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	12/11/2025

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation, interview, record review, and policy review the provider failed to ensure resident choices regarding bedtime requests were being followed for one of one sampled resident (14).Findings include:1. Observation and interview on 12/9/25 at 9:20 a.m. with resident 14 in his room revealed:*He was sitting in his recliner watching television.*He stated there were days when he was tired and wanted to go to bed at 6:00 p.m.*Staff told him he had to wait until 7:00 p.m. before he could go to bed because some residents were still eating supper.2. Interview on12/10/25 at 4:06 p.m. with certified nursing assistant (CNA) E revealed:*If a resident requested to go to bed at 6:00 p.m. she would not have accommodated that request.*She felt that was too early for a resident to go to bed.*She knew resident would request to go to bed early some evenings.*Staff were still helping some residents in the dining room at that time.3. Interview on 12/11/25 at 9:12 a.m. with CNA G revealed:*If a resident wanted to go to bed early, she would talk to the charge nurse.*The charge nurse would normally have the resident try to stay awake until at least 7:00 p.m. 4. Interview on 12/11/25 at 1:03 p.m. with registered nurse (RN) F revealed:*Some residents requested to go to bed early at times.*Staff needed to ensure all the residents were out of the dining room after supper before they started getting residents ready for bed so call lights could get answered.*Some residents finished supper early and then requested to lay down for bed.*She stated those residents would only have to wait 15 or 20 minutes for staff to help them with that.*She agreed it was the residents right to decide when they went to bed at night.5. Interview on12/11.25 at 1:21 p.m. with social services designee (SSD) H revealed:*She knew some residents liked to go to bed early in the evening.*Staff may try to encourage a resident to stay up longer so they were not in bed that long at night.*She confirmed there were not certain hours residents could be awake or asleep. *She agreed it was the resident's right to request to go to bed early.6. Interview on 12/11/25 at 2:10 p.m. with director of nursing (DON) B revealed:*Residents were encouraged to stay up until 7:00 p.m.*Nursing staff were assisting residents in the dining room until 6:30 p.m. or 7:00 p.m.*She agreed it was the residents' right to request to go to bed when they wanted to.*She knew resident 14 requested to go to be early at times.*She was not sure if nursing staff would always accommodate his requests.7. Review of resident 14's electronic medical record (EMR) revealed:*He had a Brief Interview for Mental Status (BIMS) assessment score of 9 which indicated his cognition was moderately impaired.*His 5/8/25 care plan stated he liked to wake up around 7:00 a.m. and go to bed around 8:00 p.m. or whenever he was sleepy.8. Review of the provider's undated Resident's Rights document revealed:*When you leave your home to live in a nursing facility, you take your rights with you.*All residents in nursing facilities have the same rights, although there will be times when there is give and take.*You have the right as a resident of a nursing facility to use all these rights given to you by law, and also to use all the rights you have as a citizen of your State and a citizen of the United States.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and policy review, the provider failed to ensure the staff members followed standard infection prevention practices for:*Storing clean resident use equipment, specifically lift slings, without the slings touching the floor.*Replacing oxygen tubing for one of four sampled residents (35) every 30 days according to the provider's policy.*Personal protective equipment, such as gloves and gowns (PPE), use by one of one observed certified nursing assistant (CNA) D when providing care for one of one sampled resident (15) on enhanced barrier precautions (EBP).Findings include: 1. Observation on 12/9/25 at 10:04 a.m. of the clean linen room revealed more than five lift (a mechanical device used to lift a person's body) slings were touching the floor.2. Interview on 12/11/25 at 1:00 p.m. with infection preventionist (IP)/registered nurse (RN) C revealed that she was not aware that the lift slings were touching the floor. She acknowledged that the floor was not considered a clean surface and that created a potential infection control risk. She then removed the slings that were touching the floor to have them laundered.3. Observation on 12/9/25 at 2:32 p.m. of resident 35's oxygen concentrator revealed that the humidification container and oxygen tubing were dated 11/3/25.4. Interview on 12/11/25 at 1:00 p.m. with infection preventionist (IP)/registered nurse (RN) C revealed that oxygen tubing was expected to be replaced every four weeks by the night shift nurse.5. Review of resident 35's TAR revealed that the task of replacing her oxygen tubing was documented as completed on 11/24/25 by RN I.6. Interview on 12/11/25 at 1:15 p.m. with director of nursing (DON) B revealed that when the oxygen tubing was replaced, the night shift nurse would document that task as completed in the treatment administration record (TAR). She reported that the facility was currently performing audits to ensure oxygen tubing had been replaced on schedule. She expected that if the task was not completed, it would not be documented as completed in the TAR.7. Observation on 12/10/25 at 11:43 a.m. of certified nursing assistant (CNA) D and resident 15 in the shower room revealed CNA D wheeled resident 14 into the shower room and closed the door. CNA D then provided a shower to resident 15 and did not wear a gown or gloves.8. Interview on 12/10/25 at 12:49 with CNA D revealed that she was aware that resident 15 was on enhanced barrier precautions [also called EBP. EBP included the use of PPE to decrease the spread of multi-drug organisms (MDRO)]. She acknowledged that she was not wearing PPE when she assisted resident 15 to undress and when she started the resident's shower. She stated that she did put on a gown and gloves when she realized she forgot to put them on until she had seen the surveyor observe her without them on.9. Interview on 12/11/25 at 1:00 p.m. with IP/RN C revealed that the staff were expected to wear appropriate PPE when providing cares for resident's on EBP.10. Review of the provider's 4/2025 Cleaning of Durable Medical and Therapy Equipment revealed:*8. Oxygen Treatments: 3) Every month, replace cannula [a flexible tube with two prongs that fit into the nostrils to deliver supplemental oxygen or humidified air] or mask, and tubing.11. Review of the provider's 4/1/24 Enhanced Barrier Precautions policy revealed that Enhanced barrier precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced barrier precautions involve gown and glove use during high contact resident care activities for residents know to be colonized or infected with MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). High-contact resident activities include: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube. Wound care: and skin opening requiring a dressing.