STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Strand-Kjorsvig Community Rest Home	801 S Main Roslyn, SD 57261

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 50916 Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI) review, observation, record review, interview, and policy review the provider failed to ensure the safety of one of one sampled resident (1) by staff who did not observe the resident take her medications after preparting them, which enabled the resident to not ingest multiple doses, hide those medications in her room, and then ingest those medications all at once as an act of self-harm. Findings include: 1. Review of the providers submitted SD DOH FRI on 8/22/24 revealed: *On 8/19/24 resident 1 was transferred from the facility to the hospital for hypotension (low blood pressure) and profound weakness. *Resident was admitted to the hospital. *On 8/20/24 the ultrasound revealed a lesion on her liver and she was in liver failure. *On 8/21/24 resident 1 told hospital staff that she consumed several Tylenol on 8/17/24 in order to end her life. *Resident stated she had taken the Tylenol from her medication cup the nurses gave her and put them in a plastic container which she hid in her dressser drawer. 2. Review of resident 1's electronic medical record (EMR) revealed: *There was a 10/11/23 order for two tablets of Tylenol Extra Strength 500 milligrams (mg) to be given at bedtime. *There was no order for her to self-administer any of her medications. *Her Brief Interview for Mental Status (BIMS) score was 15 which indicated she was cognitively intact. *Her care plan stated she was seen by mental health professionals on a scheduled basis. (continued on next page)

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

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*She was diagnosed with depression, anxiety, bipolar disorder, adult failure to thrive, and drug-induced subacute dyskinesia (a movement disorder caused by certain medications that can lead to involuntary and abnormal movements). *She required supervision/touching assistance from the staff when eating. *The staff were to monitor her for signs and symptoms of dysphagia (difficulties swallowing). *There was no documentation within the progress notes provided by nurses that the resident was self-administering her medications. 3. Record review of resident 1's mental health evaluations from 9/8/23-7/16/24 revealed: *She seen a mental health professional once a month. *She declined psychiatric help at all her visits. *She accepted psychiatric medications. *Her severe weight loss was noted and addressed which she said was intentional. 4. Observation and interview on 9/10/24 at 11:19 a.m. with resident 1 in her room revealed: *She was sitting in her recliner watching TV and had her call light within reach. *Her left eye was bloodshot and she appeared thin. *She was pleasant and open about her incident on 8/19/24. *When asked how she was doing she stated, I am very depressed. *She stated that before the incident: -The nurses would leave her Tylenol on her bedside table and leave the room. -She would put the Tylenol in a plastic container and hide it in her dresser drawer. -She was unsure how many Tylenol tablets she had saved. - She stated, I just did not want to be here anymore. *She stated after the incident the nurses would wait for her to take her medications before leaving the room. 5. Interview on 9/10/24 at 3:15 p.m. with certified nursing assistant (CNA) F regarding resident 1 revealed: *She has made excuses to get out of meals, activities, and bathing. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	*She consistently has refused breakfast and has only ordered a sandwhich and a pop for evening meals. *She has lost a considerable amount of weight, but she has refused to believe the numbers on the scale. 6. Interview on 9/10/24 at 5:05 p.m. with CNA's D and E regarding resident 1 revealed: *They had not seen family or friends visit her. *She had seemed very depressed, isolated herself in her room, and would barely eat. *She used to be independent in her room before her 8/19/24 incident and she now needed one staff person to assist her to complete her activities of daily living (ADLs). *She had refused to participate in activities. 7. Interview on 9/11/24 at 8:05 a.m. with director of nursing (DON) A regarding resident 1 revealed: *She believed the staff had failed her because they trusted her to take her medications by herself prior to the 8/19/24 incident *The only education that was provided regarding the resident's incident was during the informal meetings held and documented on 8/21/24 and 8/22/24 that she had with only select staff members. *She stated she would like to audit/monitor the nurses during medication administration in the future. *She had not done any medication audits or monitoring since the resident's 8/19/24 incident. *She stated the resident used to participate more in activities and meals when she stayed at the facility before, compared to now. 8. Review of the provider's 11/17/07 Medication Administration of oral medications policy revealed: *To administer oral medications in an organized, accurate, and safe manner. *10. Administer medication and remain with resident while medication is swallowed. Do not leave a medication in a resident's room without orders to do so along with documentation of self-administration. Use caution with residents who have difficulty with swallowing. *12. Follow all medication with 4 to 8 ounces (120-240mL) of water unless otherwise ordered or specified by manufacturer.

