and, at times, requested CNAs to administer her topical medications stored in her room.Findings include:1. Observation and interview on 9/9/25 at 3:35 p.m. in resident 1's room revealed:*The resident had two bottles of eye drops in a plastic container on her bedside table. She reported she administered them herself after naptime.* She had a Tinactin antifungal spay on her nightstand and stated the certified nursing assistants (CNAs) would spray it on her toes every night when they get her ready for bed.*She had Voltaren gel (for joint pain) on her nightstand, and she reported the CNAs applied it a few times a day for her when she asked.*She had antifungal cream, Calmoseptine cream (for skin protection and wound healing), and Nystatin antifungal powder in her nightstand drawer. They were identified with the resident's permission. Review of resident 1's electronic medical record (EMR) revealed:*She was admitted on [DATE].*She had diagnoses of a history of blood clots, obesity (overweight), anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), unspecified encephalopathy (a brain disease that alters the brain function or structure), and paralytic syndrome (a condition that causes the loss of muscle control). *She was hospitalized on [DATE] for treatment of a urinary tract infection and was readmitted to the nursing home on 7/22/25 with hospice services.*Her 7/28/25 Brief Interview for Mental Status (BIMS) was 15, which indicated her cognition was intact.*Resident 1's 7/28/25 Medication Self-Administration Self-Assessment stated the resident had occasional confusion and altered mental status. It indicated the resident was able to self-administer eye drops, nasal spray, and to maintain creams safely in her room.*An 8/15/25 hospice progress note at 2:16 p.m. indicated the hospice nurse talked with Minimum Data Set (MDS) coordinator B, who told the hospice nurse that the resident's confusion had been getting noticeably worse.*She had physician orders for the following medications to be kept at bedside and for her to self-administer:- Olopatadine HCL Solutions 0.2%, instill one drop in both eyes daily for allergic conjunctivitis [irritation].- Systane Ultra Solution 0.4-.03%, instill one drop in both eyes as needed for dry eyes.- Biotene Moisturizing Mouth (Dry Mouth Agents and Artificial Saliva) Solution PRN [as needed for dry mouth].- Fluticasone Propionate Suspension 50MCG/ACT 2 spray[s] in both nostrils daily as needed for one time a day [for allergies].- Preparation H Cream 1-0.25-14.1-15% (Pramox-PE-Glycerin-Petrolatum), insert 1 application rectally as needed for itching QID [four times a day].- Tinactin Aerosol Powder 1% (Tolnaftate), apply to toes/feet topically as needed for fungal infection BID [twice daily] PRN.- Voltaren Gel 1% (Diclofenac Sodium), apply 2 gram[s] transdermally [on skin] as needed for pain QID PRN.- Biofreeze Gel 4% (Menthol (Topical Analgesic)), apply to rt [right] upper back, shoulders topically as needed for pain. up to 4x/day [four times per day].- Calmoseptine [a skin protectant]: Apply to any redness or excoriation [damaged skin] PRN when providing pericare. CNA's may apply as needed.-Her orders for Nystatin powder and Lotrisone External Cream 1-0.05%; did not indicate she could self-administer those medications or that they could be left at the bedside.*Nursing did not document Tinactin and Volataren Gel as self-administered on the eMAR, and monthly checks on all the self-administered medications were not completed, as indicated in the provider's policy.Interview on 9/10/25 at 3:15 p.m. with CNA F revealed:*Tinactin fungal spray was applied by the CNA under resident 1's armpits every day and on her toes after her bath.*The CNAs applied that for her as she is unable to do it herself.*The CNAs applied her Voltaren gel, creams, and powders if resident 1 asked them to.*CNA F reported she did not administer resident 1's eye drops, and resident 1 was not able to self-administer those medications, as she was unable to twist the caps off, because her hands shook, and she was more (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confused.Interview on 9/10/35 at 3:18 p.m. with registered nurse (RN) G revealed:*Resident 1 had not asked her to assist her with her medications that were in her room, but the resident would tell RN G when they needed to be reordered.*Her self-administered medications were not documented when she took them.*She was not aware that CNAs were applying those medications for her and agreed they should not have been.Interview on 9/11/25 at 10:05 a.m. with MDS coordinator B and interim director of nursing (IDON) C revealed:*She was not aware that the CNAs were administering resident 1's topical medications for her, per the resident's request, and they should not have been.*She acknowledged that resident 1's self-administered medications had not been documented when the resident self-administered them.Review of the provider's 7/8/25 Self-Administration of Medications Policy Revealed:*Self-administration of medications will be evaluated at least quarterly.Screenings may take place more frequently if it is determined that the resident's status has changed and there is a question as to whether self-administration should continue. *Indicate on eMAR in 'Administration Notes' that medications are self-administered by the resident. Monthly checks will be done on all self-administered medications.

