

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435122	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/02/2024
NAME OF PROVIDER OR SUPPLIER  St William's Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  103 N Viola St Milbank, SD 57252	

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)
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>50916</p> <p>Based on record review and interview the provider failed to ensure appropriate and timely Medicare notices had been provided for two of three sampled residents (47 and 250) who discharged from skilled services. Findings include:</p> <p>1. Review of resident 47's Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review form provided by social services designee E revealed:</p> <ul style="list-style-type: none"> <li>*Her Medicare Part A Skilled Episode start date was 7/25/24.</li> <li>*Her last covered day of Part A Service was 8/20/24.</li> <li>*Her signed SNF Advance Beneficiary Notice of Non-coverage (ABN) form had been completed on 8/19/24.</li> <li>*She had not been given notice 48 hours prior to her services ending.</li> <li>*Her Notice of Medicare Non-Coverage (NOMNC) form was outdated and did not have the correct header.</li> </ul> <p>2. Review of resident 250's CMS SNF Beneficiary Protection Notification Review form provided by social services designee E revealed:</p> <ul style="list-style-type: none"> <li>*He was discharged to his home on 6/4/24.</li> <li>*His Medicare Part A Skilled Episode start date was 5/17/24.</li> <li>*His last covered day of Part A Service was 6/4/24.</li> <li>*His SNF ABN form was completed and signed on 6/4/24.</li> <li>*He had not been given notice 48 hours prior to his services ending.</li> <li>*His NOMNC form was outdated and did not have the correct header.</li> </ul> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Interview on 10/2/24 at 10:46 a.m. with social services designee E regarding Medicare non-coverage notices revealed:</p> <p>*She had been completing the Medicare beneficiary reviews since 2021.</p> <p>*She was aware that notices were to be given 48 hours prior to services ending.</p> <p>*She was unaware that the forms were old and needed updating.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>50916</p> <p>Based on interview, record review, and policy review, the provider failed to provide a bed-hold notice to the resident or their representative when transferred to the hospital for one of one sampled resident (26). Findings include:</p> <ol style="list-style-type: none"> <li>1. Interview on 9/30/24 at 2:00 p.m. with resident 26 revealed she had thought she went to the hospital recently but forgot what for.</li> <li>2. Review of resident 26's electronic medical record (EMR) revealed: <ul style="list-style-type: none"> <li>*She was transferred to the hospital on 8/13/24.</li> <li>-Her power of attorney (POA) was notified of her transfer.</li> <li>-There was no documentation the bed hold information was given to the resident or her POA.</li> </ul> </li> </ol> <p>*On 8/19/24 she returned to the facility from the hospital.</p> <ol style="list-style-type: none"> <li>3. Interview on 10/2/24 at 8:18 a.m. with social services designee E regarding resident 26's bed hold notice revealed: <ul style="list-style-type: none"> <li>*She had never received the bed hold notice from the nurses.</li> <li>*She knew for certain it had not gotten done.</li> <li>*She had stated it was the nurse's responsibility to complete the bed hold notices when a hospital transfer occurred.</li> </ul> </li> <li>4. Interview on 10/2/24 at 10:02 a.m. with director of nursing B revealed: <ul style="list-style-type: none"> <li>*There was no bed hold notice for resident 26's hospital transfer on 8/13/24.</li> <li>*The social services designee was ultimately responsible for ensuring bed hold notices were completed.</li> </ul> </li> <li>5. Review of the provider's undated Bed Hold Policy revealed: <ul style="list-style-type: none"> <li>*As per the admission agreement, the facility must transfer or discharge a resident when the facility determines that such action is appropriate in order to meet the resident's needs for healthcare services.</li> <li>*Private Pay Residents: provider will hold the bed for an agreed upon length of time.</li> </ul> </li> </ol> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Medicaid Residents: provider will hold the bed for up to five (5) consecutive days for each separate and distinct medically necessary hospital stay.</p> <p>*There was no documentation for Medicare residents.</p> <p>6. Review of the provider's Admission Agreement revealed it did not include information about bed hold policies.</p> <p>7. Review of the provider's Admission Handbook revealed:</p> <p>*Bed Hold Policy: If desired accommodations at facility may be reserved for a resident during times they are on a leave from the facility, either for a leave of absence or a hospital leave. A bed hold policy will be given prior to a leave.