

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Dells Nursing and Rehab Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 Thresher Dr Dell Rapids, SD 57022	

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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>45383</p> <p>Based on interview, record review, policy review, and review of the South Dakota Department of Health (SD DOH) facility reported incident (FRI), the provider failed to ensure a controlled medication (medication with potential for abuse and addiction) for one of one sampled resident (41) had remained secured and was accounted for. This citation is considered past non-compliance based on a review of the corrective actions the provider implemented following the incident.</p> <p>Findings include:</p> <p>1. Interview on 1/16/25 at 8:40 a.m. with registered nurse (RN) D regarding resident narcotic medication counting at the end of her shift revealed:</p> <p>*She had counted the resident narcotics when she had arrived to begin her shift on 11/23/24 6:00 a.m. with no discrepancy identified.</p> <p>*RN D did not count the resident narcotics with licensed practical nurse (LPN) R at the end of her shift on 11/23/24 at 6:30 p.m.</p> <p>*RN D had not left her shift and not counted resident narcotics before 11/23/24 at 6:30 p.m.</p> <p>*LPN R refused to do the narc count until RN D insisted on it.</p> <p>*She had been notified on 11/24/24 at 6:25 a.m. by administrator A to return to work and help locate the morphine sulfate (a controlled pain medication) liquid that had been missing.</p> <p>*RN D had called LPN R on 11/24/24 at 7:00 a.m. and LPN R had already left the facility without locating the missing medication.</p> <p>2. Interview on 1/16/25 at 10:30 a.m. with nurse manager C regarding the missing morphine sulfate revealed:</p> <p>*She had been notified on 11/24/24 that six milliliters (ml) of morphine sulfate liquid had not been accounted for.</p> <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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Nurse manager C had been working with the pharmacy to complete the investigation of the missing medication and staff education that had been completed on 12/19/24.</p> <p>*LPN R had been instructed to stay at the facility until RN D arrived to help locate the missing medication.</p> <p>*She had not thought that the missing medication would have been considered theft until the pharmacy had informed her that the missing medication was theft.</p> <p>3. Interview on 1/16/25 at 11:50 a.m. with pharmacist T regarding the missing medication revealed:</p> <p>*He had been informed on 11/24/24 of the missing six ml of morphine sulfate.</p> <p>*Pharmacist T had been involved with the investigation of the missing medication.</p> <p>*He had helped with providing education to staff regarding medication safety, procedures and regulations.</p> <p>4. Review of the controlled drug receipt/record/disposition form for resident 41's liquid morphine sulfate revealed the last dose of morphine sulfate had been administered on 11/16/24 at 5:00 a.m. with six ml remaining in the bottle.</p> <p>5. Review of the provider's undated Narcotic Count Policy revealed:</p> <p>*Narcotics will be counted by licensed nursing personnel to assure they are properly accounted for at the beginning and ending of each shift.</p> <p>*The ongoing and off going nurse at shift change will perform a physical count of the narcotic drawer.</p> <p>6. The provider implemented changes to ensure the deficient practice does not recur was confirmed on 1/16/25 after record review revealed the facility had followed their quality assurance process, education was provided to all staff who were approved to administer medication regarding the regulations for controlled substances, that a system to account for controlled medication is in place and followed, receipt and disposition of medication, a shift-to-shift controlled medication count is completed by the appropriate staff to ensure accurate reconciliation of medications on hand, interviews revealed staff understood the education provided regarding those topics, and observation of controlled medication count compared to the medication supply on hand was accurate.</p> <p>Based on the above information, non-compliance at F602 occurred on 11/24/24, and based on the provider's implemented corrective action for the deficient practice confirmed on 1/16/25, the non-compliance is considered past non-compliance.