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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, review the providers dialysis agreement, and policy review, the provider failed to ensure the resident's chosen advance directive (a document that expresses a person's health care wishes if they become unable to speak for themselves) was accurately reflected in the resident's medical record and communicated to the dialysis center for one of one sampled resident (7) who received dialysis services.Findings include:1. Review of resident 7's electronic medical record (EMR) revealed:*He was admitted on [DATE]*His Brief Interview for Mental Status (BIMS) score was 6, which indicated he had severe cognitive impairment.*He had diagnoses of unspecified encephalopathy (disease that alters brain function), end-stage renal disease, dependence on renal dialysis (mechanical cleaning of blood), acute kidney failure with acute cortical necrosis (death of the tissue in the outer part of the kidney), unspecified dementia (a group of symptoms affecting memory, thinking, and social abilities), dysphagia following cerebral infarctions (difficulty swallowing after a stroke), hypertension, chronic obstructive pulmonary disease (COPD)(lung disease that blocks airflow), anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), weakness, and a history of malignant neoplasm (cancer) of the prostate.*His code status was do not resuscitate and do not intubate (DNR/DNI) (no life-sustaining measures when one's heart or breathing stops).*He received hemodialysis (a treatment that removes waste products and excess fluid from blood when the kidneys are unable to) twice a week.2. Review of resident 7's Diamond Care Center Directives to Define Scope of Medical Care form revealed:*Resident 7 and his power of attorney (POA) chose his code status as DNR, which was signed on 3/22/25 by his POA.3. Interview on 9/10/25 at 4:28 p.m. and 9/11/25 at 12:05 p.m. with registered nurse (RN) G revealed:*Based on her report sheet, resident 7 was a full code (life-sustaining measures if one's heart or breathing stops).*She reviewed the resident's current orders and stated he had DNR/DNI code status orders.*When reviewing his signed advanced directive, she stated his code status was DNR.*She verified his code status on her report sheet, and in the EMR was not what his advance directive indicated.*Communication sheets were sent with the resident when he went to receive dialysis, in a folder inside his bag that was on his wheelchair.*RN G reviewed his communication sheets and verified that his advance directive was not included on those sheets sent with him to receive dialysis. 4. Interview on 9/11/25 at 12:24 p.m. with the Minimum Data Set (MDS)/ infection preventionist/RN B, and the interim director of nursing (IDON) C revealed:*They expected a resident's code status order entered in the resident's EMR and on the report sheet to indicate what the resident's signed advance directive indicated. They reported that resident 7's code status was DNR.*MDS RN B updated the nursing report sheets, which had indicated the resident was a full code.* They explained resident 7's daughter had visited him while he was receiving dialysis in March. She filled out the advance directive form while he was at the dialysis center and sent the document back to the nursing home.*They assumed resident 7's daughter would have given a copy to the dialysis center.*They would not document when they would provide a resident's advance directives to the dialysis center. 5. Interview on 9/11/25 at 12:36 p.m. with a nurse at the dialysis center where resident 7 received dialysis, revealed they did not have an advance directive on file for resident 7, and indicated that without an advance directive on file, he would be a full code while he was there. 6. Interview on 9/11/25 at 12:46 p.m. with administrator A and IDON C revealed:*They reviewed the contract with resident 7's dialysis center, signed by administrator A on 9/24/24, and verified that they were to have provided the dialysis center with any advance directive executed by the resident.7. Review of the provider's 9/24/24 Nursing Home Dialysis Transfer Agreement revealed:*.the facility [nursing home] shall ensure that all appropriate medical, social, administrative, and other information accompany all Designated Residents at the time of transfer to (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[the dialysis] Center. This information shall include, but is not limited to, where appropriate, the following:. (g.) Any advance directive executed by the Designated Resident.8. Review of the provider's 7/14/25 Dialysis Policy revealed, pertinent health information and vital signs will be communicated to the dialysis center.9. Review of the provider's 2/11/25 Advance Directive Policy and Procedure policy revealed: It is the policy of the facility to establish, implement and maintain written policies and procedures for advance directive. Resident wishes will be communicated to the staff via the care plan and (identify facility protocol for communication of advance directives, either in written or oral format) and to the resident physician. Changes to the resident choices for advance directives will be documented, included in the resident plan of care,. physician orders will be obtained to reflect new choices as applicable and all items will be communicated to staff providing resident care.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, record review, interview, and policy review, the provider failed to ensure resident care plans had been revised to reflect their current needs for fall prevention for two of two sampled residents (25 and 3) who were identified to have a risk for falling and had fallen.Findings include:1. Observation and interview on 9/10/25 at 8:56 a.m. with resident 25 revealed: *She had been sitting in a recliner at the nurse's station with her walker in front of her. *Her glasses were missing the earpiece on the right side of the frames and were just resting on her nose. *She stated that she could get around well but could not remember if she had fallen recently or what happened to her glasses. Review of resident 25's electronic medical record (EMR) revealed: *She was admitted on [DATE]. *She had a Brief Interview of Mental Status (BIMS) assessment score of 6, which indicated she had severe cognitive impairment. *She had a diagnosis of dementia (a group of symptoms affecting memory, thinking, and social abilities). *She used a walker for ambulating (to move/walk) independently. *Her Morse Fall assessments (an evaluation of one's risk level for falling) revealed: -On 10/24/24 and 1/11/25 she had a high risk for falling. -On 3/31/25 and 6/18/25 she had a moderate risk for falling. *The nursing progress notes indicated she had fallen on 3/28/25 and 8/31/25. *She had post-fall assessments completed on 3/31/25 and 9/1/25 which indicated her care plan had been reviewed. *Her care plan did not indicate she had a risk for falling. Interview on 9/11/25 at 9:53 a.m. with registered nurse (RN) G revealed: *When resident 25 last fell, she and her roommate were unsure of who had fallen first and were trying to help one another get up off of their bathroom floor. *She had never updated a care plan because she did not have access to do that. