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	06/26/2025

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the provider failed to ensure the proper Medicare notices were filled out completely and were in the required format for three of three sampled residents (9, 37, and 294) prior to their discharge from Medicare Part A skilled services. Findings include: 1. Review of the Entrance Conference Worksheet completed by the provider on 6/25/25 revealed the list of residents identified as having been discharged from Medicare Part A skilled services included the following: *Two residents (9 and 37) remained in the facility following their discharge from Medicare Part A skilled services. *One resident (294) was discharged to home following his discharge from Medicare Part A skilled services. 2. Review of resident 9's SNF (Skilled Nursing Facility) Beneficiary Notification Review form completed by social services designee (SSD) E revealed: *The resident's Medicare Part A Skilled Services Episode start date was 12/16/24. *Her last covered day on Medicare Part A Service was 1/24/25. Review of resident 9's electronic medical record (EMR) revealed: *She was re-admitted to the facility on [DATE] after a three-day hospital stay with Medicare Part A covering her stay. *On 1/25/25, after her Medicare Part A stay ended, she remained in the facility as indicated on the Entrance Conference Worksheet. *Her 3/9/25 Brief Interview for Mental Status (BIMS) evaluation was scored at seven which indicated she had severe cognitive impairment (a decline in mental abilities including thinking, learning, remembering, and making decisions). (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of resident 294's SNF Beneficiary Notification Review form completed by SSD E revealed: *The resident's Medicare Part A Skilled Services Episode start date was 3/4/25. *His last covered day on Medicare Part A Service was 4/4/25. Review of resident 294's EMR revealed: *He was admitted on [DATE] with Medicare Part A covering his stay. *His 3/6/25 BIMS evaluation was scored at twelve which indicated he was moderately cognitively impaired. *On 4/5/25, after his Medicare Part A stay ended, he was discharged to his home as indicated on the Entrance Conference Worksheet. 4. Review of resident 37's SNF Beneficiary Notification Review form completed by SSD E revealed: *The resident's Medicare Part A Skilled Services Episode start date was 3/26/25. *Her last covered day on Medicare Part A Service was 4/10/25. Review of resident 37's EMR revealed: *She was re-admitted to the facility on [DATE] after a four-day hospital stay with Medicare Part A covering her stay. *On 4/11/25, after her Medicare Part A stay ended, she remained in the facility as indicated on the Entrance Conference Worksheet. *Her 4/11/25 BIMS evaluation was scored at five which indicated she had severe cognitive impairment. 5. Review of the Notice of Medicare Non-Coverage (NOMNC) form CMS-10123, with a revision date of 12/31/11, for residents 9, 37, and 294, completed by SSD E revealed: *The 12/31/11 NOMNC form was outdated and was not the updated form that was required to be used as of 1/1/25, with an expiration date of 11/30/27. *The first bullet point that explained Your Medicare provider . have determined that Medicare probably will not pay for your current {insert type} services . was not completed with the type of services ending. -The type of services ending should have been identified as skilled nursing. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The How to Ask For an Immediate Appeal section was to provide contact information in the fourth bullet point that indicated to Call your QIO [Quality Improvement Organization] at: {insert QIO name and toll-free number of QIO} to appeal, . was not completed with the name and telephone numbers, including TTY (teletypewriter for people with hearing or speech difficulties) of South Dakota's (SD) QIO. *The Additional Information (Optional) section indicated SSD E had spoken by phone with the residents' representatives regarding therapy services ending on the actual date Medicare Part A services would end, the reason why Medicare Part A services were ending, and SSD E's signature. *The form indicated on the Signature of Patient or Representative signature line that the residents' representatives had been contacted verbally by a phone call and the date line indicated the date that phone conversation had taken place. -The information provided had not included all of the information required in the 10/31/24 Medicare Claims Processing Manual's Section 260.3.8 - NOMNC Delivery to Representatives Exceptions to in person notice delivery. Review of the 2018 Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) Form CMS-10055 for resident 9 and 37, completed by SSD E revealed: *The 2018 SNF ABN form was outdated and not the updated 2024 form that was required to be used as of 10/31/24. *The forms indicated the notices had been provided verbally during a phone call to the residents' representatives. 