

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025
NAME OF PROVIDER OR SUPPLIER Michael J Fitzmaurice South Dakota Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 Minnekahta Avenue Hot Springs, SD 57747	

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>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), observation, record review, and interview, the provider failed to protect the resident's right to be free from neglect by one of one licensed practical nurse (LPN) (U) who failed to initiate standing orders for an upset stomach for one of one sampled resident (210) after he became sick in the dining room at supper time and later that night aspirated on his emesis and passed away. This citation is considered past non-compliance based on a review of the corrective actions the provider implemented immediately following the incident. Findings included:</p> <p>1. Review of the provider's SD DOH FRI submitted on 2/14/25 at 10:35 a.m. revealed:</p> <p>*Nurse manager P had been completing a chart audit for an Ombudsman report regarding resident 210 and had concerns regarding some missing documentation the day before he passed away.</p> <p>*Nurse manager P had completed a camera review and discovered resident 210 had an episode of emesis (vomiting) in the dining room on 1/24/25 at 5:45 p.m. before the evening meal.</p> <p>-Staff had taken resident 210 to his room to clean him up and then brought him back to the dining room.</p> <p>-Staff had placed a full meal in front of him when he returned from his room after he had been cleaned up.</p> <p>--Resident 210 had eaten 100% of his supper.</p> <p>*Later during the evening shift, resident 210 was found to have aspirated on his emesis and passed away in his room.</p> <p>*Nurse manager P reviewed resident 210's daytime documentation in his electronic medical record (EMR) and it had shown:</p> <p>-On 1/24/25 LPN U did not document that he had an emesis during the evening meal. The documentation stated he had no complaints of pain.</p> <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: 43A136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025
NAME OF PROVIDER OR SUPPLIER Michael J Fitzmaurice South Dakota Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 Minnekahta Avenue Hot Springs, SD 57747	
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>-There was no documentation that LPN U initiated the standing orders for an upset stomach, made any changes to his diet such as from a regular diet to clear liquids, no assessments of the residents condition were completed, and no vital signs were taken.</p> <p>*Homemaker X had reported to LPN U that resident 210 was not feeling well and that he had stomach pains.</p> <p>*LPN U was placed on administrative leave effective 2/12/25.</p> <p>*An investigation was initiated by staff interviews.</p> <p>*Education was provided to all staff that included understanding of the documentation processes, assessments, vital sign assessments, the importance of comprehensive change of shift reporting, and a change of a resident's condition.</p> <p>2. Review of resident 210's EMR revealed:</p> <p>*He was admitted on [DATE] and his diagnoses included dementia, chronic obstructive pulmonary disease (COPD), atrial fibrillation (irregular, rapid heart rate), diabetes, chronic kidney disease, post-traumatic stress disorder (PTSD), Parkinson's disease, and hypertension (high blood pressure).</p> <p>*His Brief Interview for Mental Status (BIMS) assessment score was 1, which indicated he was severely cognitively impaired.</p> <p>On 5/1/25 at 11:46 a.m. LPN U's personal file was requested from DON A, but it had been closed and sent to the Human Resources Department.</p> <p>3. Interview on 5/1/25 at 1:46 p.m. with director of nursing (DON) A regarding resident 210 revealed she:</p> <p>*Had watched the 1/24/25 camera footage and had seen LPN U put her hand on resident 210's head but LPN U did not listen to his stomach or do any vitals after his emesis.</p> <p>*Stated LPN U did not initiate the standing order for an upset stomach.</p> <p>*Stated the staff gave resident 210 a regular diet that evening instead of thin liquids for his upset stomach.</p> <p>*Stated LPN U reported to the night nurse that he had an emesis once but was fine.</p> <p>4. Homemaker X was unavailable for an interview at the time the survey was conducted.</p> <p>5. Phone interview on 5/1/25 at 3:07 p.m. with agency certified nursing assistant (CNA) V regarding resident 210 revealed:</p> <p>*She was working the evening shift on 1/24/25 and had heard that resident 210 had an emesis earlier that day.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025
NAME OF PROVIDER OR SUPPLIER Michael J Fitzmaurice South Dakota Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 Minnekahta Avenue Hot Springs, SD 57747	
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>*She had heard a loud sound coming from resident 210's room after supper.</p> <p>-He was sitting on the side of his bed, and his walker had fallen over.</p> <p>*He had told her he wanted to lie down and rest.</p> <p>*She stated she raised the head of the bed 45 to 60 degrees due to him having emesis earlier that day.</p> <p>*She stated she checked on him until 10:00 p.m., then she left due to being assigned to another resident area. It wasn't until later when the nurse in that neighborhood got a call from a CNA that resident 210 had aspirated and needed assistance.</p> <p>6. Phone interview on 5/1/25 at 3:11 p.m. with agency licensed practice nurse (LPN) W regarding resident 210 revealed:</p> <p>*She was working the evening shift on 1/24/25 and had heard he had an emesis earlier that day and later that evening, she got a call from a CNA that resident 210 had aspirated and needed assistance.</p> <p>*She stated that when she had gotten to his room, he was air hungry; and he had an advanced directive of a do-not-resuscitate.</p> <p>-She stated the head of the bed was elevated 45 to 60 degrees.</p> <p>*She had called his power of attorney (POA), and the POA said to make him comfortable, and when she returned to resident 210's room, he had passed away within one to two minutes.</p> <p>*She said he had emesis all over his clothes and while she cleaned him up and turned him over to his side, more of the emesis had come out of his mouth.</p> <p>7. Interview on 5/1/25 at 4:27 p.m. with DON A regarding LPN U revealed:</p> <p>*LPN U had multiple coaching sessions with a nurse educator.</p> <p>*The nurse educator would often be with LPN U on the floor, ensuring LPN U completed her nursing duties as required.</p> <p>*She stated LPN U's performance had improved for a while.</p> <p>*Some of the issues they had with LPN U included her lack of safety measures, which included not locking the medication cart, not using appropriate hand hygiene, failure to accurately chart on residents, failure to properly assess residents conditions, and medication administration errors.</p> <p>*They continued to investigate LPN U's competency as a nurse, and had moved forward with termination.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025
NAME OF PROVIDER OR SUPPLIER Michael J Fitzmaurice South Dakota Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 Minnekahta Avenue Hot Springs, SD 57747	
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>The provider implemented actions to ensure the deficient practice does not recur was confirmed after record review revealed the facility had followed their quality assurance process, education was provided to all staff regarding understanding of documentation processes, assessments, vital sign assessments, the importance of comprehensive change of shift reporting, and a change of a resident's condition. Audits were being continued for completion of nursing assessments after an incident and discussed in QAPI. Interviews and observations indicated staff understood the education provided.</p> <p>Based on the above information, non-compliance at F600 was determined to have occurred on 1/24/25, and the provider's implemented 3/23/25 corrective actions for the deficient practice confirmed on 5/1/25; the non-compliance is considered past non-compliance.</p>		