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*She thought Minimum Data Set (MDS) coordinator B updated the residents' care plans. Interview on 9/11/25 at 1:30 p.m. with MDS coordinator B revealed: *She was responsible for updating the residents' care plans. *She tried to update residents' care plans as soon as something occurred that needed to be updated on the care plan such as fall prevention interventions for residents who had fallen or changes in residents' mental status. *She confirmed that resident 25's risk for falling and fall prevention interventions had not been included in her care plan. *She agreed that resident 25's Morse fall assessments were filled out incorrectly as she had not marked on those assessments that the resident used a walker to ambulate. *She stated resident 25 should have been considered as having a high risk for falling. Interview on 9/11/25 at 6:00 p.m. with interim director of nursing (IDON) C revealed: *She would update residents' care plans regarding wounds and MDS coordinator B would update the care plans everything else. *She expected a residents' care plan to be updated when there was a new order or when an assessment had been completed. *The provider's fall protocol was to update the resident's care plan with new interventions after a resident fell. 2. Observation and interview with resident 3 on 9/9/25 at 3:25 p.m. and again on 9/10/25 at 9:34 a.m. revealed: *He was lying in bed. *He mumbled when he talked and was hard to understand. *He did not answer most of the questions during the conversation. *He had abrasions on both of his knees that were covered with a Tegaderm (a clear dressing). Review of resident 3's EMR revealed: *He was admitted on [DATE]. *His 6/14/25 BIMS score was 7, which indicated he had severe cognitive impairment. *He had diagnoses of anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), bronchitis (respiratory infection), neuromuscular dysfunction of the bladder (nerve damage to the bladder that can lead to problems with (continued on next page)

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	435114	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diamond Care Center	901 N Main Ave Bridgewater, SD 57319

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the bladder filling and emptying), difficulty walking, hypotension (low blood pressure), atrial fibrillation (irregular heart beat), and long-term use of anticoagulants (medication used to thin the blood to help prevent blood clots). *His 8/19/25 Morse Fall Scale assessment indicated he had a high risk of falling. *His care plan indicated he had a high risk for falls related to his deconditioning, gait (walking)/balance problems, and he had no safety awareness. *His care plan indicated he had fallen and had minor injury on 5/17/25, 8/19/25, 9/2/25, 9/4/25, and had fallen with no injury on 8/30/25. *Fall interventions listed on his care plan included: -Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Date Initiated: 07/27/2024 -Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Date Initiated: 07/27/2024 -Follow facility fall protocol. Date Initiated: 07/24/2024 -PT [physical therapy] to eval [evaluate] and treat if indicated. Date Initiated: 09/04/2025 -Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter [and/or] remove any potential causes if possible. Educate resident/family/caregivers/IDT [interdisciplinary team] as to causes. Date Initiated: 07/24/2024 *A progress note on 9/4/25 indicated that a PT staff member had been at the door after his fall, and they requested PT orders to evaluate and treat. *Besides the intervention of PT orders to evaluate and treat on 9/4/25, his care plan regarding his fall interventions had not been reviewed or revised since 7/27/24. *His care plan did not include interventions to keep his wheelchair away from him in his room, that he was to transfer with shoes on or with the use of a gait belt, or that his bed was to be kept in a lower position, but not too low to not cause anxiety. Interview on 9/10/25 at 9:34 a.m. with certified nursing assistant (CNA) F in resident 3's room revealed: *Resident 3 had sores on both knees from having fallen. *He fell out of bed because he was in a hurry, and he did not turn his call light on for staff assistance. *He was not supposed to transfer himself. *His fall precautions included his bed was to be in a low position and his wheelchair was to be placed (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	out of his reach while he was in bed to help deter him from transferring without assistance, which he still self-transfers. Interview on 9/11/25 at 12:08 p.m. with RN G revealed: *Resident 3 was not supposed to transfer himself. *He was to have shoes and a gait belt (a waist strap gripped as support for safe mobility and transfers) on for transferring. *He did not have a fall mat by his bed, but they would implement that if he were sliding or falling out of his bed. *He did not walk by himself. *His wheelchair was to be kept right by his bed, so he did not walk by himself to get the wheelchair. *She did not expect the CNA to move the wheelchair away from his bed to keep it out of his reach. Interview on 9/11/25 with the interim director of nursing (IDON) C and MDS coordinator B revealed: *Resident 3's fall interventions included reminding him to use his call light, physical therapy to evaluate, placing the bed in a low position but not too low as that may increase his anxiety, no fall mat as that may increase his anxiety and he might stand up on it and fall, and to keep his wheelchair away from him so he would not transfer himself. *They stated he had a respiratory infection in the last few weeks, so they felt he was weaker. *They reviewed all resident falls at an interdisciplinary (a group of professionals with diverse expertise who collaborate to address problems) meeting and discussed fall interventions. Review of the provider's reviewed 7/2025 Fall Policy revealed: *To provide a safe living environment for the residents and to protect them from injury. *A licensed nurse will update the care plan to reflect interventions instituted to prevent further falls. *The resident's fall will be discussed with interdisciplinary team (IDT) as soon as possible after the falls to determine new interventions to try. Review of the provider's revised 1/1/25 Care Plan Policy revealed: *Facility staff must develop the comprehensive care plan within seven days of the completion of the comprehensive assessment and review and revise the care plan after each assessment. *The resident's care plan must be reviewed after each assessment, as required by 483.20, except discharge assessments, and revised based on changing goals, preferences, and needs of the resident and in response to current interventions.