6. Interview on 6/26/25 at 5:08 p.m. with SSD E regarding the above NOMNC forms and SNF ABN forms she had completed revealed she: *Was not aware the forms she had used were outdated and that new, updated forms were required to be used. *Agreed that the type of services ending on the NOMNC forms was not clearly identified. *Agreed that the QIO's name and toll-free phone number had not been provided on the NOMNC forms as required. *Was not aware of the information that was required to be documented on the NOMNC form when a resident's representative was contacted by telephone. *Confirmed she had not filled out the forms completely, according to their instructions. 7. Review of the cms.gov website revealed: *On 8/28/2024: With the help of our contractors, we revised the SNF ABN, Form CMS-10055, and the form instructions. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The SNF ABN form and instructions are located in the download section and are available for immediate use, but will be mandatory for use on 10/31/2024. *On 11/18/2024: New NOMNC and DENC for Original Medicare and Medicare Advantage: -The Office of Management and Budget (OMB) has approved a revised Notice of Medicare Non-Coverage (NOMNC / CMS-10123) . -Please note the updated NOMNC .are to be used for both Original Medicare and Medicare advantage . -Providers must use the revised NOMNC beginning January 1, 2025 . Review of the Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123 revealed: *{Insert type}: Insert the kind of service being terminated, i.e., skilled nursing, home health, comprehensive outpatient rehabilitation service, or hospice. *In the section How to Ask For an Immediate Appeal Insert the name and telephone numbers (including TTY) of the applicable QIO in no less than 12-point type. Review of the 10/31/24 Medicare Claims Processing Manual's Section 260.3.8 - NOMNC Delivery to Representatives Exceptions to in person notice delivery revealed: *The provider must complete the NOMNC as required and telephone the representative at least two days prior to the end of covered services. *The NOMNC must be annotated with the following information on the day that the provider makes telephone contact: -The beneficiary's last day of covered services, and the date when the beneficiary's liability is expected to begin. -The beneficiary's right to appeal a coverage termination decision. -A description of how to request an appeal by a QIO. -The deadline to request a review as well as what to do if the deadline is missed. -The telephone number of the QIO to request the appeal. *Reflect that all of the information indicated above was communicated to the representative. *Note the name of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A. Based on observation, interview, record review, and policy review, the provider failed to ensure: *One of two certified nursing assistants (CNA) (K) wore appropriate personal protective equipment (PPE) while caring for two sampled residents (22 and 32) who were on enhanced barrier precautions (EBP), which is a type of infection control strategy used in nursing homes to reduce the spread of multidrug-resistant organisms. *One of one CNA (N) practiced appropriate infection control techniques during catheter cares for one of one observed resident (22). *Four of four CNAs (L, M, N, and O) were knowledgeable of the provider's revised catheter care policy and had the skills to implement that policy. *Medical supplies, such as plastic syringes and containers of normal saline found in one of one resident rooms (22) and two of three supply rooms (Rising Sun whirlpool room and the medical supply room), were labeled, stored, and disposed of in an appropriate manner. Findings include: 1. Observation on 6/24/25 at 8:28 a.m. in room [ROOM NUMBER] revealed: *There was a magnet that read EBP at the top of the doorway. *There was PPE hanging on the back of the door. *A poster from the Centers for Disease Control and Prevention (CDC) explaining what EBP was and what direct care staff were required to perform was posted next to the PPE. The poster read: -ENHANCED BARRIER PRECAUTIONS -EVERYONE MUST: --Clean their hands, including before entering and when leaving the room. -PROVIDERS AND STAFF MUST ALSO: --Wear gloves and a gown for the following High-Contact Resident Care Activities. --Dressing --Bathing/Showering --Transferring --Changing Linens (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Providing Hygiene --Changing briefs or assisting with toileting --Device care or use: central line, urinary catheter, feeding tube, tracheostomy --Wound Care: any skin opening requiring a dressing. 