

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Scotchman Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 503 West Pine Philip, SD 57567	
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 0600 Level of Harm - Actual harm Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>46453</p> <p>Based on interview, observation, and document review, the provider failed to protect one of one sampled resident's (4) right to be free from neglect by one of one certified nursing assistant (CNA) N who had not followed the resident's care plan related to transferring (moving from one place to another) which resulted in an open wound on her leg. This citation is considered past non-compliance based on review of the corrective actions the provider implemented immediately following the incident.</p> <p>Findings include:</p> <p>1. Interview on 12/17/24 at 3:42 p.m. with resident 4 revealed:</p> <ul style="list-style-type: none"> *She was talking about her recent dermatology appointment. *When asked if she had any sores or wounds, she pulled up her left pant leg. *She said she got that wound on her leg over a year ago. *She explained that CNA N helped her into bed and her left leg got caught on something. -She got a skin tear from that accident. -CNA N transferred her using the pivot technique rather than with the full-body mechanical lift. -She said that [CNA N] was in a hurry. *She did not blame the CNA for the accident and was very complimentary of the care he provided. <p>2. Review of resident 4's electronic medical record revealed:</p> <ul style="list-style-type: none"> *Her care plan included a total of seven interventions that mentioned the use of a Hoyer lift (a band of full-body mechanical lift) and/or a total lift. -Staff are to use [Hoyer] lift with all transfers. Initiated on 12/17/21. Revised on 6/12/23. <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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Scotchman Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 503 West Pine Philip, SD 57567	
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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-DRESSING: .Resident needs assist with staff member and Hoyer lift for dressing abilities. Initiated on 10/23/17. Revised on 4/1/23.</p> <p>-TRANSFER: The resident is fully dependent on staff with [Hoyer] lift for all transfers with two staff at all times. Initiated on 10/23/17. Revised on 11/6/22.</p> <p>-TOILET USE: The resident utilizes a total lift with 2 staff for toileting needs. Initiated on 10/23/17. Revised on 11/6/22.</p> <p>-Resident utilizes Tena products [a brand of incontinence products] to promote ability to toilet with Hoyer lift. Initiated on 6/12/18. Revised on 11/6/22.</p> <p>-Resident uses [Hoyer] lift for transfers, however at times she refuses due to the amount of time it takes to hook up resident and transfer. Initiated on 6/26/19. Revised on 2/27/24.</p> <p>-Tena product utilized for [incontinence] and availability to change product while utilizing a [Hoyer] lift. Initiated on 10/23/17. Revised on 11/6/22.</p> <p>*Her 9/19/24 quarterly Minimum Data Set assessment indicated she had a Brief Interview for Mental Status score of 15, indicating she was cognitively intact.</p> <p>*There was a physician's order that read, Wound care to LEFT lower leg: clean w/ wound cleanser. Apply Bacitracin ointment [an antibiotic ointment]. Cover with collagen pad. Secure with bordered gauze. Change QOD [every other day]. [One] time a day on even days change after showering.</p> <p>*Progress note from 2/23/24 at 7:57 a.m.</p> <p>-Staff was transferring resident from her bed into her wheelchair using a pivot transfer, while transferring resident's left leg was cut open. A [four to five-inch] laceration noted to left lower extremity, gauze and paper tape applied to control bleeding. Assessed by wound care nurse, steri strips and mepilex applied.</p> <p>*She had a diagnosis of bullous pemphigoid, an autoimmune skin condition causing large, fluid-filled blisters.</p> <p>*At the time of the survey, the wound was still healing due to blisters forming in the wound area and continually opening per RN skin assessments.</p> <p>3. Interview on 12/18/24 at 2:33 p.m. with registered nurse (RN) F about resident 4's skin revealed:</p> <p>*She remembered the accident where resident 4's skin on her left leg was torn due to an inappropriate transfer by a CNA. It happened on 2/23/24.</p> <p>*The resident's skin was very fragile due to a rare skin condition.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Scotchman Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 503 West Pine Philip, SD 57567	