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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** Based on policy review, record review, and interview the provider failed to follow nursing professional standards of practice to ensure nursing staff:*Followed physician orders, and provider's policy for one of two sampled residents (5) with orders for insulin administration and blood sugar level monitoring, and to ensure low blood sugars were reported to the physician per the provider's policy.*Assessed one of one sampled resident (25) for risk of falling, fall prevention interventions had been in place.Findings Include:1. Review of the provider's 6/7/22 Blood Sugar Monitoring policy revealed:*1. Check physicians [physician's] order for blood sugar testing frequency.2. Notify provider if 2 glucose checks are <70 [less than 70] or >400 [greater than 400] in 24 hours and/or change in condition. If no change in condition, notify the PCP [primary care provider] the next day.Hypoglycemia1. If patient is symptomatic, conscious, and able to swallow.2. Administer 6oz of fruit juice, milk, regular soda, or other high calorie carbohydrate.3. Repeat BG [blood glucose] after 15 minutes: If <70; repeat above interventions4. if patient can swallow; give a high protein snack with drink5. If after 2 attempts to treat and BG is still <70; notify PCPIf patient is unresponsive or unable to swallow.1. Administer Glucagon 1mg IM.6. Communicate occurrence of any hypoglycemic event to PCP the next business day Review of resident 5's electronic medical record (EMR) revealed:*She was admitted on [DATE].*She had diagnoses of type 2 diabetes (a condition involving disruptions in how the body regulates blood sugar) with chronic kidney disease, senile degeneration of the brain (a progressive decline in cognitive function), unspecified dementia (a group of symptoms affecting memory, thinking, and social abilities), legal blindness, and long-term use of insulin.*Her 6/30/24 Brief Interview for Mental Status (BIMS) assessment score was a 4, which indicated she had severe cognitive impairment.*She had current physician's orders for:-A FreeStyle Libre (a continuous glucose monitoring device), and the sensor was to be changed every 14 days and as needed.-Blood sugars to be checked if she displayed signs of hypoglycemia (low blood sugar) or had an altered mental status.-If her blood sugar was more than 400, staff were to recheck it in one hour.-Staff were to document all of her hypoglycemic episodes and treatments provided.-She had physician's orders to have her blood sugar checked before meals, two hours after every meal three times per day (at 10 p.m., 2 p.m., and 8 p.m.), and as needed.-To receive 20 units of Novolog insulin in the morning.-To receive 18 units of Novolog insulin twice daily at lunch and supper.-To receive 50 units of Lantus (long-acting insulin) at bedtime.-To receive 0.5mg of Ozempic weekly at bedtime, and she had received all doses. Resident 5's July 2025 through September 2025 medication administration records (MARs), progress notes, and glucose logs indicated:*Her blood sugar level was not checked before breakfast on 7/8/25, before lunch on 7/8/25, 7/12/25, 7/13/25, 7/14/25, 7/15/25, 7/16/25, 7/21/25, 7/22/25, 7/23/25, 7/28/25, and 7/29/25, or before supper on 7/1/25, 7/11/25, 7/20/25, and 7/26/25.*Her Novolog morning dose was held (not given) on 7/3/25 as she did not eat breakfast, 7/7/25 as she did not eat much breakfast, and her blood sugar was 106, and 7/23/25 as her blood sugar was 101; her lunch doses were held on 7/9/25 as she only ate bites of her lunch, 7/12/25 as her blood sugar was 118, 7/13/25 no reason was indicated, 7/15/25 no reason was indicated, 7/16/25 as her blood sugar was low and she did not eat much, 7/21/25 no reason was indicated, 7/25/25 for poor intake, and 7/26/25 as she was sleeping; Her supper dose was held on 7/10/25 for poor intake, 7/11/25, 7/18/25 as she refused to eat, and 7/20/25 as she did not eat much and her blood sugar was 81.*She refused her Novolog morning dose on 7/22/25 and 7/29/25; her lunch dose on 7/22/25, 7/23/25, and 7/29/25; her supper dose on 7/1/25, 7/7/25, 7/26/25, 7/27/25, and 7/31/25.*Her Lantus was held on 7/7/25 as her blood sugar was 119 and she did not eat supper, 7/9/25 as her blood sugar was low, 7/10/25 no reason was indicated, 7/14/25 as her blood sugar was low, 7/23/25 as her blood sugar was low, 7/24/25 as she did not eat much supper or her snack, 7/25/25 as her blood sugar was low, and 7/30/25 as her blood sugar was low.*She refused the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Lantus on 7/17/25, 7/18/25 (a note indicated she had refused supper on 7/18/25), and 7/22/25.*A progress note on 7/1/25 at 5:25 a.m. indicated the resident's phone alarmed due to a low blood sugar of 62 at 1:00 a.m. She had been given a granola bar and a boost, her blood sugar was rechecked and was 119.-Her glucose log indicated her blood sugar was 62 at 1:27 a.m. and it was 119 when it was rechecked at 2:08 a.m.-The nurse did not follow the provider's policy to recheck her blood sugar 15 minutes after the intervention.*A progress note on 7/19/25 at 4:26 p.m. indicated her blood sugar at 2:00 p.m. was 85. She did not have signs of hypoglycemia noted at that time. She was given a glass of orange juice. At 3:00 p.m. the certified nursing assistant (CNA) reported to the nurse that the resident's blood sugar was 58. She did not have any signs of hypoglycemia. She was given another glass of orange juice with sugar mixed in it. Her blood sugar was rechecked at 4:00 p.m., and was 102.-Her glucose log indicated her blood sugar was 82 at 1:31 p.m. and 1:41 p.m.-Her blood sugar of 58 at 3:00 p.m. was not documented on the blood glucose log.-Her blood sugar of 102 at 4:00 p.m. was not documented on the blood glucose log.-The nurse did not follow the provider's policy to recheck her blood sugar 15 minutes after intervention. *A progress note on 7/30/25 at 10:19 p.m. indicated the resident was sleeping and did not wake for supper. Her blood sugar was 115, and Novolog was given. The resident was not arousable and unable to swallow her bedtime medications. Her glucose monitor was alarming and indicated her blood sugar had been 52. The resident was given orange juice, and she did not open her eyes. The resident's bedtime dose of Lantus was held. After an hour, her blood sugar had increased to 106, and she was not in distress.