STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dells Nursing and Rehab Center Inc	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)
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. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, interview, job description review, and policy review, the provider failed to ensure blood pressure medications were administered as ordered by the physician for one of one closed resident records (1) by three of three certified medication aides (CMAs) (C, D, and E). These errors in medication administration had the potential to impact the resident's health and well-being. Review of October 2025 closed electronic medical review (EMR) revealed resident 1 was admitted to the facility 10/1/25 and discharged from the facility on 10/27/25 due to an unexpected death. He had primary diagnoses of type 2 diabetes (unstable sugar levels in the blood), orthostatic hypotension (sudden drop in blood pressure when you stand up, which can cause dizziness, lightheadedness, or fainting), and weakness.Upon admission, he had physician orders to take Midodrine 5 milligrams (mg) twice a day for low pressure. This medication was ordered to be held if his systolic blood pressure (SBP) was greater than 135. Also, upon admission, he had physician orders to take Fludrocortisone 0.1mg daily for low blood pressure. This medication was ordered to be held if his SBP was greater than 140.Review of resident 1's October 2025 Medication Administration Record revealed Resident 1 had refused his Fludrocortisone and Midodrine once on 10/11/15.His Midodrine should have been held six times in October 2025 when he had a SBP greater than 135, according to the ordered parameters for the medication. On 10/4/25 his BP was 165/84, on 10/5/25 his BP was 174/98, on 10/9/25 his BP was 139/81, on 10/14/25 his BP was 156/77, on 10/19/25 his BP was 206/60, and on 10/23/25 his BP was 149/74 the medication should have been held according to the ordered parameters, but it was documented as administered.The Midodrine should have been given five times when he had a low blood pressure in October 2025 according to the ordered parameters. On 10/2/25 his BP was 93/62, on 10/4/25 his BP was 66/53, on 10/7/25 his BP was 90/65, on 10/8/25 his BP was 66/63, and on 10/14/25 his BP was 71/62 and the medication was documented as not given but should have been according to the orders. His low blood pressures were not documented as rechecked until the next day for any of the times his Midodrine was held.His Fludrocortisone should have been held twice in October 2025 when he had a SBP greater than 140 according to the ordered parameters. On 10/4/25 his BP was 165/84, and on 10/14/25 his BP was 156/77 and the medication should have been held but was documented as administered. Interview and record review on 10/30/25 at 2:57 p.m. and 4:22 p.m. with director of nursing (DON) A revealed the check mark under the dates, in the row of medications for Midodrine and Fludrocortisone, on resident 1's October 2025 medication administration record (MAR), indicated that the medication was administered to the resident, and the initials indicated which staff administered the medication on those dates. She identified the three staff who administered resident the residents medication when it should have been held were CMAs C, D, and E. She stated, if a resident had blood pressure medication hold parameters ordered, she expected that the blood pressure (BP) would be checked prior to medication administration. If the resident's BP was out of the parameters, she would expect the medication not to be administered by the staff. If the resident's BP was not within parameters, per the policy, she would have expected the resident's physician to be notified each time. DON A confirmed the medication errors and the blood pressure policy had not been followed.Interview and record review on 10/30/25 at 4:25 p.m. with CMA C revealed that, when administering residents' medications that had BP hold parameters, she would check the resident's blood pressure, and if it was out of parameters, she would not administer the medication. If she were to have administered the medication and later noticed that the medication should not have been given, she would have reported it to the nurse. She was not aware she had administered medication twice in October 2025 to resident 1 when it should have been held.When checking the resident's vital signs, and they were not normal for the resident, she would notify the nurse. She was not aware of the facility's Blood Pressure Parameter Policy, and when she should notify the nurse related to blood pressure concerns. Interview on 10/30/25 at 4:33 p.m. with RN B revealed, if she had noticed that a resident's medication was given that should have been held, she would have checked the resident's vital signs and followed the facility's medication error policy and notified the residents physician, the DON, and the resident's family.If a resident's BP was out of parameters, she would recheck the resident's BP after a few minutes, and if it was still out of parameters, she would notify the resident's physician. To know if the vital signs were out of parameters, she would look at the reference sheet that had the parameters listed on it, which was located at the nurses' station. Review of the provider's 8/6/13 medication aide job description revealed the CMA was responsible for observing symptoms and responses to medications and for reporting such to the charge nurse. They were to take and