</p> <p>Review of education provided on 12/19/24 to all staff that administer medication revealed:</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45383</p> <p>Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, and policy review the provider failed to report the missing controlled medication (medications with potential for abuse and addiction) had been reported timely to SD DOH.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of the provider's 12/4/24 SD DOH FRI revealed on 11/24/24 six milliliters (ml) of morphine sulfate (a controlled pain medication) had been unaccounted for. Interview on 1/16/25 at 11:28 a.m. with nurse manager C regarding the reporting the missing controlled medication revealed: <ul style="list-style-type: none"> *She had not known the timeline requirement for reporting the missing controlled medication to SD DOH. *She had not known that the missing medication could be considered theft of personal belongings. *She had known that she had not followed the facility's policy for reporting the potential diversion of a controlled substance. *On 11/25/24 she had begun the paperwork the pharmacy had provided her for drug diversion. *The pharmacy had informed her that it was a misappropriation of a personal item on 12/4/24. Interview on 1/16/25 at 12:16 p.m. with administrator A regarding the reporting of the missing controlled medication revealed: <ul style="list-style-type: none"> *She had not been aware of the timeline for reporting missing medication to the SD DOH. *Administrator A agreed that she had not followed their policy for reporting the potential diversion of a controlled substance. <p>Review of the provider's undated Reporting and Investigating Diversion of Controlled Substances Policy revealed:</p> <ul style="list-style-type: none"> *The investigation will be conducted with the assistance of human resources and will be completed within 48 hours of the incident's discovery. *Severity of the theft or loss must be evaluated when considering reporting. *Agencies to whom narcotic thefts may be reported include local office of [NAME] licensing. 		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45383</p> <p>Based on observation, interview, record review, and policy review the provider failed to ensure resident care plans had been revised to reflect their current needs for:</p> <p>*Three of three sampled residents (4, 9 and 34) who had fallen.</p> <p>*One of one sampled resident (7) who had a facility acquired pressure ulcer.</p> <p>*One of one sampled resident (10) who had a history of urinary tract infections.</p> <p>*One of one sampled resident (11) who developed a facility acquired pressure sore.</p> <p>*One of one sampled resident (29) who had attempted to leave the facility without staff knowledge.</p> <p>Findings include:</p> <p>1. Review of resident 34's electronic medical record (EMR) revealed:</p> <p>*She had fallen on 8/25/24, 10/12/24, and 12/28/24.</p> <p>*On 12/28/24 resident 34 had an injury after her she fell and required a laceration repair above her left eye in the emergency room .</p> <p>*On 8/14/24 the care plan had identified her as at risk for falls.</p> <p>Interventions on the 8/14/24 initiated care plan included a physical therapy evaluation to treat as needed and to follow the facility's fall protocol.</p> <p>Interview on 1/15/25 at 2:00 p.m. with Minimum Data Set (MDS)/director of nursing (DON) B regarding interventions for resident 34 due to her falls revealed:</p> <p>*She had an intervention for physical therapy (PT) to evaluate and treat as ordered initiated on 8/14/24.</p> <p>*MDS/DON B stated that the facility's fall protocol was the same as their fall policy.</p> <p>45683</p> <p>2. Observation and interview on 1/14/25 at 8:26 a.m. of resident 10 while in her room revealed:</p> <p>*She was sitting in her recliner working with an occupational therapist.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Then hourly visual checks were completed during the day.</p> <p>-From 8:00 p.m. to 8:00 a.m. she would have been on 30-minute visual checks.</p> <p>*She completed the Elopement Risk Tool on 12/14/24.</p> <p>-That identified resident 29 as at risk for elopement.</p> <p>*Care plans were to be updated by MDS/DON B.</p> <p>*She was unsure if a tile alarm device was used on resident 29 following the incident.</p> <p>Interview on 1/15/25 at 3:00 p.m. with MDS/DON B revealed:</p> <p>*Regarding resident 29's elopement risk they would have considered her behaviors not the score on the assessment.</p> <p>*On 10/18/24 her elopement risk score was 10, and she was not considered an elopement risk at that time.