-The resident's glucose log indicated her blood sugar was 52 at 9:35 p.m. Her other blood sugar checks documented in the nurse's note had not been documented in the resident's glucose log.-The resident was unable to swallow medications and was not arousable, and the nurse had her drink orange juice, placing her at risk for aspiration (when fluid enters the lungs).- The nurse did not follow the provider's policy to, if unresponsive and unable to swallow, the resident was to have glucagon 1mg IM (intramuscular)(a shot given in the muscle) administered.- The nurse did not follow the provider's policy to recheck the resident's glucose 15 minutes after interventions.-The nurses did not follow the provider's policy to notify the resident's physician of her hypoglycemic event.*Her morning blood sugars were not checked on 8/5/25, 8/7/25, 8/8/25, 8/9/25, 8/11/25, 8/14/25, 8/19/25, 8/21/25, 8/22/25, 8/23/25, 8/25/25, 8/26/25; before lunch on 8/5/25, 8/7/25, 8/8/25, 8/10/25, 8/11/25, 8/21/25,8/22/25, 8/23/25, 8/25/25, 8/26/25, 8/27/25; before supper on 8/7/25, 8/11/25, 8/13/25, and 8/22/25.*Her morning Novolog dose was held on 8/4/25 for having low blood sugar, 8/5/25 due to poor intake, and 8/19/25 for poor intake.*She refused the morning Novolog dose on 8/7/25, 8/8/25, 8/9/25, 8/11/25, 8/14/25, 8/21/25, 8/22/25, 8/23/25, 8/25/25, 8/26/25, and 8/30/25- a nurse note indicated the resident refused breakfast.*Her lunch Novolog dose was held on 8/5/25 for poor intake and 8/27/25 as she did not eat.*She refused the lunch Novolog dose on: 8/9/25, 8/11/25, 8/21/25, 8/22/25, 8/23/25, 8/25/25, and 8/26/25.*Her supper Novolog dose was held on: 8/7/25 due to poor intake, 8/8/25 for poor intake, and 8/12/25 for poor intake and low blood sugar.*She refused the supper Novolog doses on: 8/4/25, 8/5/25, 8/9/25, 8/10/25, 8/11/25-a nurse note indicated she did not eat supper, 8/13/25, 8/14/25, 8/18/25, 8/22/25, 8/24/25-A nurse's note indicated she did not eat much and her blood sugar had been 135, 8/26/25, 8/27/25, 8/28/25, and 8/31/25.*Her bedtime Lantus insulin dose was held on 8/6/25 for low blood sugar, 8/8/25 no indication was given, 8/12/25 for poor intake, 8/21/25 for low blood sugar, and 8/23/25 for poor intake.*She refused the Lantus bedtime dose on 8/4/25, 8/5/25, 8/10/25, 8/13/25, 8/14/25, 8/18/25, 8/22/25, 8/28/25, and 8/31/25.*A progress note on 8/3/25 at 1:52 a.m. indicated the resident's phone alarmed due to a low blood sugar of 68. She was given orange juice, and her blood sugar increased to 86.- According to her glucose log, the resident's blood sugar was 68 at 12:15 a.m. and 86 at 12:45 a.m.-The nurse did not follow the provider's policy and recheck her blood sugar 15 minutes after the intervention. *On 8/4/25 at 8:36 a.m., her glucose log indicated her blood sugar was 57.-There was no nurse's note documented regarding interventions that were done to bring her blood sugar up.-Her blood sugar was checked (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	again at 9:57 a.m. and was 126.-The nurse did not follow the provider's policy to recheck blood sugars 15 minutes after intervention. *A progress note on 8/7/25 at 12:09 a.m. indicated the resident's blood sugar was 66. Orange juice and peanut butter crackers were given. Her blood sugar was rechecked and was 77.- Those blood sugars were not documented in the glucose log.*A progress note on 8/20/25 at 1:25 a.m. indicated the resident had been having low blood sugars that evening. She was given granola bars and orange juice, and her blood sugar recheck was 83. At 1:10 a.m., her blood sugar was 71, and she was given a boost, and her blood sugar recheck was 91.-Resident's glucose log indicated: -Her blood sugar on 8/19/25 at 9:51 p.m. was 68. -Her blood sugar on 8/19/25 at 10:18 p.m. was 74. -Her blood sugar on 8/20/25 at 12:29 a.m. was 67. -Her blood sugar on 8/20/25 at 1:08 a.m. was 71. -Her blood sugar on 8/20/25 at 1:52 a.m. was 91.-The nurse did not notify the physician of the resident's two blood sugars that were less than 70 in a 24 hour period of time.*According to the glucose log, on 8/21/25 at 8:47 p.m., the resident had a blood sugar of 59.-The nurse held her Lantus, according to the MAR. -There was no documentation of interventions taken to correct the hypoglycemia. -Her blood sugar was not rechecked until 8/22/25 at 10:42 a.m., 13 hours and 55 minutes later. *A progress note on 8/25/25 at 11:00 p.m. indicated the resident's phone alarmed due to a low blood sugar, which was 69. The resident was given a bar, and her blood sugar recheck on 8/26 at 12:02 a.m. was 72.-The nurse did not follow the provider's policy to recheck blood sugars 15 minutes after intervention.-The nurses did not follow the provider's policy to notify the resident's physician of her hypoglycemic events.*Her morning blood sugars were not checked on 9/4/25 or 9/9/25; before lunch on 9/4/25; before supper on 9/1/25; and her 2 hour after mealtime on 9/7/25.*Her morning Novolog dose was held on 9/2/25 for poor intake, 9/4/25 as her blood sugar was 135, 9/5/25 as her blood sugar was 111, 9/8/25 as she did not eat, and 9/9/25 for poor intake.*Her lunch Novolog dose was held on 9/1/25 due to low blood sugar and poor intake, 9/4/25 as she did not eat, and 9/8/25 as she did not eat.*Her supper Novolog dose was held on 9/1/25 because the nurse missed that dose.*Her bedtime Lantus insulin dose was held on 9/6/25, and no indication was given and 9/11/25 as her blood sugar was low.*She refused the Lantus bedtime dose on 9/3/25, 9/4/25, 9/7/25, 9/8/25, and 9/9/25.*The resident did not have a physician's orders to hold any of her insulin doses.*Staff failed to notify her physician that her insulin had been held or refused.*A progress note on 9/1/25 at 10:15 a.m. indicated she had a blood sugar of 69 and was given orange juice. Her blood sugar recheck at 1:02 p.m. was 161.-The nurse did not follow the provider's policy to recheck glucose within 15 minutes of intervention.-The nurse failed to notify the resident's physician of her hypoglycemic event.*A progress note on 9/1/25 at 8:18 p.m. indicated her insulin dose had not been given as the nurse missed it.