2. Observation on 6/24/25 at 8:31 a.m. in residents 15 and 22's room revealed: *There was a magnet that read EBP at the top of the doorway. *There was PPE hanging on the back of the door. *There was no EBP poster with instructions for staff as described above. *To the left of the handwashing sink, there was a black plastic trash bag tied to the towel rod. -Approximately three feet of clear plastic tubing was hanging out the trash bag. -There was moisture on the inside of the tubing. -There was a urinary catheter collection bag inside of the trash bag. *To the right of the handwashing sink, there were two black metal storage shelves with personal care products that included: -Two opened containers of normal saline were on each shelf. Neither container was labeled with the date opened or with the resident's initials to identify which resident it belonged to. -One opened plastic package that contained a plastic syringe was on the bottom shelf. Observation on 6/25/25 at 10:23 a.m. in residents 15 and 22's room revealed: *The black plastic trash bag was still tied to the towel rack to the left of the sink. *The catheter tubing was no longer hanging out of the trash bag. *There was moisture buildup on the inside of the catheter collection bag and tubing. Interview on 6/25/25 at 2:50 p.m. with registered nurse (RN) I about resident catheter bags revealed: *He indicated he was a travel nurse and had been working at that facility for four weeks. *Surveyors went with RN I to residents 15 and 22's room to discuss the catheter bag stored there. -It was his understanding that the catheter collection bags should not have been reused. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He indicated that the black plastic trash bag that was tied to the towel rack to the left of the resident's sink contained a urinary catheter collection bag, and it still had traces of urine. -He confirmed that the catheter collection bag was not labeled or dated, and the end of the tube was not capped to protect it from potential contamination. -He confirmed that was not the proper way to store the catheter collection bag. Interview on 6/25/25 at 3:24 p.m. with CNA M about the catheter in residents 15 and 22's room revealed: *CNA M recently passed her CNA certification exam and had been working as a CNA for a couple of weeks. *She confirmed that resident 22 had a suprapubic (SP) catheter and wore a urinary catheter collection bag on her leg (leg bag). *She indicated that she was instructed to keep the leg bag on her leg during the night, rather than switching to a larger bed bag at night. *She confirmed that she also noticed resident 22's urinary catheter collection bag that was in a plastic trash bag and was tied to the towel rack in the resident's room. -She did not know how long that had been stored there like that. Interview on 6/25/25 at 3:35 p.m. with CNA N about catheter care procedures revealed: *Resident 22's leg bag was secured to her right leg during the day. *A bed bag was used to collect urine at night for the resident. *Their normal practice was to rinse and reuse urinary catheter collection bags. -The urinary catheter collection bags were stored in the black plastic garbage bag that was tied to the towel rack in the resident's room. *She explained that a blue solution was used to sanitize the catheter tubing and collection bag. -She did not know what the blue solution was called. -The cleaning solution was supposed to have been stored in the black metal storage shelves located opposite of the towel rack in the resident's room. -She confirmed there was no cleaning solution in resident 22's room. *The blue solution was squeezed through the catheter tubing and into the collection bag. The bag would be filled with about one inch of cleaning solution. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She explained that they allowed the cleaning solution to sit in the collection bag during the day while it was stored in the plastic garbage bag. -The bag was emptied and rinsed with water before switching from one collection bag type to the other. Interview on 6/25/25 at 4:35 p.m. with CNA L about catheter care procedures revealed: *She confirmed that when she helped resident 22 get ready for bed, she would disconnect the resident's leg bag and connect the resident's bed bag for the night. *They stored the bed bag in the black plastic garbage bag that was tied to the towel rack during the day when she was using the leg bag. *The catheter bags they were reusing were cleaned with a liquid in the hopper room (a room where soiled laundry was processed). -She could not find the liquid in the hopper room or in resident 22's room. -She did not know what the liquid was called. -The liquid was bluish-purple in color. Interview on 6/25/25 at 4:48 p.m. with CNA O about catheter care procedures revealed: *She confirmed that residents' urinary catheter leg bags and bed bags were reused. *She would rinse the bags and tubing with water when she changed from one bag to another. -She indicated that she would request other CNAs to clean the catheter tubing and bags because she did not know the procedure for cleaning them. -She had only been a CNA for a few months at the time of the survey. *She did not know what solution was used to clean the catheter tubing and bags. Observation and interview on 6/26/25 at 9:06 a.m. with CNA N while she assisted resident 22 get out of bed revealed: *CNA N confirmed that she and another CNA had assisted the resident to transfer from her bed to her wheelchair. *Resident 22's bed bag was sitting directly on the floor. *CNA N put on a gown, gloves, and a face mask. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*CNA N removed a new leg bag from its sterile packaging, uncapped the end of the tubing, and wiped it with an alcohol wipe. -She accidentally touched the resident's leg, the SP catheter tubing, and the bed bag tubing with the end of the new catheter tubing as she struggled to disconnect the bed bag tubing from the SP catheter tubing, potentially contaminating the end of the new catheter tubing. *Once she successfully disconnected the bed bag and connected the leg bag, she brought the bed bag to the bathroom and poured the urine contents into a graduated cylinder (a type of measuring cup) on the floor. She left the graduated cylinder containing urine on the floor in the bathroom, indicating that she would come back after resident 22's shower to clean the cylinder. *She brought the empty bed bag to the sink and said, Where's your garbage bag? -She then grabbed a new black plastic garbage bag and placed the soiled bed bag and tubing inside and tied the garbage bag to the towel rack. *She indicated that she would clean the bed bag after she helped resident 22 take a shower. *She removed her PPE and did not perform hand hygiene before helping resident 22 put her glasses on and brushed her hair out of her face. *She did not perform hand hygiene upon exiting the resident's room. Continued observation and interview on 6/26/25 at 9:46 a.m. with CNA N revealed: *She wanted to correct her comments from the previous day about the catheter cleaning solution. -She learned that the process recently changed to using three parts vinegar to one part water as a cleaning solution. *She went to the medical storage room, grabbed a covered specimen cup and a new plastic syringe, and filled the cup about three-fourths of the way with vinegar. *She brought those supplies to resident 22's room. *Upon entering the room, it was discovered that the graduated cylinder containing urine was no longer there. She stated that someone else must have emptied the cylinder. *She filled the specimen cup of vinegar with water until it was full. *After squeezing the vinegar-water solution through the catheter tubing and into the collection bag, she explained that the new policy was to swish the solution around in the bag and empty it. They were no longer supposed to leave the cleaning solution in the bag throughout the day or overnight. *After pouring the contents of the catheter bag into the toilet, she wiped the end of the catheter tubing with an alcohol wipe and placed it back into the same potentially soiled garbage bag that it had been stored in before she cleaned it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She stated she sometimes changed the resident's catheter bag to a new one on the resident's bath days, and it was changed at least monthly. Interview on 6/26/25 at 10:39 a.m. with Minimum Data Set (MDS) coordinator/infection preventionist C and director of nursing (DON) B revealed: *It was their expectation that residents' catheter bags should not have been directly on the floor to protect them from potential damage and contamination. *If the insertion tube on a catheter was potentially contaminated by touching other objects, it was their expectation that it should have been sanitized with an alcohol wipe before inserting it into the resident's SP catheter tube. *It was their expectation that staff should have cleaned the SP catheter tube after disconnecting the old collection tube. *They had not used the blue cleaning solution for cleaning catheter bags in a long time. -DON B indicated that she had been working at the facility for one and a half years and they had always used the vinegar solution to clean the catheter bags. *The management team had recently been updating policies and they implemented a new catheter care policy the previous week. -They placed the new policies in the policy binder at the nurse's station on Monday 6/23/25. -They informed staff to review the new policies both verbally and via a sign by the staff's clock-in station. -Once staff reviewed the new policies, they should have signed a piece of paper in the policy binder indicating that they reviewed the policies. *They recently started completing nursing staff competencies in April 2025 by recommendation of their nurse consultant. -Their first nursing staff competency was focused on peri cares (the hygiene and cleaning of the perineal area, which includes the genitals and anal area) due to the high rate of urinary tract infections amongst residents. *They expected staff to drape the catheter bag and tubing over the towel rack to drain and dry and place a bin beneath to catch any liquids draining from the bag. -They indicated that placing the catheter bag into the black plastic garbage bags for storage when not in use was acceptable for dignity purposes, if that still allowed for adequate draining and drying of the catheter bag. *They expected staff to perform hand hygiene before putting on PPE, and after taking off PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Staff should have been dating and labeling the resident's products like the containers of normal saline, and staff should not be