</p> <p>*The elopement risk assessment score of 25 completed on 12/14/24, identified her as at risk for elopement.</p> <p>*She agreed resident 29's care plan should have been updated after interventions were initiated.</p> <p>*Nurse manager C and administrator A would decide on the use of tile device alarms. As an elopement prevention intervention.</p> <p>*She agreed resident 29's care plan had not been updated to following the above attempted elopement or any interventions put in place.</p> <p>Interview on 1/15/25 at 3:00 p.m. with administrator A and nurse manager C revealed:</p> <p>*Resident 29 had used a tile device following the above incident on 12/14/24.</p> <p>-Her family had approved and consented to the use of the device.</p> <p>*They would have expected the care plan to have been updated following the elopement.</p> <p>*Elopement education was provided to staff following resident 29's elopement on 12/14/24.</p> <p>*Behavioral health had recommended memory care placement for resident 29.</p> <p>50916</p> <p>4. Observation on 1/14/24 at 9:09 a.m. with resident 4 in the dining room revealed:</p> <p>*She was seated in her wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*She had an electronic monitoring device on her wrist.</p> <p>Review of resident 4's electronic medical record (EMR) revealed:</p> <p>*She was admitted on [DATE]</p> <p>*She had a Brief Interview of Mental Status (BIMS) assessment score of 8, which indicated she was moderately cognitively impaired.</p> <p>*Her diagnoses included cellulitis, dementia, and bulbous pemphigoid (an autoimmune disease that causes skin blisters).</p> <p>*She had fallen on 8/9/24, 8/13/24, 8/14/24, 8/15/24, 8/28/24, 9/9/24, 10/10/24, 10/11/24, 10/13/24, and 12/18/24.</p> <p>*She had an electronic monitoring device on her wrist that would alarm to alert staff of position changes as a fall prevention.</p> <p>*There was no documentation of interventions in her care plan that addressed fall prevention since her admitted on 5/23/24.</p> <p>5. Observation and interview on 1/14/24 at 10:35 a.m. with resident 9 in her room revealed:</p> <p>*She was seated in her wheelchair listening to an audiobook.</p> <p>*She had a full body mechanical lift sling underneath her.</p> <p>*She had recently fallen.</p> <p>*She used her walker for transfer assistance before she had fractured her ankle.</p> <p>*She was transferred with the use of a full body mechanical lift and the assistance of two staff.</p> <p>Review of resident 9's EMR revealed:</p> <p>*She was admitted on [DATE].</p> <p>*She had a BIMS assessment score of 11, which indicated she was moderately cognitively impaired.</p> <p>*Her diagnoses included chronic obstructive pulmonary disease, Parkinson's disease, and hypertension.</p> <p>*She had fallen on 10/27/24, 10/28/24, 11/3/24, 12/9/24, 12/19/24, 12/20/24, and 12/22/24.</p> <p>*There was no documentation of interventions in her care plan that addressed fall prevention since her admitted on 2/14/24.</p> <p>Interview on 1/15/25 at 1:01 p.m. with registered nurse (RN) D revealed:</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*Resident 7 stated that her daughter brought her the waffle cushion for her comfort.</p> <p>*She did not remember if she had any sores or skin problems.</p> <p>Review of resident 7's electronic medical record (EMR) revealed:</p> <p>*She was admitted on [DATE].</p> <p>*Her 12/7/24 brief interview for mental status (BIMS) assessment was 12, which indicated moderate cognitive impairment.</p> <p>*Her diagnoses included dementia, repeated falls, and weakness.</p> <p>*She had a stage II pressure ulcer (a shallow open ulcer that resulted due to pressure) identified on 11/16/24.</p> <p>*The stage II pressure was documented as healed on 12/6/24.</p> <p>*She was prescribed mirtazapine with an Indication for Use: antidepressant.</p> <p>*She did not have a diagnosis of depression.</p> <p>Review of resident 7's 1/14/25 care plan revealed:</p> <p>*She had a focus area of I have the potential to have impairment to skin integrity which was initiated on 5/30/24 and updated on 6/3/24.</p> <p>*The use of the ROHO cushion or the waffle cushion was not included in the care plan.</p> <p>*A focus area of I have a potential nutritional problem r/t [related to] hx [history] of CHF [congestive heart failure]; COPD [chronic obstructive pulmonary disease] and recent hip fracture with repair initiated on 7/8/24 included an intervention of Resident with stage II wound to left hip. Dislikes supplements. Will offer extra 1 oz [ounce] of protein with meals to aid in wound healing that was initiated on 12/6/24.