-Missed doses are considered a medication error. -Her physician was not notified. Interview on 09/11/2025 8:56 AM with registered nurse (RN) G revealed:*She verified there were no orders by the physician for if or when to hold resident 5's insulin.*She would expect there would be a progress note in the resident's EMR that the resident's physician was notified. *If she had a resident with a blood sugar level in the 50's, she would not administer the resident's insulin, give glucose gel, and would call the physician. Interview on 9/11/25 at 9:01 a.m. with the interim director of nursing (IDON) C and Minimum Data Set (MDS) coordinator/infection preventionist/RN B revealed:* They expected the nurse to give a resident who had low blood sugar something to bring the blood sugar up.* They expected the nurse to recheck a resident's blood sugar every 15 minutes until the resident's blood sugar was within normal range.*They expected a note to be documented and the physician to be notified by the nurse. *If the hypoglycemic episode occurred during a night shift, they expected the physician to be notified by fax; unless the blood sugar remained low, then it would need to be done sooner. *She would expect the nurse to hold the resident's insulin for low blood sugars and the physician to be notified that the insulin was held. *Resident 5's physician was not available on 9/11/25 for an interview. 2. Observation and interview on 9/10/25 at 8:56 a.m. with resident 25 revealed:*She had been sitting in a recliner at the nurse's station with her walker in front of her.*Her glasses were missing the earpiece on the right side of the frames and were (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	just resting on her nose.*She stated that she could get around well but could not remember if she had fallen recently or what happened to her glasses. Review of resident 25's electronic medical record (EMR) revealed:*She was admitted on [DATE].*She had a Brief Interview of Mental Status (BIMS) assessment score of 6, which indicated she had severe cognitive impairment.*She had a diagnosis of dementia (a group of symptoms affecting memory, thinking, and social abilities).*She used a walker for ambulating (to move/walk) independently.*Her Morse Fall assessments (an evaluation of one's risk level for falling) revealed:-On 10/24/24 and 1/11/25 she had a high risk for falling.-On 3/31/25 and 6/18/25 she had a moderate risk for falling.*The nursing progress notes indicated she had fallen on 3/28/25 and 8/31/25.*The nursing progress notes indicated she had a bruise from her fall on 8/31/25 but did not indicate where.*Her care plan did not indicate she was a risk for falling. Interview on 9/11/25 at 9:53 a.m. with registered nurse (RN) G revealed:*She was a travel nurse but had worked at the facility for the past five years and felt she knew resident 25 well.*She stated resident 25 is usually steady on her feet and had used a walker.*When resident 25 last fell, she and her roommate were unsure of who had fallen first and were trying to help one another get up off of their bathroom floor. Review of the provider's reviewed July 2025 Fall Policy revealed:*To provide a safe living environment for the residents and to protect them from injury.*A licensed nurse will update the care plan to reflect interventions instituted to prevent further falls.*The resident's fall will be discussed with interdisciplinary team (IDT) as soon as possible after the falls to determine new interventions to try.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and policy review, the provider failed to ensure the safety of:*Two of two sampled residents (1 and 4) who used motorized wheelchairs had been assessed for their ability to safely use motorized wheelchairs according to the provider's policy and ensure the safety of other residents.Findings include: 1. Observation and interview on 9/9/25 at 3:35 p.m. with resident 1 in her room revealed: *Certified Nursing Assistants (CNAs) N and O were dressing her and were getting her up in her electric wheelchair. *They used a total-body lift (a mechanical lift and sling used to lift a person's full body) to transfer the resident into her electric wheelchair. *She had been in the hospital recently and was placed on hospice services due to her decline. Review of Resident 1's electronic medical record (EMR) revealed: *She was admitted on [DATE]. *She had diagnoses of anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), unspecified encephalopathy (a brain disease that alters the brain function or structure), and paralytic syndrome (a condition that causes the loss of muscle control). *Her 7/28/25 BIMS was 15, which indicated her cognition was intact. *She had a recent hospitalization on 7/17/25 for a urinary tract infection. *Her Minimum Data Set (MDS) assessment indicated she had a significant change in her health status on 7/28/25, due to having been admitted to hospice. *An 8/15/25 at 2:16 p.m. hospice progress note indicated the hospice nurse talked with MDS coordinator B, and MDS coordinator B who told the hospice nurse that the resident's confusion had been getting noticeably worse. *A 9/10/25 at 4:11 p.m. progress note stated that the resident got stuck in her bathroom in her electric wheelchair. The resident reported to the CNA that she had forgotten how to use the joystick on the wheelchair. The CNA had to steer the electric wheelchair out of the bathroom. *She did not have an assistive device assessment completed to assess her ability to safely use her electric wheelchair. Interview on 9/10/25 at 3:15 p.m. with CNA F revealed resident 1 had been more confused lately. Interview on 9/11/25 at 2:20 p.m. with certified occupational therapy assistant (COTA) M revealed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435114	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diamond Care Center	901 N Main Ave Bridgewater, SD 57319

