

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/09/2026
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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the provider failed to ensure that the resident's baseline care plan (a standardized, person-centered guide developed for newly admitted residents) was completed, reviewed with the resident or the resident's representative, and that a written copy was provided to the resident or their representative within 48 hours of the resident's admission to the facility for two of two sampled residents (8 and 48). Findings include: 1. Review of resident 8's electronic medical record (EMR) revealed that he admitted to the facility on [DATE]. He had a 6/15/26 Brief Interview for Mental Status (BIMS) assessment score of 14, which indicated his cognition was intact. There was no baseline care plan in his EMR, and no documentation that it had been reviewed with him or his representative. A copy of the baseline care plan was requested. In response to the request, the facility provided a copy of the care plan (a personalized plan that addresses a resident's care needs, goals, and interventions) dated 6/17/26 that had a handwritten note on it that read Baseline CP [care plan]. The care plan was not signed by the resident or the resident's representative. 2. Review of resident 48's EMR revealed that he was admitted to the facility on [DATE]. He had a 7/7/26 BIMS assessment score of 9, which indicated his cognition was moderately impaired. There was no baseline care plan in his EMR, and no documentation that it had been reviewed with him or his representative. A copy of the baseline care plan was requested. In response to the request, the facility provided a copy of the care plan dated 7/8/26. A handwritten note on the care plan read Baseline CP. The care plan was not signed by the resident or the resident's representative. 3. Interview on 7/9/26 at 3:11 p.m. with director of nursing (DON) B revealed that registered nurse (RN)/Minimum Data Set (MDS) coordinator C was responsible for completing the residents' baseline care plans. DON B was asked whether she could provide the baseline care plans for residents 8 and 48. She stated she was having difficulty locating the baseline care plans in the EMR and called RN/MDS coordinator C to her office to assist. RN/MDS coordinator C stated, You're not going to find them. They're not in there. She explained that their process was to use the comprehensive admission assessment to develop the care plan, which was then updated as residents' needs changed. She said that when residents were admitted, she focused more on social aspects, such as dining and the activities they would enjoy. When asked whether she addressed functional abilities and how the staff would know how to care for residents, such as whether a resident would need assistance with transfers, she stated that residents completed a survey prior to admission that covered those topics. She also stated that what residents reported on that survey often differed from what was actually observed. She was aware that baseline care plans were to be completed within 48 hours of admission but stated she did not get them into the EMR within that timeframe. She had gotten away from that. She acknowledged that comprehensive assessments were not completed within 48 hours of admission, as required for (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 43A136

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/09/2026
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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	baseline care plans. When asked whether the baseline care plan was discussed with residents or their representatives and whether they were offered a written copy, RN/MDS coordinator C stated, When they ask for it. We don't document that we offer a copy.		