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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Her skin was a constant cycle of open and closed.</p> <p>-Resident 4 also had a habit of picking at her skin.</p> <p>*She confirmed that resident 4 was supposed to have been transferred using the full-body mechanical lift rather than with a pivot transfer according to her care plan.</p> <p>4. Interview on 12/18/24 at 2:59 p.m. with CNA N about the accident with resident 4 revealed:</p> <p>*At the time of the accident, resident 4 was not able to use the toilet in her room.</p> <p>*He was planning on taking resident 4 to the shower room to use the toilet.</p> <p>*He cut corners and transferred her using the pivot technique.</p> <p>-He later admitted the transfer technique he used was not the pivot technique as resident 4 was not able to put her feet on the ground.</p> <p>-Instead, he explained that he assisted her to the edge of her bed, he wrapped his arms around her, lifted her up and transferred her to the wheelchair.</p> <p>*Resident 4's left lower leg got caught on either the bedframe or her wheelchair and caused a skin tear.</p> <p>*There was significant bleeding when that occurred.</p> <p>*Staff brought the resident to the neighboring clinic for treatment of the skin tear.</p> <p>*A large investigation was conducted after the accident.</p> <p>*He received verbal and written reprimands and education about following residents' care plans and how to properly transfer residents.</p> <p>*He knew what he did was wrong and that he should have transferred her according to her care plan.</p> <p>*All staff were reeducated on the importance of following residents' care plans at the February 2024 all-staff meeting.</p> <p>5. Interview on 12/18/24 at 4:50 p.m. with director of nursing (DON) B revealed:</p> <p>*She confirmed that CNA N had not transferred resident 4 using the full-body mechanical lift on 2/23/24 which resulted in the skin tear to her left lower leg.</p> <p>*The wound was still healing.</p> <p>*Her skin condition made it hard for wounds to heal.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Scotchman Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 503 West Pine Philip, SD 57567	
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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>*The investigation process included interviewing resident 4 and CNA N to get the whole story related to the accident.</p> <p>*They also interviewed other staff and residents to determine if anyone had concerns with the care that CNA N was providing.</p> <p>*CNA N was reeducated on safe resident transferring and the importance of communicating with coworkers and following residents' care plans.</p> <p>*DON B reeducated all staff at the monthly staff meeting in February 2024.</p> <p>-Those staff who were not in attendance were reeducated prior to their next working shift on accident hazards and following residents' care plans.</p> <p>6. Random interviews with residents during the survey on 12/17/24, 12/18/24, and 12/19/24 revealed no other residents voiced concerns regarding potential neglect.</p> <p>7. Observations and interviews during the survey on 12/17/24, 12/18/24, and 12/19/24 with nursing staff throughout the survey revealed appropriate resident transfers according to residents' care plans.</p> <p>8. Review of staff training records revealed staff were educated about the above resident's accident and re-educated about following residents' care plans on 2/26/24 and 2/28/24.</p> <p>9. The provider's implemented systemic actions to ensure the deficient practice does not reoccur was confirmed on 12/19/24 after record review revealed the facility had followed their quality assurance process, education was provided to all staff about accident prevention and following resident care plans, and observations and interviews revealed staff understood the education provided regarding those topics.</p> <p>Based on the above information, non-compliance at F600 occurred on 2/23/24, and based on the provider's implemented corrective actions for the deficient practice confirmed on 12/19/24, the non-compliance is considered past non-compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Scotchman Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 503 West Pine Philip, SD 57567	
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>51816</p> <p>Based on observation, record review, interview, and policy review, the provider failed to ensure four of sixteen sampled residents (4, 8, 21, and 22) had their care plans updated, and revised promptly to reflect their current status and care needs. Findings include:</p> <p>1. Observation on 12/17/24 at 3:42 p.m. in resident 4's room revealed:</p> <p>*There was an oxygen concentrator machine next to her sink.</p> <p>*She was using the portable oxygen machine at the time.</p> <p>-The flow rate was set at 2L/min (liters per minute) via nasal cannula.</p> <p>Review of resident 4's electronic medical record revealed:</p> <p>*There were two physician's orders related to her supplemental oxygen:</p> <p>-Oxygen 1-10 liters to be applied PRN [as needed] via NC [nasal cannula] or high flow NC to maintain SPO2 [oxygen saturation] above 90% as needed for hypoxia. Ordered on 6/30/23.</p> <p>-Oxygen 1-10 liters to be applied PRN via NC or high flow NC to maintain SPO2 above 90% three times a day. Ordered on 6/30/23.</p> <p>*Her care plan included the following intervention:</p> <p>-Apply oxygen PRN 1-5L NC to maintain oxygen level above 90%. Date initiated 2/17/20. Revised on 7/12/23.</p> <p>46453</p> <p>2. Interview on 12/17/24 at 1:06 p.m. during entrance conference with administrator A, director of nursing (DON) B, and clinical care coordinator/social service director (CCC/SSD) C revealed the facility was a non-smoking facility and there were no residents who smoked.</p> <p>Review of resident 8's medical record revealed:</p> <p>*Her admitted was 11/1/23.</p> <p>*Her diagnosis included: dementia, depression, psychotic disturbance, mood disturbance, anxiety, history of urinary tract infections, history of pulmonary embolism, hearing loss, osterarthritis, wedge compression fracture of first lumbar vertebra, chronic obstructive pulmonary disease and chronic bronchitis.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Scotchman Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 503 West Pine Philip, SD 57567	