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*She had not completed an assistive device safety assessment for Resident 1's electric wheelchair, but indicated she would have if she had received an order to do so. 2. Observation and interview on 9/10/25 at 8:35 a.m. with resident 4 while operating her motorized wheelchair revealed: *She was driving into the bathroom and ran into the bathroom door while entering the bathroom. *While she was exiting the bathroom in her motorized wheelchair she ran into the bathroom door again. 3. Observation on 9/10/25 at 2:00 p.m. of resident 4 while operating her motorized wheelchair revealed she had required her daughter's assistance to operate her motorized wheelchair safely around other residents. Review of resident 4's electronic medical record (EMR) revealed:*She was admitted on [DATE] and had diagnoses of Parkinson's disease with dyskinesia (involuntary, uncontrolled, and repetitive muscle movements). *Her 7/28/25 BIMS score was 15 which indicated her cognitively intact.*An assessment of her use motorized wheelchair had been completed on 1/2/25.-Results of that assessment indicated resident 4 could operate her motorized wheelchair independent (no assistance) for routine use with occasional assist (assistance) with excessive congestion.*Her current care plan indicated Focus: Resident has selfcare deficit related to Parkinson's, limited mobility, and musculoskeletal impairment.-And Intervention/Task: Mobility Devices: wheelchair or electric wheelchair depending on alertness.*Resident 4's Task: Electric scooter documentation revealed: -from 8/31/25 through 9/11/25 resident 4 had been observed running into objects (all, tables, chairs, doors, etc.) fourteen times. Interview on 9/11/25 at 11:07 a.m. with social service designee (SSD) D regarding resident 4's motorized mobility device revealed: *She had been aware that she had completed resident 4's assessment on 1/25/25.*She had not been aware resident 4 had been observed running into objects.*SSD D was not aware per their policy an assessment needed to be completed quarterly. Interview on 9/11/25 at 2:53 p.m. with certified nursing assistant (CNA) F if she observed regarding resident 4's operation of her motorized wheelchair revealed:*She observed resident 4 run into the medication cart and pushed it down the hall.*She had observed resident 4's unsafe use of a motorized wheelchair and documented that in the EMR. Interview on 9/11/25 at 2:57 p.m. with registered nurse (RN) G regarding resident 4's operation of her motorized wheelchair in the facility revealed:*RN G was unsure of how many times resident 4 had run into the medication cart.*RN G had observed her resident 4 running into doorways with her motorized wheelchair at times.*She had noticed a progression of resident 4's involuntary arm and leg movement related to resident 4's Parkinson's diagnosis. Review of the provider's November 2024 Resident Use of Motorized Wheelchairs and Scooters policy revealed:*The therapy assessment (to determine safe operation of motorized devices) will be completed according to physician orders.*A new therapy assessment will be done quarterly and if the resident at any has an acute change in condition or exhibits poor safety awareness.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and policy review, the provider to maintain the supply of controlled medication (medication at risk for abuse and addiction) according to the provider's policy to ensure:*Oral and injectable lorazepam (controlled anti-anxiety medication) stored in one of one medication storage room had been accounted for with each shift change.*One of one bottle of oral liquid morphine sulfate (pain medication) observed in a drawer at the nurses' station had been stored in a secure area.Findings include: 1. Observation and interview on 9/11/25 at 10:32 a.m. of the medication refrigerator in the medication storage room with registered nurse (RN) G revealed:*A small locked black box which contained one lorazepam oral liquid and one lorazepam injectable for emergency use.*Staff did not count those medications at each shift change.*She was unsure why they had not been counting those medications but agreed that they should have been counted at shift change.*RN G agreed those medications should have had the amount counted like the medications locked in the medication cart.*Nurses are the only people who would have had access to the keys to open the medication storage room and the locked box.*RN G had been aware there was one set of keys to open the medication storage room and the locked box. 2. Observation on 9/11/25 at 11:00 a.m. of a lab draw supply drawer in the nurses' station revealed: *An opened bottle of morphine sulfate (pain medication) liquid. *The drawer had been unlocked and did not have a lock.Interview immediately after the above observation with RN G regarding the morphine sulfate that had been in the unlocked drawer in the nurses' station revealed:*She had removed that bottle of morphine sulfate liquid from the locked compartment in the medication cart and placed that medication bottle in that drawer this morning.*She had been waiting for another nurse to destroy the medication with her and had forgotten it was in that drawer. Interview on 9/11/25 at 3:55 p.m. with Minimum Data Set (MDS) coordinator/infection preventionist RN regarding the counting of the lorazepam in the medication storage room refrigerator revealed:*They had not been counting the lorazepam in the medication refrigerator.*She agreed those medication amounts should had been counted at each shift change with each act of exchanging of keys.*She commented she thought that it had been a case of out of sight, out of mind but staff should have counted those medications the same way the medications in the locked medication cart are counted.Review of the provider's February 2025 Medication Storage in the Facility policy revealed:*Scheduled two through five medications and other medications subject to abuse or diversion are stored in a permanently affixed double-locked compartment separate from all other medications per state regulation.*At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerator items is conducted by two licensed nurses and is documented on the shift verification of controlled substances count.