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>50916</p> <p>Based on observation, interview, record review, and policy review the provider failed to follow physician orders for two of six residents (36 and 32) during medication administration that resulted in a medication error rate of 5.13%. Findings include:</p> <p>1. Observation, record review, and interview on 10/1/24 at 5:53 p.m. with licensed practical nurse (LPN) O during resident 36's medication administration revealed:</p> <p>*She withdrew naproxen sodium (pain and fever medication) 220 milligram (mg) tablet from the medication cart.</p> <p>*The physician's order on the resident's medication administration record (MAR) was for naproxen sodium 250mg tablet.</p> <p>*She stated she would give the resident the medication because it was a lower dose.</p> <p>*She stated she would call the physician later to verify the correct dose.</p> <p>2. Observation, record review, and interview on 10/2/24 at 7:25 a.m. with LPN O during resident 32's medication administration revealed:</p> <p>*She withdrew brimonidine tartrate 0.2% solution eye drops from the medication cart.</p> <p>*Prescription on the bottle said to instill one drop into each eye twice a day.</p> <p>*The physician's order on the resident's MAR directed to instill two drops into each eye twice a day.</p> <p>*She stated she would call the doctor to verify the correct dosing.</p> <p>*She instilled one drop in each of the resident's eyes.</p> <p>3. Interview on 10/2/24 at 9:53 a.m. with director of nursing (DON) B revealed:</p> <p>*Nurses were to verify orders from the physicians with orders in residents' MARs.</p> <p>*She expected staff to verify the prescription on the medications with the physicians' orders before administering medications to residents.</p> <p>*If there was an error, she expected the staff to call the physician and pharmacy before administering medications to residents.</p> <p>4. Review of provider's reviewed 7/19/24 Administration/Self-Administration of Medication policy revealed:</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*The correct medication(s) will be given to the correct resident, at the appropriate time, in the dose ordered by the physician or physician extender by the correct route and for a specific diagnosis.</p> <p>*There was no mention of what should be done when incorrect dosing/orders were found.</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43021</p> <p>Based on interview, observation, and record review the provider failed to ensure room trays were served at a satisfactory temperature for three of thirteen sampled residents (30, 47, and 150) who chose to eat meals in their rooms due to the long wait time for meals to be served in the dining room.</p> <p>Findings include:</p> <p>1. Interview on 9/30/24 at 1:54 p.m. with resident 30 revealed:</p> <p>*She had been living at the facility for almost two years.</p> <p>*She chose to eat her meals in her room as she felt it took too long to be served in the dining room.</p> <p>*She stated the food on her room tray was often cold when it should have been hot.</p> <p>-She had asked staff to reheat a food item once.</p> <p>-By the time her warmed up food item was returned to her, she was done eating the rest of her meal.</p> <p>*She felt she was the last resident to get her room tray delivered.</p> <p>2. Interview on 9/30/24 at 4:10 p.m. with resident 47 revealed:</p> <p>*She was recently admitted on [DATE] and ate a regular diet.</p> <p>*After her admission she went to the dining room for meals but decided to eat meals in her room as she felt it took too long to get served in the dining room.</p> <p>*Regarding her room trays, she stated her food was often cold by the time she got her room tray delivered.</p> <p>-She stated her food was not warm at all and actually cold.</p> <p>-She had not mentioned it to any of the staff as she was new and had not wanted to make waves [cause trouble].</p> <p>3. Interview on 10/1/24 at 8:06 a.m. with resident 150 revealed he:</p> <p>*Was recently admitted on [DATE].</p> <p>*Stated he had to wait a long time to be served in the dining room, so he decided to eat his meals in his room.</p> <p>*Had complaints regarding the food on his room tray being cold when it should have been hot.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Interview on 9/30/24 at 10:40 a.m. with director of nursing (DON) B regarding their dining room meal times revealed:</p> <p>*Breakfast was served at 7:30 a.m.</p> <p>*Lunch was served at 11:30 a.m.</p> <p>*Supper was served at 5:30 p.m.</p> <p>5. Observation on 9/30/24 of the noon meal revealed:</p> <p>*At 11:38 a.m. cook P wheeled the cart containing the food items into the dining room and loaded the residents' food items into the steam table.</p> <p>*Ten minutes later, at 11:48 a.m., the first room tray was plated and loaded into the insulated food cart.</p> <p>*At 11:57 a.m., cook P announced over the walkie-talkie that the room trays were ready and prepared the first plate for the dining room.</p> <p>*At 12:23 p.m. the meal service was completed for the dining room.</p> <p>-The first resident to be served in the dining room waited 27 minutes after the stated meal service time.</p> <p>-The last resident served in the dining room waited 53 minutes from the stated meal service time.</p> <p>6. Review of the 9/10/24 resident council meeting minutes revealed:</p> <p>*Eleven residents and one family member attended.</p> <p>*Resident 17 expressed a suggestion because there have been residents complaining that meal times are taking too long.