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of resident 8's care plan revealed:</p> <ul style="list-style-type: none"> *Monitor location every 2 hours and PRN. Document wandering behavior and attempted diversional interventions in behavior note. -There were no specific diversional interventions listed. *Provide resident with preferred food sources to encourage consumption. -There were no specific preferred foods listed. *An 11/14/23 intervention of Educate the resident/family/caregiver about: ., the adverse effects of tobacco and alcohol, . -The resident 8 did not use tobacco. <p>3. Review of resident 21's medical record revealed:</p> <ul style="list-style-type: none"> *He had a diagnosis of dementia. *His Brief Interview of Mental Status score was 4, which indicated he had severe cognitive impairment. *He resided in the memory care unit. *His care plan included he was ambulatory and had a history of wandering. -Interventions for his wandering included: <ul style="list-style-type: none"> -Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. --There were no specifically identified pleasant diversions, structured activities, food, conversation, television, books. <p>4. Observation on 12/17/24 at 4:01 p.m. of resident 22 in her room revealed:</p> <ul style="list-style-type: none"> *She was awake and lying in bed. *There was an oxygen concentrator in the room that was providing her oxygen through a nasal cannula. <p>Review of resident 22's care plan revealed:</p> <ul style="list-style-type: none"> *There was a revised 8/14/23 intervention that included Encourage resident to avoid alcohol, smoking, <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Scotchman Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 503 West Pine Philip, SD 57567	
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*There was a revised 8/7/23 intervention that included Encourage resident to . stop smoking, .</p> <p>-Resident 22 did not smoke.</p> <p>5. Interview on 12/18/24 at 5:11 p.m. with Minimum Data Set nurse D, CCC/SSD C, and DON B, regarding the provider's care plan process revealed:</p> <p>*Care plans were reviewed each quarter and with a significant change of condition or status by the interdisciplinary team.</p> <p>-Resident care changes could happen daily.</p> <p>-The interdisciplinary team included the resident, their family or representative, CCC/SSD, DON, dietary manager, activity director, a nurse, therapy staff, a CNA and the resident's medical provider.</p> <p>*Any staff member with appropriate access to the resident's medical record was able to change the resident's care plan.</p> <p>*The facility was a non-tobacco and smoke free facility.</p> <p>*CCC/SSD C confirmed that several areas of resident's care plans were general and were the same care plan interventions for multiple residents that were not person-centered care for each resident.</p> <p>-She confirmed the resident's care plans were not updated or revised in those areas.</p> <p>6. Review of the provider's 6/2022 Comprehensive Care Plan policy revealed:</p> <p>*The Interdisciplinary Team in conjunction with the resident and his/her family/representative develops and implements a comprehensive, person-centered care plan for each resident.</p> <p>*The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.</p> <p>*Care plan interventions are chosen only after careful data gathering, proper sequencing of events, and careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.</p> <p>*The Interdisciplinary Team must review and update the care plan:</p> <p>-a. When there has been a significant change in the resident's condition</p> <p>-b. When the desired outcome is not met</p> <p>-c. When the resident has been readmitted to the facility from a hospital stay</p> <p>-d. At least quarterly, in conjunction with the required quarterly MDS assessment.</p> <p>43844</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Scotchman Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 503 West Pine Philip, SD 57567	