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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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 50916 Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI) review, observation, record review, interview, and policy review, the provider failed to follow their medications administration policy and correctly administer medication to one of one sampled resident (1) who required hospitalization after a self-harm incident. Staff were not ensuring her medications were consumed during the administration process. Findings include: 1.Review of the provider's submitted SD DOH FRI on 8/22/24 revealed: *On 8/19/24 resident 1 was transferred from the facility to the hospital for hypotension (low blood pressure) and profound weakness. *Resident was admitted to the hospital. *On 8/20/24 an ultrasound revealed a lesion on her liver and she was in liver failure. *On 8/21/24 resident 1 told hospital staff that she had consumed several Tylenol (pain and fever-reducing medication) in order to end her life on 8/17/24. *Resident stated she had taken the Tylenol from the medication cup the nurses gave her and put them in a plastic container which she hid in her dresser drawer. 2.Review of resident 1's electronic medical record (EMR) revealed: *There was an 10/11/23 order for two tablets of Tylenol Extra Strength 500 milligrams (mg) to be given at bedtime. *There was no order for her to self-administer any of her medications. *Her Brief Interview for Mental Status (BIMS) score was 15 which indicated she was cognitively intact. *Her care plan stated she was seen by mental health professionals on a scheduled basis. *She was diagnosed with depression, anxiety, bipolar disorder, adult failure to thrive, and drug-induced subacute dyskinesia (a movement disorder caused by certain medications that can lead to involuntary and abnormal movements). *She required supervision/touching assistance from the staff when eating. *The staff were to monitor her for signs and symptoms of dysphagia (difficulties swallowing). (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	*There was no documentation within the progress notes provided by nurses that the resident was self-administering her medications. 3.Observation and interview on 9/10/24 at 11:19 a.m. with resident 1 in her room revealed: *She was sitting in her recliner watching TV and had her call light within reach. *Her left eye was bloodshot and she appeared thin. *She stated that before her incident on 8/19/24: -The nurses would leave her Tylenol on her bedside table and leave the room. -The staff did not watch her take the medications. -When they left she would put the Tylenol in a plastic container and hide it in her dresser drawer. -She was unsure how many tablets she had saved. *She stated since after the incident the nurses now waited for her take her medications before leaving the room. 4.Interview on 9/10/24 at 1:30 p.m. with medication aide C while she was performing medication administration revealed: *There were no residents who had a self-administration order for medications. *If a resident did have a self-administration order it would have been easy to see on their electronic medical record. *She stated that after resident 1's incident on 8/19/24, director of nursing A conducted an informal meeting with her and other staff members. *The informal meeting went over the incident and how to properly administer medications to residents by ensuring the residents had taken the medication. *She was unaware if there would be any other education or meetings provided following the incident. 5. Interview on 9/10/24 at 5:05 p.m. with certified nursing assistants (CNA) D and E regarding resident 1 revealed: *They had not seen nurses leaving medications in residents' room. *They had not seen family or friends visit her. *She had seemed very depressed, isolated herself in her room, and would barely eat. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	*She used to be independent in her room before her 8/19/24 incident and she now needed one staff person to assist her to complete her activities of daily living (ADLs). 6.Interview on 9/11/24 at 8:05 a.m. with director of nursing (DON) A regarding resident 1 revealed: *She believed the staff had failed her because they trusted her to take her medications by herself prior to the 8/19/24 incident. *The only education that was provided was during the informal meetings held and documented on 8/21/24 and 8/22/24 that she had with only select staff members regarding resident 1's incident. *She stated she would like to audit/monitor the nurses during medication administration in the future. *She had not conducted any audits or monitored medication administration since the resident's incident. 7.Review of provider's 11/17/07 Medication Administration of oral medications policy revealed: *To administer oral medications in an organized, accurate, and safe manner. *10. Administer medication and remain with resident while medication is swallowed. Do not leave a medication in a resident's room without orders to do so along with documentation of self-administration. Use caution with residents who have difficulty with swallowing. *12. Follow all medication with 4 to 8 ounces (120-240mL) of water unless otherwise ordered or specified by manufacturer.