</p> <p>*Social service designee E told her that she can talk to administration and the kitchen to see what their thoughts are but just not sure .</p> <p>*Resident 4 stated she likes her food hot and it is not always that way.</p> <p>7. On 10/1/24 at 6:07 p.m. the requested supper test tray was delivered to the survey team in the conference room and revealed the following food temperatures:</p> <p>*Three mini corn dogs:</p> <p>-One was at 99.1 degrees Fahrenheit (F).</p> <p>-One was at 100.6 degrees F.</p> <p>(continued on next page)</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-One was at 103.6 degrees F.</p> <p>*Baked beans that had a good flavor and was at 128 degrees F.</p> <p>*Cheesy Cauliflower Soup that tasted lukewarm and was at 132.0 degrees F.</p> <p>8. On 10/2/24 at 9:10 a.m. the requested breakfast test tray was delivered to the survey team in the conference room with a note 10/2/24 test tray served at 8:50 a.m. revealed the following food temperatures:</p> <p>*Coffee in an insulated mug was at 141.8 degrees F.</p> <p>*Cream of Rice in an insulated bowl was at 138.7 degrees F.</p> <p>*Scrambled eggs were at 115.1 degrees F.</p> <p>*The sausage link was at 104.6 degrees F.</p> <p>*The waffle was at 93.4 degrees F.</p> <p>*The syrup was at 88.1 degrees F.</p> <p>Interview on 10/2/24 at 10:50 a.m. with dietary manager D revealed:</p> <p>*She was not aware of any food complaints from September's resident council meeting.</p> <p>*She stated it had been quite awhile since she had received any concern forms and stated either residents would bring her a concern form or social service designee E would forward her a concern form.</p> <p>Continued interview with dietary manager D regarding concerns with cold food on the room trays served revealed:</p> <p>*She was aware of complaints regarding food being cold on room trays served to the residents in their rooms.</p> <p>*She agreed that the Cheesy Cauliflower Soup served on the 10/1/24 supper test tray had not looked appetizing to her.</p> <p>*She stated the insulated carts work best if the room trays are served within 10 to 15 minutes.</p> <p>Interview on 10/2/24 at 11:45 a.m. with social service designee E revealed:</p> <p>*She was the complaint coordinator for the facility.</p> <p>*Resident concern forms were located inside the black box by the facility's bulletin board in the hallway as she was told to put the forms inside the box.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*In the past, she had mentioned food complaints to dietary manager D but did not keep a record of those conversations or the complaints.</p> <p>*For concerns voiced at the monthly resident council meeting she would verbally inform the respective department manager of the concern.</p> <p>*She did not fill out a concern form for the concerns raised at resident council.</p> <p>*She had only two concern forms in the past six months.</p> <p>Continued interview with social service designee regarding food complaints at the 9/10/24 resident council meeting revealed:</p> <p>*She had talked to administrator A about resident 17's suggestion and was told the resident's suggestion would not work.</p> <p>*She had not discussed the food complaints with dietary manager D.</p> <p>Interview on 10/2/24 at 12:06 p.m. with administrator A revealed:</p> <p>*She was aware of concerns with cold food on the meal trays delivered to residents' rooms.</p> <p>*She and DON B attended the individual resident care conferences and she stated they would note the concerns expressed but do not use the concern forms.</p> <p>Interview on 10/2/24 at 12:30 p.m. with DON B revealed:</p> <p>*She was aware of cold food complaints regarding resident room trays.</p> <p>*A dietary aide delivers the insulated food cart to the nursing unit hallway and certified nursing assistants (CNAs) deliver the food trays to the resident rooms.</p> <p>*She would have expected room trays to be delivered to resident rooms within 15 minutes.</p> <p>*She was not sure if this was happening.</p> <p>*The policy on resident room trays was requested.</p> <p>Interview on 10/2/24 at 12:55 p.m. with CNA L revealed:</p> <p>*There were ten room trays for breakfast.</p> <p>*There were six room trays for lunch.</p> <p>*She was not sure how many supper room trays there were as she did not work the evening shift.</p> <p>*It usually took her about 10 minutes to pass the meal trays to the residents' rooms.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the provider's Resident Grievance Form revealed:</p> <ul style="list-style-type: none"> <li>*A space at the top of the form for the resident's name and room number.</li> <li>*The first section indicated to Describe the concern in detail:</li> <li>*The second section indicated What was done resolve [sic] issue and department that resolved issue.</li> <li>*The third section indicated Are you happy with the way the issue was handled and resolved?</li> <li>*A space at the bottom of the form for: <ul style="list-style-type: none"> <li>-The resident's signature and date.</li> <li>-The department staff's signature and date.</li> </ul> </li> </ul> <p>The policy on resident room trays was not received by the end of the survey.</p>