

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2026
NAME OF PROVIDER OR SUPPLIER Custer Care and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1065 Montgomery St Custer, SD 57730	
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the provider failed to ensure that a resident's advance directive (a legal document that expresses a person's health care wishes if they become unable to speak for themselves) and code status (specifies the type of emergent treatment a person wishes to receive if their heart or breathing would stop) were accurately documented to reflect the resident's chosen wishes for one of one sampled resident (16) with documented code status discrepancies. Findings include: 1. Interview on [DATE] at 10:42 a.m. with resident 16 in her room revealed she resided at the facility since [DATE]. She was rehabbing after a hospitalization and hoped to regain strength and return to living at home with her husband. 2. Review of resident 16's electronic medical record (EMR) revealed that she admitted to the facility on [DATE]. Her [DATE] Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. There was a banner displayed in her EMR, which indicated she did not want CPR (cardiopulmonary resuscitation, an emergency procedure to provide chest compressions and often rescue breathing to preserve brain function and maintain blood circulation). Her [DATE] baseline care plan (a short-term, personalized plan to address care needs, developed within 48 hours of a resident's admission) indicated her code status was DNR (do not resuscitate). She had a [DATE] physician's order for DNR. There was no advance directive form in her EMR. A copy of her advance directive was requested. 3. Review of resident 16's signed [DATE] advance directive revealed that she wanted CPR and full resuscitative measures. 4. Interview on [DATE] at 3:19 p.m. with administrator A and director of nursing (DON) B revealed that the facility did not use paper charts for the residents. Their process for advance directives was that the scheduled nurse was responsible for having the advance directive form signed by the resident or the resident's representative. That form was then to be placed in a folder for the resident's physician to sign. After the physician signed the form, the nursing staff were to enter the order into the resident's EMR. The business office manager was then responsible for scanning the advance directive into the resident's EMR. 5. Interview on [DATE] at 9:17 a.m. with registered medication aide (RMA) H revealed that she confirmed no paper charts were used and that all resident care information and orders were documented in the resident's EMR. 6. Interview and EMR and documentation review on [DATE] with DON B revealed that she acknowledged resident 16's code status in her EMR did not match her wishes on her signed advance directive form. She acknowledged that without the advance directive form being scanned into the EMR, the staff would not be able to verify that the code status matched the resident's advance directive, and stated, I think we have an opportunity to tighten up that process. She acknowledged that the facility's policy that addressed advance directives was not specific about the process for obtaining and documenting residents' advance directives. 7. Review of the provider's [DATE] (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Admission, Transfer, and Discharge Policy and Procedure revealed, At the time of admission, the facility will have the physician's orders for the resident's immediate care, consistent with the resident's present physical and mental status. Minimal content of these orders will include a list of diagnosis, medication, advanced directives, diet order, therapy order, and routine care to maintain or improve functional capabilities; until the comprehensive assessment is conducted and the interdisciplinary care plan is developed.		

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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 standard infection control practices were followed for the cleaning of one of one water and ice dispenser located in a passthrough room between the 200 and 400 hallway. Findings included: 1. Observation on 8/5/26 at 2:30 p.m. revealed the water and ice dispenser had visible residue and buildup. The wire rack had white buildup on top, around the sides, and underneath. A brown-colored substance was observed underneath the wire rack, floating in the water. One of the pipes leading from the water into the interior of the dispenser had approximately one inch of white-tan crusted film wrapped around it. Inside the ice dispenser, there was one half of an inch of white film up the inside of the dispenser with streaks running the full length of the interior surface. Additionally, inside the water and ice dispenser, a piece of white-tan crusted film approximately two inches in length was observed lying on a metal component. 2. Interview on 8/5/26 at 2:40 p.m. with certified nursing assistant (CNA) F revealed she was employed at the facility since 4/29/25 and had never observed the water and ice dispenser being cleaned. She stated the staff use the dispenser to provide water and ice for the residents. 3. Interview on 8/5/26 at 2:52 p.m. with maintenance manager C regarding the water and ice dispenser revealed he was unaware that cleaning the water and ice dispenser was his responsibilities and he had never cleaned it. 4. Interview on 8/5/26 at 3:05 p.m. with director of nursing (DON) B revealed she was unsure who was responsible for cleaning the water and ice dispenser. She had observed the direct care using the dispenser to provide ice and water to the residents. She was aware of the above observed condition of the water and ice dispenser. 5. Interview on 8/5/26 at 4:33 p.m. with registered medication aide (RMA) E revealed she had informed maintenance manager C multiple times about how dirty the water and ice dispenser was. 6. Interview on 8/6/26 at 11:00 a.m. with administrator A regarding the water and ice dispenser revealed maintenance manger C was responsible for cleaning the water and ice dispenser. She provided him with a daily task list that remained unchanged, with different tasks from what needed to be done, and it does not get changed unless she updated it, and if the water and ice dispenser was not included on that list, he would not have known it needed to be cleaned. She agreed the dispenser should have been cleaned. 7. Review of the provider's December 2023 Infection Control Plan policy revealed it did not include education or procedures regarding cleaning the water or ice dispenser as part of infection control practices.		