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 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50915</p> <p>Based on record review, observation, interview, and policy review, the provider failed to adequately treat pressure injuries for one of one sampled resident (11) by not following wound care nurse recommendations, and not notifying the resident's physician, resulting in a non-healing pressure injury. Findings include:</p> <p>1. Review of resident 11's electronic medical record (EMR) revealed:</p> <ul style="list-style-type: none"> *He had decreased feeling in his lower legs due to paraplegia (the inability to voluntarily move the lower extremities) from a previous spinal cord injury. *He also had diagnoses of congestive heart failure and dementia. *He had a pressure related injury to his left lateral ankle diagnosed on [DATE]. *His wound care was being managed by wound care registered nurse (RN) G. *RN G assessed his wound once weekly and placed orders for how to care for the pressure injury. <p>2. Review of resident 11's care plan revealed:</p> <ul style="list-style-type: none"> *The resident has an ADL [activities of daily living] self-care performance deficit r/t [related to] paraplegia. *BATHING/SHOWERING: The resident requires extensive assist with 1 to 2 staff with bed bath 2x [two times] weekly and as necessary. *BED MOBILITY: The resident is able to assist with turning in bed with use of grab bars. Staff assist of 1-2 needed for position changes. *Resident transferred with staff assist of 2 and hoyer lift [mechanical lift that uses a sling] when getting out of bed or obtaining weights. *The resident has potential for pressure ulcers r/t immobility and paraplegia. <p>-Assess/record/monitor wound healing q [every] Week. Measure length, width, depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD [physician]. Revision on: 12/31/2020.</p> <p>-Follow facility policies/protocols for the prevention/treatment of skin breakdown. Date Initiated: 12/28/2020.</p> <p>-Wash feet daily with warm soap and water, pat dry. Apply silicone cream. Ensure heels and LEFT lateral ankle is floated at all times. Date Initiated: 04/05/2021. Revision on 03/02/2023.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Scotchman Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 503 West Pine Philip, SD 57567	
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 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Wound care nurse to assess on Wednesdays. Date Initiated: 07/13/2023.</p> <p>-Heel protectors on while in bed and in wheelchair. Nurse to check skin and placement every shift. Date Initiated: 10/23/2023.</p> <p>-Ensure LEFT lateral ankle is floated [elevated to avoid pressure] with pillow support whenever in bed. Date Initiated: 12/17/2024.</p> <p>3. Observation on 12/17/24 at 3:16 p.m. of resident 11 revealed the resident laying in his bed with his left ankle not floated, laying directly on a pillow without support under his calf.</p> <p>4. Observation on 12/18/24 at 2:15 p.m. RN G performing a dressing change on resident 11's left ankle pressure injury revealed:</p> <p>*The dressing was removed, there was a small amount of blood-tinged drainage to the dressing.</p> <p>*A small circular wound to his left outer ankle.</p> <p>*RN G measured the wound, measurements were 0.8 cm (centimeters) x (by) 0.5 cm.</p> <p>*The wound was cleansed with wound cleaner.</p> <p>*New dressing was applied.</p> <p>*Resident 11 did not have complaints of pain.</p> <p>5. Observation on 12/18/24 at 2:45 p.m. revealed a sign on resident 11's closet door that read, Float Left Outer Ankle. Remove heel protector and use it and a pillow under the calf area. This should float the heel as well, preventing pressure injury to it. Thank you! [RN G].</p> <p>6. Observations on 12/18/24 at 5:00 p.m. and 6:23 p.m. revealed the resident laying in his bed with his left ankle not floated, laying directly on a pillow without support under his calf.</p> <p>7. Observation and interview on 12/19/24 at 11:43 a.m. with RN F of resident 11 in his room revealed:</p> <p>*RN F reported that the wound care RN would see the resident weekly on Wednesdays.</p> <p>-She reported that care instructions would frequently change after the wound care nurse visit, and those instructions usually were not verbalized to nursing staff, but were updated in the resident's care plan.</p> <p>*The resident was sitting up in his wheelchair.</p> <p>*His left ankle was resting on a pillow with no pillow support under his calf to float it.</p> <p>*RN F's definition of floating the resident's ankle would be by placing main support under the resident's calf to avoid pressure on the resident's ankle.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Scotchman Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 503 West Pine Philip, SD 57567	