</p> <p>*A focus area of, I use antidepressant medication (mirtazapine) and interventions to:</p> <p>-Administer ANTIDEPRESSANT medication as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT.</p> <p>-Monitor/document/report PRN [as needed] adverse reactions to ANTIDEPRESSANT therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL [activities of daily living] ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs [problems], movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, wt [weight] loss, n/v [nausea/vomiting], dry mouth, dry eyes</p> <p>7. Observation and interview on 1/14/25 at 9:20 a.m. with resident 11 revealed:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Dells Nursing and Rehab Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 Thresher Dr Dell Rapids, SD 57022	
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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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*She was admitted to the facility after she fell and broke her hip.</p> <p>*She stated she was mixed up.</p> <p>*During the conversation resident 11 spoke with her eyes closed.</p> <p>Review of resident 11's EMR revealed:</p> <p>*She was admitted on [DATE].</p> <p>*Her 10/7/24 BIMS assessment was 10, which indicated moderate cognitive impairment.</p> <p>*Her diagnoses included: weakness, hallucinations, generalized anxiety, and dementia with psychotic disturbance.</p> <p>*She was prescribed:</p> <p>-lorazepam 0.5 mg (milligrams) every four hours as needed for anxiety or restlessness.</p> <p>-olanzapine 5 mg two times per day related to dementia with psychotic disturbance.</p> <p>Review of resident 11's care plan revealed:</p> <p>*A focus area of, I use psychotropic medications (olanzapine) with interventions to:</p> <p>-Administer PSYCHOTROPIC medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT.</p> <p>-Monitor/document/report PRN adverse reactions to PSYCHOTROPIC medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person.</p> <p>*Lorazepam or interventions to monitor for adverse effects was not referenced in resident 11's care plan.</p> <p>*Non-pharmalogical interventions relating to her hallucinations, anxiety, or psychotic disturbance, was not addressed in resident 11's care plan.</p> <p>Interview on 1/15/25 at 3:28 p.m. with MDS/DON B revealed:</p> <p>*She expected staff to follow the interventions on the residents' care plans.</p> <p>*She was responsible for updating resident care plans.</p> <p>*Care plan were to be updated when there were changes in resident care.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*She agreed that resident 7's care plan was not updated to include her facility-acquired pressure ulcer.</p> <p>Interview on 1/16/25 at 8:34 a.m. with nurse manager C revealed:</p> <p>*She expected resident care plans to be updated to include pressure-reduction devices.</p> <p>*She believed that the staff knew how to access resident care plans.</p> <p>Interview on 1/16/25 at 10:21 a.m. with registered nurse (RN) D revealed:</p> <p>*She had access to view resident care plans.</p> <p>*She was not able to edit the care plans.</p> <p>*Therapy [physical and occupational] was to be initiated for residents with pressure ulcers.</p> <p>*If therapy placed ROHO cushions in residents' chairs they were to inform MDS/DON B to update the care plans.</p> <p>*Nurse manager C worked with the pharmacist on the psychotropic medications.</p> <p>*The charge nurse did not chart the side effects and effectiveness of the psychotropic and antidepressant medications.</p> <p>Review of provider's 3/2024 Care Planning Process Policy revealed:</p> <p>*Using an intradisciplinary approach, each resident will have an individualized plan of care which addresses the resident's needs and severity of condition, impairment, disability, or disease and based on the universal care standards identified by the DNRC staff as the minimum standards for all residents.</p> <p>*It is the responsibility of the IDT members to access the resident, individualize the plan of care, evaluate the effectiveness and the plan of care, revise the plan of care as the resident's needs change and attend care conferences.</p> <p>Review of the provider's undated Fall Policy revealed:</p> <p>*A licensed nurse will update the care plan to reflect interventions instituted to prevent further falls.</p> <p>*The resident's fall will be discussed with interdisciplinary team as soon as possible after the falls to determine new interventions to try.</p>		