*Controlled substances remaining in the facility after the order has been discontinued or the resident has been discharged are retained in the facility in securely locked area with restricted access until destroyed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to follow infection control practices to ensure:*Two of two sampled residents (29 and 9) oxygen and nebulizer tubing was dated to identify when the tubing had been placed in the residents' room for use according to the provider's process. *One of one sampled resident (1) with an open wound caused by prolonged pressure (pressure ulcer) had been placed on enhanced barrier precautions according to the provider's policy. Findings include: 1. Observation and interview on 9/9/25 at 2:44 p.m. with resident 29 while seated in his recliner in his room revealed:*He was wearing a nasal cannula (flexible tubing with prongs that delivers oxygen through the nose) and received oxygen at a flowrate of two liters via oxygen concentrator.*The nasal cannula tubing had not been dated to indicate when it was put in use. *Resident 29 had a portable oxygen tank attached to his wheelchair which also had an undated nasal cannula attached to it.*The nebulizer machine (converts liquid medication into an inhalable mist) had tubing that was dated 8/25/25 at 5:00 a.m. Review of the resident 29's treatment administration record (TAR) revealed:*Nebulizer Set Up Change Routine:-Change set up and tubing weekly.-Be sure to date it.-Every night shift every Sunday of weekly duty.*Oxygen-Tubing Change Routine:-Change O2 (oxygen) tubing and set up weekly. -Record date and time on the tubing N.O. (nursing order).-Every night shift every Sunday for weekly duty.*His oxygen tubing and nebulizer setup had been signed off as changed on 9/7/25. 2. Observation and interview on 9/11/25 at 2:05 p.m. with Minimum Data Set (MDS)/infection preventionist (IP) registered nurse (RN) B regarding the date on resident 29's nebulizer tubing revealed:*She agreed the date on the tubing was 8/25/25.*She agreed the oxygen tubing for the concentrator and the portable oxygen tank had not been dated.*MDS/IP RN B stated the tubing should have been dated and timed when it had been changed according to their care practice.*She had not been aware the tubing had been signed off as having been changed on 9/7/25. The provider did not have a policy specific for oxygen and nebulizer set up tubing changes. Observation on 9/9/25 at 4:30 p.m. in resident 9's room revealed she had been receiving oxygen by nasal cannula tubing that was not dated. Interview on 9/11/25 at 2:39 p.m. with certified nursing assistant (CNA) I revealed: *He sometimes would see oxygen tubing dated. *The night shift nurses would replace the residents' oxygen tubing weekly. Review of Resident 9's electronic medical record (EMR) revealed: *She was admitted on [DATE]. *She had diagnoses of chronic obstructive pulmonary disease (COPD) (a group of lung diseases that block airflow and make it difficult to breathe), congestive heart failure (CHF) (a disease where the heart does not pump blood well), dependence on supplemental oxygen, hypoxia (when the body does not get enough oxygen), and anxiety. *She had orders for her oxygen tubing changing to be changed every Sunday night shift, and the date (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and the time that was done was to be labeled on the oxygen tubing. Observation and interview on 9/9/25 at 3:35 p.m. in Resident 1's room revealed: *CNAs N and O were not wearing gowns while assisting the resident with getting dressed. *CNA N applied Calmoseptine skin protectant cream to the resident's groin folds. *CNA N removed his gloves, did not perform hand hygiene (hand washing), then put on a new pair of gloves. *Resident 1 had a foam dressing on her coccyx (tailbone), that was dated 9/9/25. *The CNAs were not sure if she had an open wound to her coccyx. *After assisting the resident to dress, both of the CNAs removed their gloves and did not perform hand hygiene. *They then, without wearing gloves, moved her up in bed using the slide sheet. *CNA O, without gloves on, removed the dirty garbage bag and replaced it with a new one, and did not perform hand hygiene. *CNA O then maneuvered the resident's electric wheelchair, using the joystick, into position to prepare to transfer the resident. *Without wearing gloves, CNA N and O used a full body lift (mechanical lift and sling used to lift a person's full body), and transferred the resident into her electric wheelchair. *CNA O picked up the garbage bag, exited the room with it, did not perform hand hygiene, and entered the dirty utility room. *CNA N performed hand hygiene using alcohol sanitizer before leaving the resident's room. Review of resident 1's electronic medical record (EMR) revealed: *She was admitted on [DATE]. *She had a 9/2/25 physician's orders for daily skin and wound monitoring. *She was found to have a pressure ulcer on her coccyx on 9/2/25 and received physician's orders to clean her pressure ulcer on her coccyx with wound cleanser, apply collagen powder, and cover with Mepilex (a type of foam dressing). Change every three days and as needed. Interview on 9/10/25 at 9:22 a.m. with registered nurse (RN) G revealed: *Because resident 1 had a pressure ulcer on her coccyx, she should have been on EBP. Interview on 9/11/25 at 9:01 a.m. with Minimum Data Set (MDS) coordinator B revealed she did not (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	think resident 1 needed to be on EBP until her wound became chronic, and explained chronic as it having been open for 3 weeks. She stated that this was what their policy stated. Review of the providers' 7/2025 Enhanced Barrier Precautions policy revealed: *Policy: It is the policy of this facility to implement enhanced barrier precautions for prevention of transmission of multidrug-resistant organisms (MDROs). CMS notes that facilities have some discretion when implementing EBP and balancing the need to maintain a homelike environment for residents. Definitions: -EBP are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). -High-contact resident activities include: -Dressing -Bathing/showering -Transferring -Providing hygiene -Changing linens -Changing briefs or assisting with toileting -Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator -Wound care: any skin opening requiring a dressing *Enhanced barrier precautions are recommended for residents with indwelling medical devices or wounds, who do not otherwise meet the criteria for contract precautions, even if they have no history of MDRO colonization or infection.This is because devices and wounds are risk factors that place these residents at higher risk for carrying or acquiring a MDRO, and many residents colonized with a MDRO are asymptomatic.