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 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-When the surveyor asked if the resident's ankle was floated, RN F replied No.</p> <p>-She agreed that a lack of circulation to the resident's wound could delay wound healing.</p> <p>8. Interview on 12/19/24 at 11:55 a.m. with resident 11 revealed:</p> <p>*He was unsure of how long he had resided at the facility.</p> <p>*He reported he received good care from the staff.</p> <p>*He was unsure of how long he had the pressure injury to his left ankle.</p> <p>*He had some sensation in his lower extremities, but the pressure injury did not hurt.</p> <p>9. Interview on 12/19/24 at 10:15 a.m. with director of nursing (DON) B and clinical care coordinator (CCC) C revealed:</p> <p>*Resident 11 could be difficult to provide care for due to his decreased sensation in his lower extremities and his inability to convey his feeling of discomfort to staff.</p> <p>*DON B followed the wound care of resident 11.</p> <p>*DON B expected her staff to follow the orders of the wound care nurse.</p> <p>*DON B reported that it was her impression that resident 11 should only have had his left heel floated when he was in bed.</p> <p>*DON B did not always agree with the care recommendations of the wound care nurse.</p> <p>*When asked if there had been any attempt to consult a physician when the DON was not in agreement with the wound care nurse, she responded that it was difficult to step on toes.</p> <p>10. Review of resident 11's progress notes documented by wound care RN G related to the left ankle pressure injury revealed:</p> <p>*10/23/24 Skin/Wound note, Outcome: Not progressing-LEFT lateral not floated upon arrival 10/23.</p> <p>*11/20/24 Skin/Wound note, Resident resting in bed upon arrival. Agrees to wound assessment and cares. Ankle not floated upon arrival. Staff education needed. Float instructions hanging above bed., Wound Healing % -166.67.</p> <p>*11/27/24 Skin/Wound note, Wound Healing % 0.</p> <p>*12/4/24 Skin/Wound note, Wound Healing % 0.</p> <p>*12/11/24 Skin/Wound note, Wound is stagnant with little to no progress., Wound Healing % 0.</p> <p>*12/18/24 Skin/Wound note, Wound Healing % -33.33.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Scotchman Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 503 West Pine Philip, SD 57567	
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 0686 Level of Harm - Actual harm Residents Affected - Few	<p>*There was no documentation that the resident's physician was notified of the lack of healing for the left ankle pressure injury.</p> <p>11. Review of the providers 12/2019 Pressure Ulcers policy revealed:</p> <p>*10. Pressure ulcers will be treated as ordered by the physician and/or wound care RN and documented in the medical record.</p> <p>*11. No change or deterioration in a pressure ulcer over a 2-4 week period of time will warrant physician notification for evaluation of the current treatment plan.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Scotchman Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 503 West Pine Philip, SD 57567	

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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51816</p> <p>Based on observation, record review, interview, and policy review, the provider failed to follow their Resident Weight policy and notify the registered dietitian (RD) and begin follow-up for one of one sampled resident (34) who experienced a significant weight loss. Findings include:</p> <p>1. Observation on 12/17/24 at 3:37 p.m. revealed resident 34:</p> <ul style="list-style-type: none"> *Was asleep in a group/activity room recliner with a hat and glasses on. *His clothes were loose-fitting. <p>2. A review of resident 34's medical record revealed:</p> <ul style="list-style-type: none"> *He was admitted on [DATE]. *His 10/18/24 Brief Interview of Mental Status (BIMS) assessment score was 99, indicating he had not participated or was unable to participate in the assessment. *His diagnoses included vascular dementia (a type of dementia caused by reduced blood flow to the brain) with anxiety, cerebral infarction (stroke), and depression. *Review of the resident's weight records revealed: <ul style="list-style-type: none"> -On 10/10/24, he weighed 186.4 pounds. -On 11/2/24, he weighed 185.4 pounds. On 11/9/24, he weighed 178.6 pounds. --A loss of 6.8 pounds in one week. -On 12/13/24, he weighed 170.6 pounds which was an 8.5% weight loss since his admission. *His care plan interventions for his weight included: <ul style="list-style-type: none"> -To Monitor/document/report PRN [as needed] any signs/symptoms of dysphagia [difficulty swallowing]: Pocketing [when someone holds food in their mouth rather than swallowing], Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals initiated on 10/24/24. -RD [registered dietitian] to evaluate and make diet change recommendations PRN [as needed] initiated on 10/24/24. *On 11/15/2024, the resident had an outpatient dentist appointment to check his denture fit. -The dentist's progress note indicated: <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Scotchman Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 503 West Pine Philip, SD 57567	