reusing plastic syringes. -DON B confirmed that staff used the containers of normal saline to flush the resident's SP catheter. -DON B discarded the opened and unlabeled containers of normal saline and the open syringe package from resident 22's room at that time. *When they were informed that CNA N had made a three-parts vinegar to one-part water solution rather than the three-parts water to one-part vinegar solution as their new policy stated, they did not have any comments. Interview on 6/26/25 at 4:33 p.m. with MDS coordinator/infection preventionist C revealed: *When asked how they ensured staff were aware of and educated on new policies and procedures, she repeated that they placed the policies in the policy binder, staff were to review it and sign it, and if they had questions, they were to find one of the nurse managers. *They review policies at all-staff meetings. Review of resident 22's electronic medical record revealed: *There were no physician's orders describing when the resident's urinary catheter collection bag should have been changed, such as changing the leg bag to a bed bag at night. *She had the following physician's orders: -Flush catheter every night at bedtime and as needed with 60mL [milliliters] saline or sterile water. as needed for catheter [maintenance]. Ordered and started on 3/27/25. -Flush catheter every night at bedtime and as needed with 60mL saline or sterile water. at bedtime for catheter maintenance. Ordered on 3/27/25. Started on 3/28/25. *Her suprapubic catheter was last changed on 6/10/25. *Her care plan did not include directions for when the urinary catheter collection bags should have been changed, such as changing the bed bag to a leg bag during the day. *Her care plan included the following interventions: -EBP are used for high contact cares such as transfers, catheter cares, showers. Initiated on 6/10/25. -Perform catheter cares per facility policy. Initiated on 6/10/25. -Please use enhanced barrier precautions when caring for me. Initiated on 6/1/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-PPE for enhanced barrier precautions is only necessary for performing high-contact care activities such as transfers, peri cares, dressing, and bathing. Initiated on 6/1/25. Review of the provider's 6/19/25 Changing the Urinary Collection System revealed: *Policy: The urinary collection system shall be changed at the time of a new catheter insertion per provider order or as needed based on clinical assessment (e.g., visible damage, leakage, or malfunction). Aseptic technique must be maintained throughout the procedure to preserve the integrity of the closed urinary drainage system and minimize infection risk. *Required Supplies -Clean non-sterile gloves -Alcohol swabs -Barrier (e.g., disposable pad or paper towel) -Graduated cylinder (for measuring urine) -New sterile urinary drainage bag/system *Procedure -1. Preparation -- .b. Perform hand hygiene. --c. Gather all required supplies and place a barrier on the working surface. -2. Apply Gloves and Empty Current System --a. [NAME] [Put on] clean gloves. --b. Place the graduated cylinder below the drainage spout and empty the contents of the current urinary drainage bag. --c. Record the amount and appearance of the urine per facility protocol. -3. Setup of New System --a. Open packaging of the new sterile urinary drainage bag/system, maintaining sterility of the connection port. -4. Disconnection and Cleaning --a. Clamp the catheter (if applicable per manufacturer guidance) to prevent leakage. (continued on next page)

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	435129	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dells Nursing and Rehab Center Inc	1400 Thresher Dr Dell Rapids, SD 57022

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-4. Graduated cylinder -5. Clean Gloves -6. Paper Towels -for barrier -7. Clean plastic bag- if transport is necessary *Procedure: -1. Preparation -- .Prepare a cleaning solution using three parts water to one part vinegar in a clean specimen cup. - .5. Attach New Bag --Attach a clean urinary drainage bag to the catheter tubing. Label bag with resident initials and room number. -6. Clean Used Bag --Take the used bag to the designated sink. --With the draining port open, flush the bag and tubing thoroughly with the vinegar solution. --Allow excess liquid to drain fully. -7. Hand Hygiene --Remove gloves and perform hand hygiene. *Storage Instructions for Cleaned Urinary Bags -Hang the clean urinary bag on the towel rack near the sink. -Place a basin (labeled with resident initials/room number & urinary drainage basin) below the urinary bag lined with clean paper towels beneath to absorb residual moisture. -Replace paper towels after each cleaning. Review of the provider's Education Signature Sheet that was located at the front of the policy binder at the nurse's station revealed: *Education: Updated Policies/Procedures 6/23/25 *Only two people had signed that they had reviewed the updated policies by the end of the survey on 6/26/25. (continued on next page)

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