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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>--He had not seen any sore spots.</p> <p>--The resident was not able to wear his dentures predictably due to dementia.</p> <p>--Please use soft foods- patient is not likely to keep dentures in.</p> <p>---The progress note was acknowledged by a nurse in his chart, and the note was entered into his electronic medical record (EMR).</p> <p>*On 12/12/24, the registered dietician (RD) performed a significant weight change assessment on the resident and recommended continuing his current diet order and added a Magic Cup (a nutritional supplement) once a day.</p> <p>-She did not change the resident's regular diet to a soft diet.</p> <p>*His dietary orders included:</p> <p>-Regular diet, regular consistency, large portions at meals. These were ordered on 10/10/24 on admission.</p> <p>--The diet orders had not been changed related to the dentist's 11/15/24 diet recommendation.</p> <p>-Magic Cup one time a day at noon, ordered on 12/13/24.</p> <p>*On 12/18/24 at 2:10 p.m., a nurse's note indicated that he had refused to wear his dentures that morning.</p> <p>3. Interview on 12/18/24 at 3:59 p.m. with RD (M) regarding resident 34 revealed:</p> <p>*She had reviewed the resident's weight last week while performing a significant weight loss assessment and started an intervention of adding a nutritional supplement.</p> <p>-She was unaware of the dentist's 11/15/24 recommendation for a soft diet until 12/18/24.</p> <p>Interview on 12/18/24 at 4:17 p.m. with dietary department manager J regarding resident 34 revealed:</p> <p>*He was not aware resident 34 was to have a soft diet until 12/18/24.</p> <p>*He stated the speech therapist emailed him on 12/18/24 of the diet change.</p> <p>-He was unable to find a soft diet order in the resident's current orders.</p> <p>4. A review of the provider's 5/15/23 Resident Weight policy revealed:</p> <p>*Weight Assessment</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Scotchman Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 503 West Pine Philip, SD 57567	

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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- 3. Any weight change of 5 lbs more or less since the last weight assessment is retaken the next day for confirmation.</p> <p>--a. If the weight is verified, nursing will immediately notify the dietician in writing.</p> <p>*Evaluation</p> <p>- 1. Undesirable weight change is evaluated by the treatment team whether or not the criteria for significant weight change has been met. The evaluation includes:</p> <p>--c. the relationship between current medical condition or clinical situation and recent fluctuations in weight</p> <p>- 2. The physician and the multidisciplinary team identify conditions and medications that may be causing anorexia, weight loss or increasing risk of weight loss.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Scotchman Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 503 West Pine Philip, SD 57567	

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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>46453</p> <p>Based on observation, interview, record review, and policy review, the provider failed to follow their policy related to oxygen administration for two of five sampled residents (4 and 12) who received oxygen therapy:</p> <ul style="list-style-type: none"> *Resident 4's oxygen tubing was not dated. *Resident 12's oxygen tubing was not changed monthly per facility policy. *Resident 4's nasal cannula was observed on the floor during one of three observations. *Resident 4's foam filter on the back of the oxygen concentrator machine had a buildup of dust. <p>Findings include:</p> <p>1. Observation and interview on 12/17/24 at 3:42 p.m. with resident 4 in her room revealed:</p> <ul style="list-style-type: none"> *She was wearing a nasal cannula and using a portable oxygen tank. That tubing was not dated. *There was an oxygen concentrator machine next to her sink. -The foam filter on the back of the machine had a buildup of dust and fuzz. -The nasal cannula for that machine was on the floor. <p>2. Observation on 12/18/24 at 9:39 a.m. in resident 12's room revealed:</p> <ul style="list-style-type: none"> *There was a section of extension tubing from the oxygen concentrator machine to the water chamber with a handwritten date of 9/28 on it. *The water chamber had a handwritten date of 12/13/24 on it. <p>3. Interview on 12/18/24 at 2:28 p.m. with registered nurse (RN) F revealed:</p> <ul style="list-style-type: none"> *They previously used plastic baggies to store the residents' oxygen tubing when not in use. Residents did not like these baggies and would throw them in the trash. *They now used hooks that were adhered to the side of the concentrator machines to wrap the oxygen tubing around when not in use to keep it off the floor. *She expected staff to replace a nasal cannula if it was found on the floor. *The reason why resident 12's oxygen extension tubing had not been replaced was due to supply issues. <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Scotchman Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 503 West Pine Philip, SD 57567	

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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-They did not have that particular tubing in stock.</p> <p>-The employee in charge of ordering supplies went on medical leave for approximately two months, and the backup person was not aware of that specific type of extension tubing to ensure it was ordered and available.</p> <p>*She indicated that sometimes cleaning the filter each week does not get done like it should.</p> <p>4. Observation on 12/18/24 at 2:50 p.m. in resident 4's room revealed:</p> <p>*The nasal cannula was stored wrapped up and tucked under the handle of the oxygen concentrator machine. The nasal cannula was not on the floor.</p> <p>*There was no indication to note if the nasal cannula had been replaced or not.</p> <p>*The foam filter was still dusty.</p> <p>5. Interview on 12/18/24 at 2:59 p.m. with certified nurse assistant (CNA) N about oxygen tubing revealed:</p> <p>*The nurses changed the residents' oxygen tubing weekly.</p> <p>*If he found a nasal cannula on the floor, he would have wiped it off with an alcohol wipe, wrapped the tubing up, and tucked it under the handle of the oxygen concentrator machine.</p> <p>6. Interview on 12/18/24 at 4:45 p.m. and again on 12/19/24 at 8:12 a.m. with director of nursing (DON) B revealed:</p> <p>*She expected the residents' oxygen tubing to be changed monthly.</p> <p>*The backup supply person may not have known about that style of extension tubing to be able to order it.</p> <p>*She expected the foam filters on the oxygen concentrators to be cleaned weekly.</p> <p>*RN F was usually responsible for ordering the oxygen tubing supplies for residents.</p> <p>-She indicated that RN F was probably waiting for [the employee in charge of ordering supplies] to get back to order that part.</p> <p>*She confirmed that oxygen extension tubing was about two months overdue for changing.</p> <p>7. Review of resident 4's physician orders revealed:</p> <p>*Change O2 [oxygen] tubing on concentrator/tank Q month [every month].</p> <p>-That order was scheduled one time a day every 14 day(s).</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Scotchman Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 503 West Pine Philip, SD 57567	

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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Clean O2 concentrator filter Q week [every week] one time a day every 7 day(s).</p> <p>*Those orders were placed on 6/6/23.</p> <p>8. Review of resident 4's December Treatment Administration Record revealed that the filter was documented as having been cleaned on 12/5/24 and 12/12/24.</p> <p>9. Review of the provider's 9/23 Oxygen Administration policy revealed:</p> <p>*Maintenance:</p> <ul style="list-style-type: none"> -1. Oxygen tubing is to be changed monthly. -2. Concentrator filters are to be cleaned and checked monthly. -3. Humidifier containers are to be cleaned weekly with a 1:1 [1 to 1] vinegar/water solution or as per manufacturer recommendations. <p>*Documentation:</p> <ul style="list-style-type: none"> -1. After completing the oxygen set up or adjustment, the following information should be documented in PCC [PointClickCare]. --a. The date and time the oxygen was applied . <p>*Reporting:</p> <ul style="list-style-type: none"> - .2. Report other information in accordance with facility policy and professional standards of practice.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Scotchman Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 503 West Pine Philip, SD 57567	
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46453</p> <p>Based on observation, interview, and document review, the provider failed to properly label foods and discard foods on or before the manufacturer's best-by date, and failed to maintain the following kitchen items in a clean and sanitary manner:</p> <p>*In the kitchenette:</p> <ul style="list-style-type: none"> -The flattop grill. -The grease trap drawer beneath the flattop grill. -The juice dispenser. -The overhead ventilation hood panels. <p>*In the main kitchen:</p> <ul style="list-style-type: none"> -The ceiling and ceiling vents throughout the kitchen. -The grease trap drawer beneath the flattop grill. -The deep fat fryer and the spaces in between the fryer and the adjacent equipment. <p>Findings include:</p> <p>1. Observation on 12/17/24 at 1:27 p.m. in the kitchenette revealed:</p> <ul style="list-style-type: none"> *The flattop grill was stained with a burnt-on substance. *The grease trap drawer beneath the flattop grill contained a thick brown sludge of burnt food and grease. *There was a layer of dust buildup on the overhead ventilation hood panels. *There was an unidentified white growth inside the grape juice dispenser. <p>2. Continued observation on 12/17/24 at 1:41 p.m. in the main kitchen revealed:</p> <ul style="list-style-type: none"> *There was a buildup of dust on the ceiling and ceiling vents throughout the kitchen, including above food preparation areas. *The grease trap drawer underneath the flattop grill was filled with a yellowish oily liquid. There were bits of what appeared to be eggs floating around in that liquid. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Scotchman Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 503 West Pine Philip, SD 57567	
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>*The sides of the deep fat fryer were covered in crumbs and grease.</p> <p>-The fryer was situated in between the gas stovetop and the ovens.</p> <p>-There was a buildup of grease and food crumbs on the paneling of the stovetop and the oven, which was a potential fire hazard as the gas stovetop used an open flame to operate.</p> <p>*In one of the reach-in coolers, there were two foods past the manufacturer's best by dates:</p> <p>-One opened jug of lime juice with BEST BEFORE 2024 [DATE].</p> <p>-One opened container of pesto with BEST IF USED BY: 11.11.2024.</p> <p>*There was a container of orange powder with a handwritten label of Taco Seasoning 6.1.23 - 6.1.24.</p> <p>-A measuring scoop was stored inside that container.</p> <p>*There were two large containers of what appeared to have been sugar and flour. There was no label or date on them.</p> <p>3. Interview on 12/18/24 at 3:28 p.m. with cook I revealed that the juice machine was supposed to have been taken apart and cleaned weekly.</p> <p>4. Interview on 12/18/24 at 3:51 p.m. with certified dietary manager (CDM) J revealed:</p> <p>*The overhead ventilation hoods were cleaned professionally every six months.</p> <p>-The hood panels were cleaned as needed by himself or the dietary staff.</p> <p>-He estimated the hood panels in the kitchenette had not been cleaned in approximately a month and a half.</p> <p>-That task was not on the cleaning checklist.</p> <p>*The deep fat fryer was cleaned at least every two weeks, but sometimes more depending on the menu.</p> <p>*Staff were cleaning the fryer that day.</p> <p>*He recently put the protective guards up as another layer of protection between the fryer and the gas stovetop.</p> <p>5. Interview on 12/18/24 at 4:20 p.m. with cook I revealed:</p> <p>*The grease trap drawers were supposed to have been cleaned daily.</p> <p>*She was not sure why there was so much liquid in the grease trap drawer in the main kitchen.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Scotchman Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 503 West Pine Philip, SD 57567	
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>*The flattop grill in the kitchenette was hardly ever used, and she was unsure about when the grill or the grease trap drawer were last cleaned.</p> <p>6. Interview on 12/18/24 at 4:30 p.m. with dietary aide (DA) H in the kitchenette revealed:</p> <p>*The flattop grill in the kitchenette was not used often as it would take a long time to warm up and clean afterwards.</p> <p>-She did not know when it was last cleaned.</p> <p>*The juice machine was supposed to have been cleaned weekly.</p> <p>-She indicated the juice machine was not always cleaned weekly as it took a long time to drain it, put warm water through it, take it apart, bring it back to the kitchen, wash it, bring it back to the kitchenette area, and put it back together again.</p> <p>7. Interview on 12/19/24 at 10:28 a.m. with CDM J revealed:</p> <p>*He expected staff to wipe down the ceilings and vents once per week.</p> <p>-He indicated the task on the checklist was to wipe the walls down, but he expected staff to wipe the ceilings as well.</p> <p>-He was aware that task does not always get done.</p> <p>*The grease trap drawer in the main kitchen fills up with liquid daily as they pour large volumes of water and lemon juice onto the grill to clean it. That liquid pours down the drain into the drawer.</p> <p>*He expected the drawers to have been cleaned daily.</p> <p>*He was not aware of the unidentified white growth or sediment in the grape juice dispenser.</p> <p>-He expected the juice dispenser to have been disassembled and cleaned weekly.</p> <p>-He explained that some staff may not take the machine all the way apart because they did not know how to take it apart or put it back together.</p> <p>--He confirmed there are directions to do so on the inside of the juice dispenser door.</p> <p>*He confirmed the food items that were past their best-by dates were thrown away.</p> <p>8. Review of the provider's Daily [NAME] Cleaning List for the week of 12/8/24 through 12/14/24 revealed all items on the cook's list were initialed off as having been completed.</p> <p>9. Review of the provider's Weekly Cleaning List from 11/17/24 through 12/14/24 revealed:</p> <p>*Cleaning the deep fat fryer was not included on the list.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Scotchman Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 503 West Pine Philip, SD 57567	

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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Someone had written that the fryer was cleaned the week of 12/1/24 to 12/7/24.</p> <p>*Cleaning the overhead ventilation hood panels was not on the list.</p> <p>*Wiping the ceiling and ceiling vents was not on the list.</p> <p>*Cleaning the flattop grill and the grease trap drawer was not on the list.</p> <p>*Cleaning the juice machine was a weekly task on Fridays. That task was initialed as having been completed each week.</p> <p>10. Review of the provider's 8/28/23 policy that did not have a title revealed:</p> <p>*POLICY STATEMENT</p> <p>-It is the policy of the Dietary Department that all perishable foods are refrigerated at the appropriate temperature and in an orderly and sanitary manner.</p> <p>*There were no guidelines describing expectations on labeling and storage of bulk items like sugar, flour, and taco seasoning.</p> <p>*There were no guidelines describing expectations on storage of foods past the manufacturer's best-by date.</p>